

General Documentation

Question

- 01 Each member has a separate record.
- 02 Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information, if relevant.
- 03 All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.
- 04 For children and adolescents the record includes legal documents (court mandates, parental custody, ACS/CPS custody, orders of protection, termination of parental rights etc.) confirming a child's legal custodian AND legal guardian (if different).

Initial Assessment

Question

- 05 The initial assessment for outpatient services is completed within 30 days of the member's request for services; any exceptions to this time frame are clearly documented (must be scored for all outpatient services).
- 06 A complete clinical case formulation is documented in the record (e.g., DSM primary treatment diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).
- 07 The member's reasons for seeking treatment are documented.
- 08 A behavioral health history is in the record and includes the following information: dates and providers of previous treatment, family behavioral health history information and therapeutic interventions and responses.
- 09 There is documentation that recent providers of services have been contacted to obtain discharge summaries and other pertinent information.
- 10 A medical history is in the record and includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses and family medical history information AND this health information is reviewed by a physician, NP, RN or PA.
- 11 Was a current medical condition identified? This is a non-scored question.
- 12 If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.
- 13 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.
- 14 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.
- 15 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.
- 16 If a risk issue is identified, a safety plan is documented in the record.
- 17 The record includes documentation of previous suicidal or homicidal behaviors, (dates, method, and lethality) as well as any behaviors that could be considered a danger toward self or others.
- 18 The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.
- 19 For children and adolescents the assessment includes and assessment of bullying the member has experienced or if the member has been the perpetrator of bullying.
- 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 to include sexual identity, orientation, activity status, unsafe/risky situations and practices.

- 22 For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, living arrangements, custody, and academic), are documented.
- 23 The initial screen includes an assessment for depression.
- 24 For members 12 and older, a substance abuse screening occurs using a standardized screening instrument and clinical assessment as needed. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.
- 25 For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.
- 26 For active smokers, the substance abuse screening includes documentation of the member's readiness to reduce or quit using tobacco.
- 27 For active smokers, every 3 months the member's nicotine use is reassessed.
- 28 For members under the age of 18, the substance abuse screening includes documentation of nicotine, alcohol or substance use by anyone living in the member's place of residence.
- 29 If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.
- 30 The substance identified as being misused was alcohol. This is a non-scored question.
- 31 The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.
- 32 The substances identified as being misused were alcohol and other substance(s). This is a non-scored question.
- 33 The assessment documents the spiritual and cultural variables that may impact treatment
- 34 An educational assessment appropriate to the member's age is documented (including identification of any literacy needs).
- 35 The record documents the presence or absence of relevant legal issues of the member and/or family.
- 36 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.
- 37 There is documentation that indicates the member understands and consents to the medication used in treatment.
- 38 For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.
- 39 Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.
- 40 The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.
- 41 The member's previous medication history is documented in the record.
- 42 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.
- 43 For children and adolescents, there is documentation that the legally authorized decision maker for the child understands and consents to treatment.

Coordination of Care

Question

- 44 Does the member have a medical physician (PCP)? This is a non-scored question.
- 45 The record documents that the member was asked whether they have a PCP. Y or N Only
- 046 If the member has a PCP there is documentation that communication/collaboration occurred.
- 47 If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.
- 48 Is the member being seen by another behavioral health provider (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). This is a non-scored question.

- 49 The record documents that the member was asked whether they are being seen by another behavioral health provider. Y or N Only
- 50 If the member is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.
- 51 If the member is being seen by another behavioral health provider, there is documentation that the member/guardian refused consent for the release of information to the behavioral health provider.

Treatment Planning

Question

- 52 For Outpatient Services Only: The treatment plan is completed within 30 days of admission or prior to the 4th visit.
- 53 An initial treatment plan with goals, treatment priorities, and milestones for progress is in the record.
- 054 There is evidence that the assessment is used in developing the treatment plan and goals.
- 55 At the time of the initial assessment and throughout treatment, potential barriers or difficulties to participating in treatment are identified and addressed.
- 56 If member receiving services from collateral organizations or providers (such as: probation, family court, domestic violence support, etc.) there is evidence that, when agreed upon by the member, that communication occurs as needed.
- 57 The member and the primary clinician sign the treatment plan and any treatment plan reviews.
- 58 For children and adolescents, the legally authorized decision maker signs the treatment plan and any treatment plan reviews.
- 59 The treatment plan is consistent with the diagnosis.
- 60 The treatment plan includes a recovery goal in the member's own words.
- 61 Measurable and attainable steps toward the achievement of goals are identified.
- 062 The treatment plan has estimated time frames for goal attainment.
- 63 Treatment plan goals, objectives, and services reflect the assessment and include the individual's/family's preferences and priorities.
- 64 The treatment plan is updated when goals are achieved or new goals are identified.
- 65 For Outpatient Services Only: The treatment plan is reviewed and updated as needed as determined by the individual/family and the treating clinician, but no less than annually.
- 66 When applicable, the treatment record, including the treatment plan, reflects discharge planning.
- 67 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.
- 68 The treatment record documents and addresses biopsychosocial needs.
- 69 The treatment record indicates the member's involvement in care and service.
- 70 When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.

Progress Notes

Question

- 71 For all Outpatient Services: All progress notes document the start and stop times or duration for each session when a timed code is used.
- 72 For all Outpatient Services: All progress notes document clearly who is in attendance during each session.
- 073 For all Outpatient Services: All progress notes include documentation of the billing code that was submitted for the session.
- 074 The progress note indicates the type of intervention that was used for the session
- 075 The progress notes reflect reassessments when necessary.

- 76 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.
- 77 Documentation in the record reflects that safety plans are reviewed and updated when clinically indicated.
- 078 Documentation in the record includes the reason(s) for continued services.
- 79 The progress notes describe/list member strengths and limitations and how those impact treatment.
- 80 Progress notes are linked to goals and objectives by summarizing services provided, the interventions utilized, the recipient's response, and progress toward goals.
- 81 The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.
- 82 The progress notes document the use of any preventive services (relapse prevention, stress management, wellness programs and referrals to community resources).
- 83 If the member is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)
- 84 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.
- 85 When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing clinician.
- 86 When lab work is ordered, there is evidence that the provider reviewed the results with the member.
- 87 The progress notes document the dates of follow up appointments AND when members miss appointments.
- 088 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.

Transitions Planning

Question

- 89 Was the member transferred/discharged to another clinician or program? This is a non-scored question.
- 90 If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.
- 91 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.
- 92 The reason for discharge is clearly identified.
- 93 The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.
- 094 The discharge/aftercare plan describes specific follow up activities.
- 95 When a member discontinues services, a full review of the case, including an assessment of the level of risk, is completed and efforts are made to reengage the member in services.
- 96 When a case is closed as a result of the member discontinuing services, written correspondence is sent to the member indicating they are encouraged and welcome to reengage in services at any time.

Treatment Records

Question

- 97 Treatment records are completed within 30 days following discharge from services.
- 098 The record is clearly legible to someone other than the writer.
- 099 When appropriate there is evidence of supervisory oversight of the treatment record.

Medical Necessity

Question

- 100 The documentation in the treatment record includes the onset, duration, and frequency of the symptoms the member is experiencing.
- 101 The documentation in the treatment record identifies functional deficits the member is experiencing.

- 102 The documentation in the record indicates how the services that are rendered will address the functional deficits.
- 103 The documentation in the record indicates that a lack of treatment could result in increased impairment for the member.
- 104 The documentation in the record indicates that the services the member needs cannot be effectively rendered at a lower level of care (example, a PCP office).
- 105 The documentation in the record indicates that not receiving the treatment could result in decompensation and a need for treatment at a high level of care or service type (example, inpatient).

Education

Question

- 106 There is documentation that the provider offers education to members/families about care options, participation in care, coping with behavioral health problems, prognosis and outcomes.
- 107 There is documentation that the risks of not participating in treatment are discussed with the member.

Interpreter Services

Question

- 108 If the member has limited English proficiency, there is documentation that interpreter services were offered.

Recovery and Resiliency

Question

- 109 The member is given information to create psychiatric advance directives. This is a non-scored question.