

Optum - Behavioral Network Services

TREATMENT RECORD REVIEW FORM

Clinician/ Facility Name: _____

Chart ID: _____

Reviewer Name: _____

Patient Gender: _____

Patient Age: _____

Axis I: _____

Axis III: _____

Date of Review: _____

Rating Scale: NA = Not Applicable Y = Yes N = No

Y N NA

Assessment

1 Each patient has a separate treatment record.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

2 Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

3 All entries in the treatment record include the responsible clinician's name, professional degree and relevant identification number, if applicable, and dated and signed where appropriate.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

4 An initial primary treatment diagnosis is present in the record.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

5 All five DSM IV-TR axes are used for diagnoses and signed by a licensed clinician.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

6 The reasons for admission or initiation of treatment are indicated.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Comments: _____

7 A behavioral health history is in the record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
8 A medical history and/or physical exam (appropriate to the level of care) is in the record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
9 Was a current medical condition identified? This is a non-scored question. (If #8 is N, then #9 is N/ A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
10 If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
11 If a medical condition was identified, there is documentation that the patient/guardian refused consent for the release of information to the treating medical clinician. This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
12 A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
13 The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
14 The behavioral health treatment history includes family history information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
15 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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
16 The medical treatment history includes family history information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
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, danger toward self or others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:			
18	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
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.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
20	For Adolescents: The assessment documents a sexual behavior history.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
21	For facilities (inpatient and residential) , the record documents functional impairments preventing completion of activities of daily living, assessment of fall risk, and elopement risk.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
22	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
23	The initial screen includes an assessment for depression. Should be scored Yes or No except for providers who offer ABA services. For ABA providers, it may be scored NA. This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
24	For patients 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.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
25	For patients 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
26	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
27	The substance identified as being misused was alcohol. This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:			
	28 The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	29 The substance(s) identified as being misused were alcohol and other substance(s). This is a non-scored question.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	30 The assessment documents the spiritual variables that may impact treatment	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	31 The assessment documents the cultural variables that may impact treatment	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	32 An initial treatment plan is established at each level of care with goals, treatment priorities, and milestones for progress is in the record.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	33 An educational assessment appropriate to the age and level of care is documented.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	34 The record documents the presence or absence of relevant legal issues of the patient and/or family.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	35 There is documentation that the patient was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	36 There is documentation that indicates the patient understands and consents to the medication used in treatment.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
	37 For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			

	<p>Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or 38 refills.</p>			
Comments:				
	<p>39 The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.</p>			
Comments:				
	<p>The clinician uses a Consent for Treatment or Informed Consent form with all patients; this document should be signed by the 40 patient and/or legal guardian.</p>			
Comments:				
	<p>41 There is evidence that the assessment is used in developing the treatment plan and goals.</p>			
Comments:				
Coordination of Care				
	<p>42 Does the patient have a medical physician (PCP)? This is a non-scored question.</p>			
Comments:				
	<p>43 The record documents that the patient was asked whether they have a PCP. Y or N Only</p>			
Comments:				
	<p>44 If the patient has a PCP there is documentation that communication/collaboration occurred.</p>			
Comments:				
	<p>If the patient has a PCP, there is documentation that the patient/guardian refused consent for the release of information to the 45 PCP.</p>			
Comments:				
	<p>Is the patient being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and 46 substance abuse counselor). This is a non-scored question.</p>			
Comments:				
	<p>The record documents that the patient was asked whether they are being seen by another behavioral health clinician. Y or N 47 Only</p>			
Comments:				

	<p>48 If the patient is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.</p>			
<p>Comments:</p>				
	<p>49 If the patient is being seen by another behavioral health clinician, there is documentation that the patient/guardian refused consent for the release of information to the behavioral health clinician.</p>			
<p>Comments:</p>				
<p>Documentation Related to the Treatment Plan</p>				
	<p>50 There is documentation (a signed form or in progress note) that the patient or legal guardian (based on each state's age of consent) has agreed to the treatment plan.</p>			
<p>Comments:</p>				
	<p>51 The treatment plan is consistent with diagnosis and has objective and measurable short and long term goals.</p>			
<p>Comments:</p>				
	<p>52 The treatment plan has estimated time frames for goal attainment.</p>			
<p>Comments:</p>				
	<p>53 The treatment plan includes a safety plan when active risk issues are identified.</p>			
<p>Comments:</p>				
	<p>54 The treatment plan is updated whenever goals are achieved or new problems are identified.</p>			
<p>Comments:</p>				
	<p>55 The treatment plan is reviewed and updated with the patient at regular intervals.</p>			
<p>Comments:</p>				
	<p>56 When applicable, the treatment record, including the treatment plan, reflects discharge planning.</p>			
<p>Comments:</p>				
	<p>57 If a patient is receiving group therapy, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified patient needs.</p>			
<p>Comments:</p>				

58 The treatment record documents and addresses biopsychosocial needs.

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Comments:

59 The treatment record indicates the patient's involvement in care and service.

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Comments:

60 When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.

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Comments:

Progress Notes

61 **For all outpatient services except ABA:** All progress notes document the start and stop times for each session when a timed CPT Code is used.

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Comments:

62 **For all outpatient services except ABA:** All progress notes document **clearly** who is in attendance during each session.

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Comments:

63 **For outpatient services except ABA:** All progress notes include documentation of the billing code that was submitted for the session.

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Comments:

64 The progress notes reflect reassessments when necessary.

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Comments:

65 The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.

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Comments:

66 The progress notes describe/list patient strengths and limitations and how those impact treatment.

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Comments:

67 The progress notes describe progress or lack of progress towards treatment plan goals.

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Comments:

68 The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.			
Comments:			
69 If the patient is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)			
Comments:			
70 When lab work is ordered, there is evidence the lab results were received and reviewed by the clinician.			
Comments:			
<i>Continuum of Care</i>			
71 Was the patient transferred/discharged to another clinician or program? This is a non-scored question.			
Comments:			
72 If the patient was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
Comments:			
73 If the patient was transferred/discharged to another clinician or program, there is documentation that the patient/guardian refused consent for release of information to the receiving clinician/program.			
Comments:			
74 Prompt referrals to the appropriate level of care are documented when patients 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.			
Comments:			
75 The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
Comments:			
76 The discharge/aftercare/safety plan describes specific follow up activities.			
Comments:			
<i>Clinical Records</i>			
77 Clinical records are completed within 30 days following discharge.			

Comments:			
78	The progress notes document the dates of follow up appointments.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
79	The progress notes document when patients miss appointments.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
80	The record is clearly legible to someone other than the writer.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
81	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
Education			
82	There is documentation that the clinician provides education to patients/families about treatment planning, discharge planning, supportive community services, behavioral health problems, and care options.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
83	When the patient is on medications, the prescribing clinician documents that the patient was provided with education about the risks, benefits, side effects, and alternatives of each medication.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
84	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the patient.	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
ALERT			
85	FOR OUTPATIENT SERVICES ONLY: There is a completed wellness assessment (or documentation that the patient refused to complete a wellness assessment) in the record for all master's and PhD level clinicians. If a physician or APRN completes a wellness assessment, score this as "Y".	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			
Language Assistance Program (California Only)			

	86 For California Only: If the patient has limited English proficiency, there is documentation that interpreter services were offered.			
Comments:				
	87 For California Only: If interpreter services were offered, there is documentation indicating whether the patient accepted or declined the services.			
Comments:				
<i>Recovery and Resiliency (Public Sector Only)</i>				
	88 The patient is given information to create psychiatric advance directives. This is a non-scored question.			
Comments:				
	89 The patient is provided with referrals to peer support services. This is a non-scored question.			
Comments:				
<i>Texas STAR, STAR+ PLUS, and CHIP Only (Outpatient Services)</i>				
	90 For Texas STAR, STAR+ PLUS, and CHIP Members: If the patient fails to keep their Follow Up after Hospitalization (FUH) appointment, the provider contacts the patient to reschedule the appointment within 24 hours of the no-show.			
Comments:				