

Practitioner Treatment Record Audit Tool

Provider Name: _____	Discipline: _____
Practice Name: _____	Solo <input type="checkbox"/> Group <input type="checkbox"/>
Provider ID Number: _____	
Provider Location: _____	
Address: _____	Suite: _____
_____	_____
(City) _____	(State) _____
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 <input type="checkbox"/> No <input type="checkbox"/>	
Reason for Review (please check one): Quality Review <input type="checkbox"/> Action Plan Follow-up <input type="checkbox"/> Routine Clinical Record Review <input type="checkbox"/> Recredentialing <input type="checkbox"/>	
Other <input type="checkbox"/>	
Affected Account(s) _____	_____

Practitioner Treatment Record Audit Tool

General Directions

1. The provider must achieve a minimum of 80% compliance on each treatment record element. Final scoring is based on an average of the individual records reviewed.
2. Enter the age of the enrollee whose record is under review in the appropriate box. Round up to the nearest whole number
3. Enter the full 4-5 digit DSM-IV Axis I Primary diagnosis of the enrollee whose record is under review in the appropriate box.
4. Answer each question for each record reviewed by placing a check in the YES cell if the indicator is satisfied. If the indicator is not satisfied, check NO. N/A may only be indicated if N/A is not shaded.
5. Use the general comments section at the end of the tool to make general comments about the record.

Standard		Yes	No	N/A	Comments
1.	Identification / Legibility	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.	Histories	Presenting problems, along with relevant psychological and social conditions affecting the enrollee's medical and psychiatric status, are documented in the treatment record.			
7.		A psychiatric history and relevant family information is documented in the treatment record			
8.		Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record			
9.		The clinical assessment is culturally relevant: addresses issues relevant to the enrollee's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level, etc.			

Standard			Yes	No	N/A	Comments
10.	MSE	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.				
11.	Safety	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 <i>ValueOptions</i> [®] ' written protocols.				
12.		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 able to conduct activities of daily living.				
13.		The treatment record indicates a list of the name of current medications, dosage frequency, and name of prescriber.				*This is a monitoring indicator only.
14.	Substance Abuse	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.				
15.	DSM Diagnosis	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.				
16.	Psychiatrists	<u>Psychiatrists</u> : Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. <i>For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber.</i> 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.				

Standard		Yes	No	N/A	Comments
18.	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.				
19.	Allergies, adverse reactions or no known allergies are clearly documented in the treatment record N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber.				
20.	Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.				
20a	The treatment plan will have objective goal(s).				
20b	The treatment plan will identify ways to measure goal attainments.				
20c	The treatment plan will have an established time for goal attainment				
21.	The focus of treatment interventions is consistent with the treatment plan goals and objectives.				
22.	There is evidence that the treatment plan is culturally relevant: addresses issues relevant to the enrollee's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level,				
2.	Progress notes describe enrollee strengths and limitations in achieving treatment plan goals and objectives.				
24.	The treatment record documents as appropriate relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.				
25.	The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.				
26.	There is evidence in the record of coordination of care with the PCP or declination of this coordination by the enrollee. N/A if there is documentation of the patient's refusal				
26a	Is there a signed release of information in the chart to release information to the primary care practitioner (PCP)?				

Standard			Yes	No	N/A	Comments
		N/A if there is documentation of the patient's refusal				
27.		The treatment record has evidence of continuity and coordination of care between behavioral healthcare institutions, ancillary providers and or consultants. N/A is allowed if there is no IP hx or documentation of the enrollee's refusal				
28.		The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners. N/A is allowed if there is no OP hx or documentation of the enrollee's refusal				
28a		Is there a signed release of information in the chart to release information to another behavioral health care practitioner?				
29.		The record reflects evidence of coordination with the EAP/employer if a referral was made.				
30.	Child and Adolescents	For children and adolescents, relevant prenatal and perinatal events, along with a complete developmental history N/A if the enrollee is over the age of 18.				
31.		The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated. N/A only if the enrollee is over 18.				
32.		The record indicates the parent(s) or caretaker(s) have given signed consent for the various treatments provided. N/A only if the enrollee is over 18.				
33.		The record shows evidence of an assessment of school functioning. N/A only if the enrollee is over 18.				
34.		The record indicates evidence of coordination with the youth's school to achieve related treatment goals N/A only if the enrollee is over 18.				

Standard			Yes	No	N/A	Comments
35.	State	State mandated requirements as appropriate				

Reviewer Comments:

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

Reviewer's Signature: _____

Reviewer's Name: _____

Reviewer's Credentials: _____

Reviewer's Phone Number: _____

Service Center: _____

Date of Review: _____

SAMPLE