PROVIDER CHART AUDIT
AUDIT TOOL-Inpatient

QUESTIONS		DEFINITIONS
1.	Each page in the treatment record contains the member's name or MA ID number.	Each page in the treatment record contains the member's name or ID number.
2.	Each treatment record includes the member's required demographics.	a. Member's address b. Telephone # c. Emergency contact d. School name, as applicable.
3.	Each treatment record includes the adult member's marital status, legal status, and guardianship information, if applicable.	Adult question only a. Marital status. b. Legal status issues such as DUI, probation or pending legal action if applicable. c. Guardianship if member is declared incompetent.
4.	Each treatment record contains PCP notification or declination.	Each chart should contain a release to notify the member's PCP of their involvement in treatment and evidence of notification **OR** documentation of the member's declination of PCP notification.
5.	Each treatment record contains the HIPAA Privacy Notice, appropriate releases and Consent for Treatment, signed or initialed by the member.	Statement of confidentiality or a HIPAA Notice of Privacy Practices is found in the medical record or there is documentation in the member's record that the member has received a copy of the Notice of Privacy Practices. Chart also must contain a signed consent for treatment and any releases that may be appropriate**..**
6.	All entries in the treatment record must be signed by the responsible clinician.	Full signature of clinician, and degree or relevant identification number must appear after each entry. If signature is stamped, score 'no'. If records are electronic, a unique electronic identifier is acceptable. If clinician is an ancillary staff person, all entries must be countersigned by the responsible licensed provider.
7.	All entries in the treatment record are dated.	Day, month and year on each entry.
8.	The treatment record is legible to someone other than the writer.	Entries can be read at a normal pace. Reviewer is not required to excessively figure out individual words or phrases.
9.	Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status are documented in the treatment record.	a. Presenting problems, b. Current symptoms, c. History of symptoms, d. Problem behaviors, e. Relevant psycho-social conditions affecting the patient's medical and psychiatric status are documented in the assessment.
10.	Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record.	Evidence that the enrollee was thoroughly evaluated upon initial assessment as to dangerousness to self, to others or elopement potential. b. Special status situations should be addressed at each documented contact by MHP, nurse or psychiatrist in the progress notes until resolved.

11.	Relevant medical conditions (including pregnancy) are listed, prominently identified, and revised as appropriate in the treatment record.	If a medical condition addressed on Axis 3 is identified as a presenting problem in the assessment, it must be addressed in the treatment plan and the progress notes. (N/A if medical condition is not identified as a presenting problem).
12.	*Food, drug, environmental allergies* and adverse reactions or no known allergies are clearly documented in the treatment record.	Documentation of allergies, or no known allergies NKA, any adverse reactions, any sensitivity to pharmaceuticals or other substances are documented.
13.	The treatment record indicates prescribed medications, the dates prescribed, and dosages.	For prescribers all of the following elements must be present: a. Medications prescribed, b. Dosages of each, c. Dates of initial prescriptions and refills. For non-prescribing practitioners, each treatment record should indicate: a. What medications have been prescribed, b. The name of the prescriber. N/A if medications are not prescribed. There must be a documented rationale for medication changes (type, dosage).
14.	There is evidence of a psychiatric evaluation when medication is prescribed at the facility.	A psychiatric evaluation is required at the time of the medication prescription.
15.	If medication is prescribed, there is evidence of medication education and understanding by the patient, or for a minor child, the parent/guardian.	Documentation of the risks and benefits to the patient must be present. The psychiatrist must document efficacy and rationale for changes in the medication.
16.	A medical and psychiatric history is documented in the treatment record, *which may include* previous treatment dates, hospitalizations, provider identification, therapeutic interventions and responses, relevant family information, results of laboratory tests, and consultation reports.	A family history in which the presence or absence of psychiatric and /or substance abuse history among family members may also be part of the psychiatric history.
17.	Documentation in the treatment record includes past and present use of cigarettes, alcohol, illicit drugs and abuse of prescribed or over-the-counter drugs.	N/A for a child under 10**.** If this is documented as a treatment issue, for IP it must be in the discharge plan, May include over the counter drugs such as ephedrine, herbal supplements, melatonin, St. John's Wort.
18.	A mental status that includes the member's affect, speech, mood, thought content, judgment, insight, attention span/concentration, memory and impulse control is documented.	A minimum of 7 of the 9 elements must be present.

19.	Are updates/changes reflected in the progress notes from the most recent assessment?	Re-assessment of symptoms should occur in each documented contact. Assessment of medication side effects must be documented at least one time per day.
20.	A DSM-IV/ICD9 diagnosis, is documented with a signature and date from the evaluator.	All 5 axes must be present.
21.	Treatment plans: 1) must be individualized 2) have measurable goals and objectives and identification of person responsible and modality 3) have estimated time frames for goal attainment or problem resolution 4) are signed by clinician/treatment team and the member.	Plan must have documentation of specific behaviors / symptoms/**needs** to be addressed which have been identified in the initial assessment/psych eval and relate directly to the diagnosis. Goals must be measurable with stated outcomes and time frames to accomplish the goals. Must be signed by the treatment team and the member.
22.	The treatment plan meets timeframe standards for initial development and update/review.	Time frame standards for Inpatient: The initial treatment plan must be developed within 24 hours of admission. Within 48 hours, the treatment plan must be signed by the treatment team. After 7 days, a treatment plan review must be completed.
23.	Treatment plan goals and objectives are reflected in the progress notes	Each progress note should be directly related to the treatment goal being addressed during that contact. Treatment goals should be identified, addressed and prioritized (addressing goals that are most concerning/problematic unless specifically documented). Notes should identify interventions used, treatment modality, response of member to interventions and plan to address the issues going forward.
24.	Documentation of progress or lack of progress toward treatment plan goals must be found in the progress notes.	Progress must be documented in progress notes, updated treatment plan or discharge summary. Progress includes level of the patient's participation in treatment such as group or individual therapy.
25.	Is there documentation that the patient had face to face contact with a psychiatrist within the first 24 hours of treatment?	
26.	The treatment record documents preventive services, as appropriate, relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.	Documentation of the clinician's efforts to educate the patient about approaches that might augment treatment being provided such as relapse prevention, stress or anger management, wellness program, lifestyle changes, social skills, community resources or AA.
27.	The discharge plan has been documented and updated.	Planning should be evidenced by documentation on the day of admission and continues throughout treatment. Placement/living arrangements and personal support alternatives such as patient's family, significant others, twelve step or other support groups should be identified in the plan.

28.	Closed Chart/ Member's discharge instructions are documented in the chart.	**Closed chart for IP/MH, IP/D&A 3ABC or 4AB only**, a. Follow up appointments, b. Crisis/relapse prevention as indicated, c. Medication name, dosages, and frequency if prescribed at the site, d. Signature of the member, e. May recommended ancillary or supplemental services. Score N/A if not a closed chart**.**
29.	There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level).	Cultural issues identified as a presenting problem in the assessment must be included in the treatment plan. N/A if none are identified.
30.	The treatment record has evidence of continuity and coordination of care between behavioral health institutions, practitioners, ancillary providers, consultants, outpatient behavioral health practitioners or EAP/employer if indicated.	Documented evidence of attempts to coordinate care. Look for appropriate releases. If dually diagnosed, check for a referral to MH or D&A.
31.	Closed Charts: A discharge summary/aftercare plan has been documented at the conclusion of treatment.	a. Discharge diagnosis, b. Medications, dosages and frequency if applicable, c. status of goals, d. Treatment summary, e. Barriers to treatment if applicable, f. Crisis plan/relapse prevention plan as applicable, g. Ancillary services as applicable. Score N/A if not a closed chart.
Child and Adolescent Records Only – Items 32-37		**DEFINITIONS**
32.	For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic are documented in the treatment record.	Developmental history includes: a. Physical, b. Psychological, c. Social, d. intellectual, e. Academic domains. (N/A if the child is over the age of 18)
33.	Each treatment record includes the child's legal status and guardianship information	a. Probation, pending legal issues such as DUI, b. Marital status of the parent /guardian, c. Name and phone # of the individual/agency that has legal custody of the child if other than the biological or adoptive parents.
34.	The record reflects the active involvement of the family, legal guardian or primary caretakers in the assessment and treatment of the enrollee, unless contraindicated.	Family involvement is documented unless contraindicated. N/A only if the member is over 18. Look for parent/guardian signature on the treatment plan and documentation of family involvement in the treatment notes. Score N/A for MH charts for members 14 and older) if it is indicated that the child did not want active involvement of the family, legal guardians, or primary caretakers.

35.	The record indicates the parent(s), legal guardian or caretaker(s) have given signed consent for the various treatments provided.	Parent consent for treatment is not required for members 14 or older. For substance abuse treatment of children, only the minor needs to sign the informed consent. No age restrictions for substance abuse treatment.
36.	The record shows evidence of an assessment of school functioning.	**Inpatient MH/D&A, RTF treatment: required**. Evidence that the youth's school/parent/guardian was contacted for academic and behavioral data. Look for release of information to contact the school. Score N/A if child is not of school age, not enrolled in school, or if it is documented in the chart that the release of information was refused.
37.	Deleted	
Treatment Record-Based Adherence Indicators – Score these items if the diagnosis for any case reviewed is in the 295, 296.2, 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 or 314 series. Data related to these adherence indicators are used only in the aggregate – it does not enter into the total score/evaluation of the records of this facility but the results will be shared with them.		
Major Depression – 296.2 or 296.3 Series		**DEFINITIONS**
38.	The record documentation indicates that the patient's psychiatric status and safety are monitored on every shift.	Symptoms include: mood, affect, sleep, appetite and energy, Suicidality includes: passive suicidal thoughts, passive death wish or a suicide plan. N/A exclude night shift if patient was asleep.
39.	Co-morbid problems are assessed upon initial evaluation (within 24 hours) for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
40.	Is there documentation of the patient's response to the initial treatment?	If there was no response to the initial treatment, is there documentation that the physician has considered increasing the dosage of medication, increased intensity of psychotherapy or a trial of ECT?
41.	If the patient is diagnosed Major Depressive Disorder with Psychotic features, (296.24 single episode or 296.34 recurrent) there must be evidence that the physician has recommended an antidepressant plus an antipsychotic or ECT.	
42.	Deleted	
43.	Deleted	
44.	Deleted	

Schizophrenia – 295 Series		**DEFINITIONS**
45.	There is evidence of an assessment of positive signs of psychosis, e.g., delusions and/or hallucinations.	Documentation of an assessment for positive signs of psychosis must occur within 24 hours of admission and on a daily basis thereafter
46.	Co-morbid problems are assessed upon initial evaluation (within 24 hours) for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
47.	Baseline levels of signs, symptoms, and laboratory values relevant to monitoring effects of antipsychotic therapy must be assessed and documented	Document what is missing on the answer sheet • Measure vital signs (pulse, blood pressure, temperature) • Measure weight, height and body mass index BMI • Assess for extrapyramidal signs such as repetitive, involuntary muscle movements (such as lip smacking) or an undeniable urge to be moving constantly. • ***Screen for diabetes risk factors*** (See below)and measure fasting blood glucose • Screen for symptoms of hyperprolactinemia (abnormally-high levels of prolactin in the blood) • Obtain lipid panel (includes triglyceride level, HDL , and LDL cholesterol levels) Diabetes risk factors include: • Age greater than 45 years • Diabetes during a previous pregnancy • Excess body weight (especially around the waist) • Family history of diabetes • Given birth to a baby weighing more than 9 pounds • HDL cholesterol under 35 mg/dL • High blood levels of triglycerides, a type of fat molecule (250 mg/dL or more) • High blood pressure (greater than or equal to 140/90 mmHg) • Impaired glucose tolerance • Low activity level (exercising less than 3 times a week) • Metabolic syndrome

48.	Deleted	Deleted
ADHD – 314.00; 314.01; 314.9 For 18yr old or less, C&A		**DEFINITIONS**
49.	The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the individual, unless contraindicated.	Family involvement is documented unless contraindicated. N/A if the member is over 18. Look for parent/guardian signature on the treatment plan and documentation of family involvement in the treatment notes. Select N/A if family involvement is contraindicated
50.	Co-morbid problems are assessed upon initial evaluation (within 24 hours) for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed. Assessment for substance abuse is for individuals age 10 or older.
51.	The record reflects psychoeducation about ADHD.	Psychoeducation about ADHD should include education for the parent and child about various treatment options (medication and behavioral therapy), linkage with community supports and school resources as appropriate.
52.	Deleted	
53.	When medication is prescribed, there is evidence of an evaluation of the member's response to medication and adjustments as needed.	The response to the prescribed medication or any side effects to the medications must be documented.
Bipolar Disorder – 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 Series		**DEFINITIONS**
54.	The record documentation that the patient's psychiatric status and safety are monitored on every shift?	Mood symptoms include: mood, affect, sleep, appetite and energy, Suicidality includes: passive suicidal thoughts, passive death wish or a suicide plan. N/A exclude night shift if patient was asleep.
55.	Co-morbid problems are assessed upon initial evaluation (within 24 hours) for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
56.	When Lithium, Valproic acid, (depakote, divalproex) or Tegretol (carbamazepine) are prescribed, is there evidence that laboratory tests have been ordered and reviewed by the physician? If applicable, is there evidence of a medication adjustment based on the laboratory results?	

Comments: