Optum Tooele County

TREATMENT RECORD AUDIT TOOL FY25

Consumer Name:
Admission Date:
Discharge Date:
Facility Name:
Provider Name:
Reviewer Name:
Chart Review Date:

		Rating Scale: Y = Yes N = No NA = Not Applicable	**Y**	**N**	**NA**
General Documentation Standards					
	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	There is evidence that the member received services within timely access requirements and if the member was placed on a waiting list, they received a follow-up appointment within 20 working days from the date of placement on the waiting list, regardless of diagnosis or treatment needs. *If a timely access appointment was not offered, there is evidence explaining the circumstances.*			
	4	The record is clearly legible to someone other than the writer.			
	5	There is evidence of a Consent for Treatment or Informed Consent in the record, for the member being treated, that is signed by the member and/or legal guardian.			
	6	Members are informed that they have a right to refuse participation in treatment.			
	7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the member and/or family or legal guardian.			
	8	There is evidence the member was offered the Medicaid Handbook and the topics of how to receive services, access to emergency services, transportation, how to choose a provider, and how to file a grievance or appeal were discussed.			
	9	Where there was evidence that an interpreter was needed, an interpreter was used (Family members should not be called upon, nor be allowed to volunteer, to act as an interpreter for a member).			
	10	For Adult Members Only: The member received the Advance Directives brochure.			
	11	For Adult Members Only: There is documentation that Advanced Directives were discussed with the member.			
Initial Assessment					
	12	The reasons for admission or initiation of treatment are indicated.			
	13	The behavioral health treatment history is present and includes the following information: dates and providers of previous treatment, current and past psychotropic medications/interventions and responses.			
	14	The behavioral health treatment history includes family history information.			
	15	A medical history and/or physical exam (appropriate to the level of care) is in the record and includes the following information: known medical conditions, dates, and providers of previous treatment, current treating clinicians, current and past medical medications/interventions and responses.			

	16	The medical treatment history includes family history information.			
	17	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.**			
	18	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred.			
	19	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
	20	For members 12 and older, a substance abuse screening occurs. Documentation includes assessment of past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.			
	21	For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
	22	If assessment shows evidence of current nicotine use, there is documentation of discussion of opportunities for cessation of nicotine use (Nicotine Cessation Initiative).			
	23	If the screening indicates an active alcohol or substance use problem, there is documentation that the member was referred for further SUD specific assessment.			
	24	An educational assessment appropriate to the age and level of care is documented.			
	25	The record documents the presence or absence of relevant legal issues of the member and/or family.			
	26	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse. If these are not endorsed, this is noted.			
	27	When abuse, neglect, or exploitation is indicated, there is documentation of mandatory reporting.			
	28	For Adolescents: The assessment documents a sexual behavior history.			
	29	For children and adolescents, prenatal and perinatal events along with a complete developmental history (physical, psychological, social, intellectual and academic) are documented.			
	30	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).			
	31	The assessment addresses cultural variables that may impact treatment, or lack there of. Culture variables include values, traditions, family, religious/spiritual preferences, beliefs about mental illness, etc.			
	32	A complete mental status exam is in the assessment, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
	33	The initial screen includes an assessment for depression.			
	34	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, danger toward self or others. A completed Columbia-Suicide Severity Risk Scale (C-SSRS) or comprehensive suicide screening is evident.			

	35	The record includes documentation of previous suicidal and homicidal behaviors including dates, method, and lethality. If these are not endorsed, this is noted.			
	36	An initial primary treatment diagnosis is present in the record.			
	37	The assessment includes adequate justification for the diagnosis (i.e., DSM-5 criteria). The diagnostic formulation is comprehensive and includes all relevant diagnoses or rule outs.			
	38	The diagnosis is specified on a document that is signed or co-signed by a Licensed Mental Health Therapist (LMHT); the signature includes the credentials.			
	39	If the diagnosis changed from the initial assessment, a diagnosis update or treatment plan review documents the change.			
	40	If the diagnosis changed, information is documented to substantiate the change.			
	41	For SMI/SED: The SMI/SED form has been completed and is supported by documentation within the assessment. **(Does not apply to Inpatient LOC).**			
	42	For SMI/SED: Members prescribed 1915(b)(3) services meet SMI/SED criteria. **(Does not apply to Inpatient LOC).**			
	43	For SMI/SED: The SMI/SED form is reviewed annually and documentation supports the review. **(Does not apply to Inpatient LOC).**			
	44	Treatment recommendations are documented and supported by the assessment.			
	45	The assessment/re-assessment is signed or co-signed by an LMHT; the signature includes the credentials and date.			
Treatment Planning					
	46	There is documentation (a signed form or in progress note) that the member or legal guardian has agreed to the treatment plan.			
	47	The treatment plan shows evidence of member participation in the development of the goals and objectives.			
	48	Goals are person-centered and relevant to the assessment and diagnosis. If Psychosocial Rehabilitative Services are prescribed, there must be measurable goals specific to each issue being addressed.			
	49	Objectives are measurable, reasonable and relevant to the assessment and diagnosis.			
	50	The treatment plan has estimated time frames for goal attainment.			
	51	Methods are behaviorally measurable and prescribed in amount, frequency and duration and include provider type and place of service.			
	52	There is evidence that the assessment was used in developing the treatment plan.			
	53	A treatment plan is established (at each level of care, if applicable) with goals, treatment priorities, and milestones for progress in the record.			
	54	The treatment plan addresses safety when active risk issues are identified.			

	55	If Yes is answered indicating active suicidal thoughts/ideations on the C-SSRS/suicide screening tool, a Safety Plan is created on same date of service. **(Does not apply to Inpatient LOC).**			
	56	When identified, and with cooperation with the member, treatment plan includes goals and objectives pertaining to cessation of nicotine use.			
	57	The treatment plan is updated whenever goals are achieved or new problems are identified.			
	58	There is evidence the treatment plan/progress is reviewed during individual sessions. Focus should include ongoing assessment of medical necessity, appropriateness of treatment interventions, and progress toward treatment goals and objectives.			
	59	When applicable, the treatment record, **including the treatment plan**, reflects discharge planning.			
	60	If a member is receiving group therapy, there is evidence the group meets the member's needs in the individualized assessment, treatment plan, and progress notes and are in response to identified member needs.			
	61	The treatment record documents and addresses biopsychosocial needs, as appropriate.			
	62	The treatment plan review indicates the member's involvement in care and service.			
	63	When appropriate, the treatment record indicates the family's involvement in the treatment planning process, including care decisions.			
	64	The initial treatment plan/treatment plan review is signed or co-signed by an LMHT; the signature includes the credentials and date.			
Progress Notes					
	65	All progress notes document clearly who is in attendance during each session. **(Does not apply to Inpatient LOC).**			
	66	The progress notes reflect reassessments when necessary.			
	67	The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			
	68	When there is evidence in a progress note of an active suicidal risk, there is evidence of the completion of a C-SSRS/other comprehensive suicide screening tool to assess the risk on that date of service.			
	69	The progress notes describe/list member strengths and limitations and how those impact treatment.			
	70	Each progress note includes documentation that treatment plan goals are addressed during the session.			
	71	Each progress note includes clear documentation of interventions that were utilized.			
	72	Each progress note includes documentation that justifies the need for continued treatment.			
	73	The progress notes describe progress or lack of progress towards treatment plan goals.			

	74	The progress notes show evidence of identifying and working to remove barriers to success in accomplishing goals (e.g., transportation, living arrangements, etc.). **This is a non-scored question.**			
	75	The progress notes document the dates of follow up appointments, if known. If a subsequent appointment has not been scheduled, please note the reason. **(Does not apply to Inpatient LOC).**			
	76	Progress notes reflect missed appointments/gaps in treatment and the frequency of services as outlined in the treatment plan, or documents the reason it does not, including evidence of outreach efforts to re-engage members. **(Does not apply to Inpatient LOC).**			
	77	**Group notes** list the number of members and the name(s) of staff present for each group service in alignment with the client ratio outlined with Medicaid requirements.			
	78	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.			
	79	When appropriate, there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			
	80	Progress notes are signed (or co-signed when applicable); the signature includes the credentials and date.			
Medication					
	81	If the member is on medications, did the prescribing clinician document that the member was provided education about the risks, benefits, side effects, and alternatives to each medication.			
	82	There is documentation that indicates the member understands and consents to the medication used in treatment.			
	83	For children and adolescents, documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.			
	84	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			
	85	If the member is on medication, there is evidence of medication monitoring in the treatment record (physicians and nurses).			
	86	Prescribed lab/urinalysis results and the impact to subsequent treatment is documented in the clinical record.			
Coordination of Care					
	87	Does the member have a medical physician (PCP)? **This is a non-scored question.**			
	88	The record documents that the member was asked whether they have a PCP. **Y or N Only**			
	89	If the member has a PCP there is documentation that communication/ collaboration occurred.			
	90	If the member has a PCP, and there is no collaboration/communication with that provider, there is documentation that the member/guardian refused consent for the release of information to the PCP.			
	91	Is the member being seen by another behavioral health clinician (e.g. prescriber, social worker, psychologist, mental health counselor, substance abuse counselor). **This is a non-scored question.**			

	92	The record documents that the member was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
	93	If the member is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
	94	If the member is being seen by another behavioral health clinician and there is no collaboration/communication with that provider, there is documentation that the member/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer					
	95	Was the member transferred/discharged to another clinician or program? **This is a non-scored question.**			
	96	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
	97	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.			
	98	Prompt referrals to the appropriate level of care are documented when members 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.			
	99	DSM-5/ICD-10 diagnosis is updated/documented at discharge.			
	100	The discharge summary describes the reason(s) for treatment and the extent to which treatment goals were met.			
	101	The discharge/aftercare/safety plan describes specific follow up activities.			
	102	Clinical records are completed within 30 days following discharge.			
Youth Outcome Questionnaire (Y-OQ®) and Outcome Questionnaire (OQ®)					
Information only		The YOQ®/OQ® instruments are to be administered at intake, every 30 days or every visit (whichever is less frequent), and at discharge/ discontinuation of treatment. Administration requirements EXCLUDE: members in member settings, children age 3 and under, or members being treated primarily for substance abuse.			
	103	There is documentation in the chart that the Y-OQ®/OQ® is being administered at intake and every 30 days, or documentation indicates reasons the clinician deems that this tool is not clinically appropriate.			
	104	Treatment plan reviews incorporate Y-OQ®/OQ® data into the decision-making process that either supports the current direction of the treatment plan or that suggests a change in direction.			
	105	There is evidence in the record that Y-OQ®/OQ® scores are shared with member/parents.			
Claims Validation - Member					
	106	Documentation reflects claim demographic information.			
	107	Documentation reflects verification of Member's Medicaid eligibility.			
	108	Documentation reflects service delivery as face-to-face/telehealth/phone interventions.			
Claims Validation - Provider					
	109	Rendering provider is registered with Utah Medicaid.			

	110	Rendering provider is reflected in the documentation.			[redacted]
	111	Rendering provider is appropriately credentialed/qualified for the service.			[redacted]
Claims Validation - Service					
	112	Claim diagnosis is reflected in the documentation.			[redacted]
	113	Claim service code is reflected in the documentation.			[redacted]
	114	Claim date of service is reflected in the documentation.			[redacted]
	115	Claim Unit(s) is/are reflected in the start, stop and duration documentation.			[redacted]
End					