



**Provider Record Review Tool – 2020**

|                      |  |   |  |
|----------------------|--|---|--|
| <b>Review ID:</b>    |  | <b>Plan:</b>                                |  |
| <b>Member ID:</b>    |  | <b>Member Name:</b>                         |  |
| <b>Member DOB:</b>   |  | <b>Member Age<br/>(at intake):</b>          |  |
| <b>Provider ID:</b>  |  | <b>Provider Name:</b>                       |  |
| <b>Clinician ID:</b> |  | <b>Clinician Name<br/>&amp; Discipline:</b> |  |
| <b>Primary Dx:</b>   |  | <b>Secondary Dx.</b>                        |  |

| <b>A</b> | <b>Intake and/ or Assessments</b>   | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|---|------------|-----------|------------|
| 1        | Is the reason for admission/ beginning of treatment documented?                                 |            |           |            |
| 2        | Is there consent or refusal from member, either verbal or written, to participate in treatment? |            |           |            |
| 3        | Cultural and linguistic needs addressed?  |            |           |            |
| 4        | Is there documentation of mandated assessment under 21 when applicable (ie CANS under 18)?      |            |           |            |
| 5        | Medical history and current conditions are indicated?   |            |           |            |

| <b>B</b> | <b>Medication Safety (when prescribed)</b>   | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|--|------------|-----------|------------|
| 1        | Medications are documented to the standard in the provider manual including allergies? |            |           |            |
| 2        | Monitoring adherence to medication is evident?   |            |           |            |

| <b>C</b> | <b>General Safety</b>  | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|--|------------|-----------|------------|
| 1        | Adequate risk assessment is completed?   |            |           |            |
| 2        | When risks are identified, interventions are prompt and appropriate?                                       |            |           |            |
| 3        | Was a formal tool used to complete risk assessments?   |            |           |            |
| 4        | For Outpatient services, when applicable, there are outreach attempts when a member misses an appointment? |            |           |            |

| <b>D</b> | <b>Comprehensiveness of Record (Age at Intake)</b>  | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|---|------------|-----------|------------|
| 1        | Is there evidence the member was screened for Alcohol or other substance use?   |            |           |            |
| 2        | Is the member engaged in ongoing substance treatment?   |            |           |            |
| 3        | If the member screened positive for substance use, was this addressed on an ongoing basis?                            |            |           |            |
| 4        | If member screened positive for SU, was member educated on Medication Assisted Treatment(MAT) services as applicable? |            |           |            |
| 5        | If member screened positive for SU- was family involved in treatment?   |            |           |            |
| 6        | For OP services- Is there evidence the member was screened for Depression using the PHQ-9 or PHQ-9A?                  |            |           |            |

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|    |   |  |  |  |
|----|---|--|--|--|
| 7  | For OP services- When required, if the member is age 18 or older, diagnosed with depression or dysthymia, was the PHQ-9 tool used to monitor progress of treatment? |  |  |  |
| 8  | Is there evidence the member was screened for ADHD when relevant?   |  |  |  |
| 9  | If Member screened positive for ADHD, was there a referral for a medication evaluation?   |  |  |  |
| 10 | If Member screened positive for ADHD, was family involved in treatment?   |  |  |  |
| 11 | Other Screenings if applicable are identified?  |  |  |  |

| <b>E Value Based Payment</b> - <i>Applicable to most outpatient service providers and is mandatory for Capitated Membership: Capitated Member engaged in services at a VBP Provider (Indicate NA if not applicable)</i> |   | Yes | No | N/A |
|---|---|-----|----|-----|
| 1   | Is there a release of information signed for Beacon?  |     |    | X   |
| 2   | OP - member had access to an appointment within 5 days of original request?   |     |    | X   |
| 3   | OP - member age 6-12 had at least three follow-up care visits within 10-month period, one of which was within 30 days of initial ADHD medication dispensed? |     |    | X   |
| 5   | Member meets intensity of service (clinical) criteria throughout course of treatment?   |     |    | X   |
| 6   | Member was seen by credentialed clinician within 7-days post-discharge from acute services?   |     |    | X   |
| 7   | Member was seen by credentialed clinician within 30-days post-discharge from acute services?  |     |    | X   |

| <b>F Clinical Formulation</b> |   | Yes | No | N/A |
|-------------------------------|---|-----|----|-----|
| 1                             | Member meets level of care criteria throughout treatment? |     |    |     |

| <b>G Treatment Plans</b> |   | Yes | No | N/A |
|--------------------------|---|-----|----|-----|
| 1                        | There is documentation to indicate that the Member has been involved in the treatment planning.   |     |    |     |
| 2                        | Is treatment consistent with presenting symptoms and diagnosis?   |     |    |     |
| 3                        | Are objectives and goals measurable?  |     |    |     |
| 4                        | Are there timeframes for goal attainment or problem resolution?   |     |    |     |
| 5                        | When applicable, the record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the individuals unless contraindicated? (contraindications must be noted) |     |    |     |

| <b>H Discharge</b> |   | Yes | No | N/A |
|--------------------|---|-----|----|-----|
| 1                  | Barriers to discharge were addressed timely?                |     |    |     |
| 2                  | Medical follow up is included in discharge when applicable? |     |    |     |

| <b>I Progress Notes (PN)</b> |   | Yes | No | N/A |
|------------------------------|---|-----|----|-----|
| 1                            | Include skilled clinical interventions or techniques used by provider?  |     |    |     |
| 2                            | Are goals directed & focused on treatment objectives?   |     |    |     |
| 3                            | There is adherence to best practices in documentation (e.g. patient name on each page/electronic form, all notes are signed, signatures of staff include credentials etc.)? |     |    |     |



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| <b>J</b> | <b>Coordination of Care</b>   | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|---|------------|-----------|------------|
| 1        | Is there a signed release of information in the chart to release information to the primary care practitioner (PCP)? (N/A if there is documentation of the member's refusal)                                    |            |           |            |
| 2        | Is there a signed release of information in the chart to release information for other practitioners/stakeholders?  |            |           |            |
| 3        | Is there evidence that the treatment provider contacted, collaborated, received clinical information from or communicated in any way with the PCP?  |            |           |            |
| 4        | Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated in any way with the other BH providers and/or prescribers of medication? |            |           |            |
| 5        | Is there evidence that the treatment practitioner/facility contacted, collaborated, received clinical information from or communicated with EAP, schools and other agencies as applicable?                      |            |           |            |
|          | <b>NCQA Health Plan standards – Review documentation of coordination for:</b>   | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
| 6        | Is there Accuracy - Whether the information exchanged is correct  |            |           |            |
| 7        | Is there Sufficiency - Whether the information exchanged is complete and provides adequate data for provision of care   |            |           |            |
| 8        | Is there Timeliness of communication - Whether the information is exchanged in a timely manner and does not cause a delay in care   |            |           |            |
| 9        | Is there Clarity of communication - Whether the information exchanged is easy to understand   |            |           |            |
| 10       | Is there Frequency of communication - Whether information is regularly exchanged between the medical and behavioral healthcare practitioners in the network   |            |           |            |

| <b>K</b> | <b>Measurement Based Care</b>  | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|--|------------|-----------|------------|
| 1        | Measurement-based care is evident?   |            |           |            |
| 2        | Is there evidence of a scale to measure changes in function and or improvements? |            |           |            |
| 3        | The treatment includes the use of appropriate measurement based tools?           |            |           |            |

| <b>L</b> | <b>Fraud Waste Abuse</b>  | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|---|------------|-----------|------------|
| 1        | Services are <u>not</u> misrepresented or duplicated?                   |            |           |            |
| 2        | Are there treatment notes to match claims submitted when part of audit? |            |           |            |

| <b>M</b> | <b>State Mandates and/ or Contract Requirements</b>       | <b>Yes</b> | <b>No</b> | <b>N/A</b> |
|----------|---|------------|-----------|------------|
| 1        | State mandated requirements are included when applicable? |            |           |            |

| <b>Recommendations</b> |  |  |  |  |
|------------------------|--|--|--|--|
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