2023 Carelon Behavioral Health Treatment Record Review Audit Tool

	A. Documentation	Examples of Evidence
1.	Is there documentation that the member received a copy of his or her rights?	Copy of signed Member Rights; Patient Signed Intake Forms; Progress Notes documenting rights were reviewed
2.	If medications are prescribed, are medication allergies & adverse reactions prominently noted in the record? If the member has no known allergies or adverse reactions, are these noted?	Intake Assessment/Ongoing Assessment, Case Consultation Note, Psychiatric History & Evaluations
3.	Is past medical history easily identified? If no significant medical history, is this noted?	Intake Assessment/Ongoing Assessment Progress Notes, Case Consultation Note, Psychiatric History & Evaluation
4.	Is there documentation that the member received a copy of the HIPAA notice of privacy practices?	Signed privacy practices acknowledgement, progress note indicating that the member was provided this information at intake.
	B. Continuity and Coordination - Outpatient to Outpatient	**Examples of Evidence**
1.	Is there evidence in the chart that at least one Release of Information (ROI), Authorization, or Consent was obtained to speak with at least one other Outpatient [OP] mental health or OP substance abuse treatment provider, if required? *Note: Please refer to the Outpatient Treatment Record Review Q&A document for details on when an ROI is required.*	Release of Information signed within prior 12 months, Consent for collaboration
2.	Is there evidence that the OP treatment provider contacted other OP BH Provider after initial assessment/evaluations for collaboration?	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release (fax confirmation, emails, documentation coordination of care occurred)
3.	Is there evidence that the OP treatment provider had ongoing contact with other BH Provider at other significant points in treatment e.g. medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and at termination of treatment?	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation coordination of care occurred)

4.	Is there evidence that the OP treatment provider contacted, collaborated, received clinical information from or communicated in any way with any state agencies or schools, community outlets, etc.?	Releases to other entities: DCF, Teachers, Mentors, Day Treatment, School, State Agencies. Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)
5.	Timeliness: Communication within 30 days of initial assessment	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)
C. Continuity and Coordination - PCP to Outpatient		**Examples of Evidence**
1.	Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP? (PCP must be identifiable) *Note: Please refer to the Outpatient Treatment Record Review Q&A document for details on when an ROI is required.*	Release of Information signed within prior 12 months, Consent to Obtain Information, Progress note, Evidence of Sent Release/ Communication (fax confirmation, emails, documentation showing coordination of care occurred)
2.	Is there evidence that the OP treatment provider contacted and collaborated after initial assessment/evaluation?	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)
3.	Is there evidence that the provider had ongoing contact with PCP at other significant points in treatment e.g. medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status and termination of treatment?	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)
4.	Is there evidence of bi-directional communication (*not included in overall score*)	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)

	D. Evaluation of Treating Provider Communication (BH:PCP)	Examples of Evidence
1.	Timeliness: Communication within 30 days of initial assessment	Release of Information, Consent to Obtain Information, Progress note, Contact Note, Treatment Plan, Case Consultation Note, Evidence of Sent Release/Communication (fax confirmation, emails, documentation showing coordination of care occurred)
	E. Clinical Practice Guidelines	**Examples of Evidence**
1.	Schizophrenia CPG: Was the initial assessment comprehensive?	Standardized Assessment/Screening Tools
2.	Schizophrenia CPG: Did the practitioner use quantitative measures in the initial assessment?	Standardized Assessment/Screening Tools
3.	Schizophrenia CPG: Is there a documented, person centered treatment plan?	Standardized Assessment/Screening Tools;
4.	Schizophrenia CPG: Medication assessment: 1. If there is a history of non-adherence is there documentation a Long Acting Injectable (LAI) was offered? If not, is there clear rationale for why?	Detailed progress notes
5.	Adult Psychiatric Evaluation CPG: Is there documentation of a substance use assessment? (age 18+)	Initial Assessment, Ongoing Assessment, Standardized Assessment/ Screening Tools, Psychiatric History & Evaluation
6.	Adult Psychiatric Evaluation CPG: Is there documentation of a cultural and/or linguistic assessment? (age 18+)	Initial assessment, Ongoing Assessment, Face Sheet, Standardized Assessment/Screening Tools; Psychiatric History & Evaluations
7.	Adult Psychiatric Evaluation CPG: Is there documentation of a medical assessment? (age 18+)	Initial Assessment, Ongoing Assessment, Psychiatric History & Evaluations, Case Consultations
8.	ADHD CPG: Is there documentation that the member meets the DSM-5 criteria, including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational)? (age 4-18)	Initial Assessment, Ongoing Assessment, Standardized Assessment/Screening Tools, Psychiatric History & Evaluations
9.	ADHD CPG: Is there documentation that the member meets the DSM-5 criteria based on information obtained primarily from reports from parents or guardians, teachers, or other school personnel and mental health clinicians who are involved in the child or adolescent's care? (age 4-18)	Communication - Contact Note, Treatment Plan, Case Consultation Note; Intake assessment, Progress Notes; Psychiatric History & Evaluations
10.	ADHD CPG: Is there documentation that when assessing a member's diagnosis, differential diagnoses or alternative causes were ruled out? (age 4-18)	Initial Assessment, Ongoing Assessment, Standardized Assessment/Screening

		Tools, Case Consultation Note; Psychiatric History & Evaluations
11.	ADHD CPG: Is there documentation that the provider included behavioral treatments for family and/or school settings? (age 4-18)	Contact Note, Treatment Plan, Case Consultation Note, Progress Note, Evidence of coordination of care (fax confirmation, emails, documentation showing coordination of care occurred)
F. Targeted Clinical Review		**Examples of Evidence**
1.	Is the DSM or ICD diagnosis consistent with presenting problems, history, mental status exam and treatment plan?	Initial and Ongoing Assessments, Psychiatric History and Evaluations, Treatment Plan, Standardized Assessment
2.	Does the treatment plan include objective and measurable goals?	Treatment Plan
3.	Does the treatment plan include short-term timeframes for goal attainment/problem resolution?	Treatment Plan
4.	Is utilization (e.g., frequency of visits) appropriate for diagnosis and treatment plan?	Treatment Plan, Progress Notes
5.	Are progress notes goal directed & focused on treatment objectives?	Treatment Plan, Progress Notes
G. Telehealth Member Safety (APPLICABLE TO ALL CHARTS IF TELEHEALTH MODALITY)		**Examples of Evidence**
1.	Did Provider document that session was conducted via video or phone?	Initial Assessment, Progress note
2.	Did Provider document member's physical location at beginning of session?	Initial Assessment, Progress note
3.	If there was a technical difficulty, did provider document alternate communication and how session was continued or rescheduled?	Initial Assessment, Progress note
H. State Specific Questions (California)		**Examples of Evidence**
1.	Unhealthy alcohol and drug use screening conducted using validated tool (age 11 and older)?	Verify name of screening tool and score
2.	When a screening is positive, validated assessment tool(s) used?	Verify name of assessment and score
3.	When assessment indicates need for additional evaluation and treatment, was a referral to an AUD or SUD program made?	
Notes (Delineate specific areas of weakness if requirements are not met):		