

Product Lines Affected

Medicaid	x	PHC**	x
GAMC	x	MnCare	x
MSC Plus	x	Part D	x
PWSHC*	x	Other	

Policy Name	Medical Records		
Policy Number	QM 06		
Effective Date	May 8, 2008	Review Date	October 8, 2009
Responsible Position	Quality Manager		
Regulatory Requirement(s)	<p>Minnesota Department of Human Services (DHS) 2009 Families and Children contract</p> <p>DHS 2009 Minnesota Senior Health Options (MSHO) contract</p> <p>DHS 2009 Special Needs BasicCare (SNBC) contract</p> <p>MN Rules Chaps. 4685, 9505, and 9520</p> <p>MN Stat. secs. 144, 145, and 221</p> <p>Minnesota Health Care Programs (MHCP) Provider Manual, Chapter 16</p> <p>Title 42 Code of Federal Regulations (CFR) Parts 422, 438, and 441</p> <p>45 CFR Part 164</p> <p>2008 and 2009 National Committee for Quality Assurance (NCQA) Standards QI 12</p>		

Policy

Pursuant to the above regulatory authorities, PrimeWest Health will maintain standards and guidelines for the documentation and management of PrimeWest Health members' medical and behavioral health treatment records.

Provider groups under contract with PrimeWest Health are required to have medical record keeping practices in place that comply with PrimeWest Health's standards and guidelines regarding confidentiality, availability, system of medical record organization, and methods to assess the quality of medical record keeping, as described in the following procedure.

Definition(s)

*PrimeWest Senior Health Complete (HMO) is PrimeWest Health's name for the Minnesota Senior Health Options (MSHO) program.
**Prime Health Complete (HMO) is PrimeWest Health's name for the Special Needs BasicCare (SNBC) program.

Concurrent Review – Utilization review conducted during a member's hospital stay or course of treatment. Has the same meaning as continued stay review.

Protected Health Information (PHI) – Any information held by a covered entity that concerns health status, provision of health care, or payment for health care that can be linked to an individual and includes any part of an individual's medical record or payment history.

Retrospective Review – A review conducted after inpatient hospital services are provided to a member. The review is focused on validating the diagnostic category, verifying recertification, where applicable, and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, and whether all medically necessary inpatient hospital services were provided.

Utilization Review – The evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities by a PrimeWest Health member for the purpose of determining the medical necessity of the service or admission.

Procedure

A. Requesting Medical Records

1. PrimeWest Health requires access to members' medical records and will request information from providers for the following purposes:
 - a. Quality review activities including annual medical record audit review
 - b. Evaluating the use of appropriate services and bill payment
 - c. Data collection for Healthcare Effectiveness and Data Information Set (HEDIS) and clinical practice guideline adherence
2. Portions of a member's medical records may be requested for the following:
 - a. Retrospective or concurrent review
 - b. Discharge planning
 - c. Second opinion determinations
 - d. Appeal and Grievance resolution including quality of care grievance resolution
 - e. Case management and care coordination

B. Provider Responsibility

Providers will maintain records consistent with the following instructions:

1. Maintain medical records in compliance with medical record documentation standards and guidelines outlined in this policy
2. Develop and implement medical record policies and procedures in accordance with State and federal law and PrimeWest Health policy
3. Conduct periodic medical record self-audits to ensure compliance with these standards and guidelines
4. Implement an improvement plan if deficiencies are identified during medical record self-audit
5. Review the PrimeWest Health **Annual Medical/Treatment Record Audit Report** and make changes necessary to improve documentation in the medical record as an essential component of quality care
6. Develop and implement a Corrective Action Plan (CAP) if deemed necessary by PrimeWest Health's Quality and Care Coordination Committee (QCCC)

C. PrimeWest Health Responsibility

PrimeWest Health will complete the following for purposes of maintaining appropriate medical record documentation and management:

1. Communicate medical record expectations to providers at time of initial credentialing and contracting
2. Monitor provider performance against established medical record documentation standards on an annual basis
3. Provide education, recommendations, and consultation to provider groups to improve compliance and implement medical record policies and procedures to meet PrimeWest Health standards
4. Provide written follow-up reports, including recommendations and a copy of the **Annual Medical/Treatment Record Audit Report**
5. Present results to the QCCC and Joint Powers Board (JBP)
6. Request development of a CAP if a deviation from established performance standards is identified during the medical record review and recommended by the QCCC
7. If a CAP is in place, PrimeWest Health will follow up with the provider to determine compliance and corrections are completed in accordance with the CAP

8. PrimeWest Health reviews results of the medical record audits during the recredentialing process. Results are included at the time of QCCC review if a CAP is in place.
9. The credentialing committee will take necessary action if the provider does not implement and follow a CAP
10. When a PrimeWest Health staff member requests medical records, notice will be sent to the provider identifying the date(s) of service and specific information requested
 - i. PrimeWest Health will attempt to provide a facility at least a 14-day notice of Medical Record Review or any other request for medical records.
 - ii. All medical records obtained and generated regarding a member will be maintained as confidential.
 - iii. PrimeWest Health will request access to the minimum record information necessary to investigate or make utilization review determinations as required by the Health Insurance Portability and Accountability Act (HIPAA) and will manage Protected Health Information (PHI) in compliance with applicable privacy rules and regulations.
11. PrimeWest Health will use a methodology based on the volume of members the provider sees on an annual basis, past documentation of deficiencies, or other criteria determined to be necessary for annual audits, quality review studies, and utilization management determinations

D. Criteria for Medical Record Documentation and Management

PrimeWest Health expects providers to meet the following criteria regarding medical record documentation and management (see Medical Record Documentation Standards attachment for detailed information and applicable statutory/regulatory sources):

1. Confidentiality
 - a. Medical/treatment records are stored in a secure location and manner.
 - b. Medical/treatment records are accessible only to persons who have authority to access the information contained in the records.
 - c. Release of medical/treatment record information is done only with the express permission of the patient or a legally authorized representative except as permitted by applicable State or federal law.
 - d. Recipient's consent to access: A PrimeWest Health member (by virtue of being a recipient of Medical Assistance and/or Medicare) is deemed to have authorized in writing the release of his/her medical/treatment records to PrimeWest Health for the purposes of claims or cost report investigations. The Minnesota Department of Human Services (DHS), according to MN Stat. sec. 256B.27, subds. 3 and 4, grants PrimeWest Health authority to examine a recipient's health service records related to services provided under a Minnesota Health Care Program (MHCP). The PrimeWest Health member's authorization of the release and review of health service records for services provided while the person was/is a PrimeWest Health member shall be presumed competent if given in conjunction with the member's application signed by the member or the member's guardian or authorized representative as defined in MN Rules part 9505.0015, subp. 8.
 - e. Written policies and procedures are available and easily accessible. Such policies and procedures reflect the providers' operating practices related to confidentiality of and access to medical/treatment records, as well as periodic staff training in confidentiality of member information.

2. Availability, Access, Storage and Retrieval
 - a. Medical/treatment records are accessible and available to providers at the time care is rendered and at other times as needed to coordinate service delivery.
 - b. Providers have written policies and procedures for the timely, effective, and confidential exchange of patient information between primary care practitioners, behavioral health care practitioners, specialists, and organizational providers.
 - c. Providers' written policies and procedures address archiving and destruction of inactive medical/treatment records in compliance with applicable State and federal law.
 - d. Providers' written policies and procedures address storage and maintenance of records for 10 years.
 - e. PrimeWest Health members' medical/treatment records shall be made available to the Minnesota Department of Health (MDH), DHS, Center for Medicare & Medicaid Services (CMS), PrimeWest Health, or an authorized staff member or designee of these agencies at their written request.
 - f. Requests for medical/treatment records must be honored within 14 days of the request and/or according to CMS and/or DHS definition of an expedited Appeal or Grievance (complaint).
 - g. Reimbursement for record reproduction related to Medicare or Medicaid review follows CMS and state reimbursement guidelines.
3. Organization of Medical Record
 - a. Medical/treatment records are maintained in an organized manner that supports effective and confidential patient care and quality review.
 - b. Written standards or procedures exist to address the following:
 - i. Order of the medical record
 - ii. List of documents to be filed in each section of the record
 - iii. Timely filing of medical information
4. Content and Documentation Standards (see attachments)
 - a. Medical/treatment records are to be maintained in a manner that facilitates communication, coordination, and continuity of care and promotes effective and efficient treatment.
 - b. PrimeWest Health requirements for content and documentation reflecting commonly accepted elements and standards, based on regulatory requirements, are addressed in the attached Medical Record/Behavioral Health Treatment Record Documentation Standards.
 - c. Electronic record systems must comply with all applicable medical/treatment record requirements as set forth above.

E. Performance Goals (see Performance Goal attachment)

PrimeWest Health has established standards and guidelines for medical/treatment record documentation and management. PrimeWest Health Quality staff utilizes various methods to monitor provider performance against performance goals.

1. **Site visit:** Evaluates sites to assess the provider's organizational and service delivery capabilities. See PrimeWest Health Policy and Procedure QM 05 – Provider Site Visit.
2. **Ongoing quality monitoring:** Audits are conducted against required criteria to measure and evaluate medical/treatment record documentation and quality of care.
3. **Unavailable medical record:** A threshold has been established for unavailable medical record rates during the data collection process.

Note: The systems and standards described may be superseded or supplemented by specific terms set forth in written agreement between PrimeWest Health and a provider group.

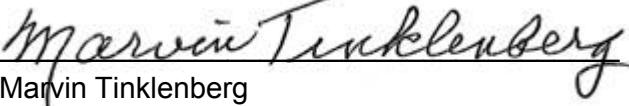
References: Specific regulatory requirements are cited in the attachments to this Policy and Procedure.

Violation of this Policy

No or only partial adherence to this policy may result in noncompliance with current regulatory requirements and subsequent penalties to PrimeWest Health. Remediation for violators will include, but not be limited to, disciplinary action up to and including termination depending on the circumstances of the situation at the time.

Signatures

Signature Approval:  Date: 10-08-09
Charles McKinzie, MD
Medical Director/Designated Senior Physician

Signature Approval:  Date: 10-08-09
Marvin Tinklenberg
PrimeWest Health Joint Powers Board of Directors

Performance Goals

<u>Data</u>	<u>Frequency</u>	<u>Standard/Threshold</u>	<u>Data Source</u>	<u>Review</u>	<u>Action</u>
1.Site Visit	At the time of the initial PrimeWest Health contract with a new provider group, at the time a provider group relocates or opens a new site, and at the time of recredentialing.	<p>Medical record keeping practices are addressed in the Provider Site Visits Policy/Procedure for:</p> <ul style="list-style-type: none"> ● Secure location ● Policy for confidentiality, release of information, and living wills ● Compliance with organization and documentation policy is monitored ● Policy for chart availability between practice sites ● Provide a sample medical record 	Site Visit results.	<p>Follow-up with provider group per established time frame.</p> <p>Review at Credentialing Committee, QCCC.</p>	Follow-up with provider group and assist as needed until issue is resolved.
2.Ongoing Quality Monitoring	Annually	<p>Content/Documentation Standards and Medical Record audit elements in the Medical Records Policy/Procedure meet 90% overall compliance rate.</p> <ul style="list-style-type: none"> ● 90% scoring of “Yes” indicates the provider group met PrimeWest Health standards overall ● 89% or below requires review by QCCC 	<p>Medical Record audits</p> <p>HEDIS and Clinical Practice Guidelines performance measurements</p>	<p>Aggregate results of Medical Record audits available 1st quarter of the following year</p> <p>Review at Credentialing Committee, QCCC</p>	Each provider group audit results and PrimeWest Health average are provided to provider groups. The groups are informed of the standards/thresholds. Assistance with improvement efforts is provided if goals are not met.

3. Unavailable Medical Record	Annually	Provider groups will not exceed an unavailable chart rate of 10% for annual Medical Record audits and/or HEDIS and Clinical Practice Guidelines performance measurements.	Medical Record audits HEDIS and Clinical Practice Guidelines performance measurements.	Review at Credentialing Committee, QCCC.	If unavailable medical record rate is > 10%, determine if denominator is great enough to require action. Follow-up with group and assist as needed until issue is resolved.
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Medical Record Documentation Standards

ELEMENT	STANDARD	REGULATORY REQUIREMENT
A. RECORD FORMAT		
1.Elements in the medical record are organized in a consistent manner.	The contents of the medical record are affixed and organized in a logical and consistent manner. Record is organized in chronological order.	NCQA QI-12
2.Member name present on every page.	A separate medical record must be maintained for each unique member with the member’s name present on every page.	MN Rules part 9505.2175, subp.2 (B); NCQA QI-12
3.Author identification present for every entry.	All entries in medical record contain the author’s identification, which may be a handwritten signature, unique electronic identifier or initials, and title. Stamped signatures are not acceptable. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Some acceptable electronic signatures are “Electronically signed by,” “Authenticated by,” “Approved by,” “Completed by,” “Finalized by,” or “Validated by,” and include the practitioner’s name, including credentials, and date signed.	CMS Manual System, Pub 100-08, CR 5971; MN Stat. 221.173; MN Rules part 9505.2175, subp. 2 (C) (4); NCQA QI-12
4.All entries dated.	Each entry in the medical record must contain the date on which the entry was made and the date on which the health service was provided.	MN Rules part 9505.2175, subp. 2 (C) (1) (2); NCQA QI-12
5.All entries legible to someone other than author.	There is a system in place to assure that all entries in the medical record are legible to someone other than the author. Content of the record is presented in a standard format that allows a reader to review without the use of separate legend/key.	MN Rules part 4685.1110, subp. 13 (A); MN Rules 9505.2175, subp. 2(A); NCQA QI-12
6.Each entry in medical record contains the length of time spent with member if the amount paid for the service depends on time spent.	If level of service is based on face time with the member, time spent must be documented in the medical record entry.	MN Rules part 9505.2175, subp. 2 (C) (3)

ELEMENT	STANDARD	REGULATORY REQUIREMENT
B. BASIC RECORD CONTENT		
1. Personal biographical data includes member address, employer, home and work phone numbers, and marital status.	Personal biographical data is documented in a prominent location in each medical record and includes member's address, employer, home and work phone numbers, and marital status.	NCQA QI-12
2. Health Care Directives are documented in the medical record for those 18 years and older.	Documentation is in a prominent part of the member's current medical record whether or not the member has executed a healthcare directive. If not executed, there is documentation that health care directive information was offered.	42 CFR 422.128 (b) (1) (i) (E); MN Stat. secs. 145C.01, 145C.02, 145C.03
3. Significant illnesses and medical conditions are indicated on problem list.	A problem list which summarizes important member medical information, such as major diagnoses, past medical and/or surgical history, and recurrent complaints, is documented. There should be a current problem list, either kept separately or within each practitioner progress note.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (D) (1); NCQA QI-12
4. Absence or presence of medication allergies and adverse reactions are prominently noted in medical record.	Documentation of presence of medication allergies, including adverse reactions, must be consistently and clearly documented in a prominent location of all medical records. If the member has no known allergies or history of adverse reactions, this is also prominently noted in the medical record. Allergies to environmental allergens, food, pets, etc., should also be noted.	NCQA QI-12
5. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations and illnesses.	There should be documentation of a past medical history obtained by the third visit and includes serious accidents, operations and illnesses.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (D) (1); NCQA QI-12
6. Past medical history for members under the age of 18 (seen three or more times) includes information such as prenatal care, birth, operations and childhood illnesses.	There should be documentation of a past medical history obtained by the third visit for members under the age of 18 and includes information such as prenatal care, birth, operations and childhood illnesses.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (D) (1); NCQA QI-12

ELEMENT	STANDARD	REGULATORY REQUIREMENT
7. For members 10 years and older, there is appropriate notation concerning the use of tobacco, alcohol and substances (for members seen three or more times or if indicated, query substance abuse history).	There is documentation concerning use of tobacco, alcohol and substances for members 10 years and older. For those members seen three or more times, substance abuse should be queried and documented.	DHS Child & Teen Checkups Program; NCQA QI-12
C. PREVENTIVE SCREENING AND SERVICES		
1. Immunization status information for all ages is recorded on a single page location.	An immunization record (for children) is up to date or an appropriate history (for adults) has been made in the medical record. Immunizations should be offered and performed based on the current U. S. Recommended Childhood and Adolescent Immunization Schedule (the MDH Recommended Childhood Immunization Schedule may be used) or U.S Recommended Adult Immunization Schedule and documented on an immunization record (single page location). Documentation of immunizations administered by the office should include the date the vaccine was administered, the manufacturer and lot number, and the name and title of the person administering the vaccine.	42 CFR 441.56 (c) (3); (d) (1); NCQA QI-12
2. Body Mass Index (BMI) is documented annually for members 2 years and older.	BMI is a proxy for total body fat, which is related to the risk of disease and death. For adults 20 years and older, BMI is calculated and interpreted using standard weight/height BMI tables and weight status categories that are the same for all ages and for both men and women. For children and teens, aged 2-19, the calculation and interpretation of BMI is both age- and gender-specific utilizing the child and teen BMI calculator and BMI-for-age growth charts for girls and boys.	HEDIS Measure; PrimeWest Health Standard
3. There is evidence that preventive screening and services are offered in accordance with PrimeWest Health's clinical practice guidelines.	A summary of preventive services screening is documented in a consistent place in the medical record. Preventive health guidelines should comply with the Minnesota Child and Teen Checkups (C&TC) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule for members under the age of 21. For member 21	42 CFR 438.236; MN Rules part 9505.0175, subp. 25 (C); MN Rules part 9505.0355; NCQA QI-12;

	years and older, utilize standards of care and clinical guidelines adopted by PrimeWest Health such as the Institute for Clinical Systems Improvement (ICSI) Health Care Guidelines.	PrimeWest Health Standard
ELEMENT	STANDARD	REGULATORY REQUIREMENT
D. ASSESSMENT, PLAN AND FOLLOW-UP		
1. History and physical exam identifies appropriate subjective and objective information pertinent to member's presenting complaints.	Subjective and objective information identifying why the member is seeking medical attention should be documented. The description should include pertinent history, symptoms, and other related information. A pertinent physical examination, relevant to the problem, should be documented.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (D) (1-2); NCQA-12
2. Laboratory and other studies are ordered, as appropriate.	The results of all diagnostic tests and examinations, consistent with the exam and assessment, must be documented in the medical record. Documentation of the order for laboratory or x-ray service must also be in the record.	MN Rules part 9505.2175, subp. 2 (D) (2) (I); NCQA QI-12
3. Working diagnoses are consistent with findings.	Working diagnosis or medical impressions that logically follow from the clinical assessment and physical exam are recorded.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (D) (3) (H); NCQA QI-12
4. Treatment plans are consistent with diagnoses.	Proposed treatment plans, therapies, or other regimens are documented and logically follow previously documented diagnoses and medical impressions. There is evidence of provider consideration of member input into the proposed treatment plan; and in consultation with any specialists caring for the member.	MN Rules part 4685.1110, subp. 13 (A); MN Rules part 9505.2175, subp. 2 (G) (H); NCQA QI-12
5. There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.	The medical record shows clear justification for diagnostic and therapeutic procedures.	NCQA QI-12
6. Prescribed medications are clearly visible in medical record.	Documentation of prescribed medications, including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the medical record.	MN Rules part 9505.2175, subp. 2 (E); NCQA QI-12
7. Unresolved problems from previous visits are addressed in subsequent visits.	Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes. The record must report the	MN Rules part 9505.2175, subp. 2 (H); NCQA QI-12

ELEMENT	STANDARD	REGULATORY REQUIREMENT
8. Encounter forms or notes include information about follow-up care, calls, or visits when indicated. Specific time of return is noted in weeks, months, or as needed.	member's progress or response to treatment, and changes in the treatment or diagnosis. Follow-up is documented for members who require periodic visits for a chronic illness and for members who require reassessment following an episodic illness. Telephone encounters (phone contact) relevant to medical issues are documented in the medical record and reflect practitioner review. Return to office in a specified amount of time is recorded at time of visit, or as follow-up to consultation, laboratory, or other diagnostic reports.	MN Rules part 9505.2175, subp. 2 (C) (2) (H); NCQA QI-12
9. Consultations are used appropriately.	Requests for consultation are consistent with clinical assessment/physical findings (specialty documented). Documentation of the order for service must also be in the record.	MN Rules part 9505.0175, subp. 35 (A); NCQA QI-12
10. Note from consultant is present for each consultation requested.	Medical records include consultation reports/summaries that correspond to specialist referrals, or documentation that practitioner attempted to obtain reports that were not received.	MN Rules part 9505.2175, subp. 2 (F); NCQA QI-12
11. Consultation, lab, and imaging reports filed in the medical record are initialed by the practitioner who ordered them, to signify review.	All reports of consultation, lab, and imaging studies ordered are documented in the medical record and are initialed by the practitioner who ordered them to signify review, or another system of ensuring practitioner review is in place. If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement.	MN Rules part 9505.0175, subp. 35 (B); NCQA QI-12
12. Clinically significant consultation, abnormal lab, and imaging reports have an explicit notation of follow-up plans.	Follow up care, communication of test results, and calls/visits should be documented to indicate continuity of care. Subsequent visit notes (treatment plans) reflect results of the reports as may be pertinent to ongoing care.	MN Rules part 9505.0175, subp. 35 (B); NCQA QI-12
13. Discharge summaries are filed in the member's record.	Discharge summaries for all diagnostic and therapeutic services for which a member was referred (such as hospital discharge reports, specialty physician reports, home health nursing reports, and physical therapy reports) are found in member's record when applicable.	MN Rules part 4685.1110, subp. 13 (A); NCQA QI-12

Behavioral Health Treatment Record Documentation Standards

ELEMENT	STANDARD	REGULATORY REQUIREMENT
A. RECORD FORMAT		
1.Elements in the treatment record are organized in a consistent manner.	The contents of the treatment record are affixed and organized in a logical and consistent manner. Record is organized in chronological order.	NCQA QI-12
2.Member name present on every page.	A separate treatment record must be maintained for each unique member with the member’s name present on every page.	MN Rules part 9505.2175, subp. 2 B; MN Rules part 9520.0790, subp. 5; NCQA QI-12
3.Author identification present for every entry.	All entries in treatment record contain the author’s name, which may be a handwritten signature, unique electronic identifier or initials, title/professional degree, and relevant identification number, if applicable. Stamped signatures are not acceptable. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Some acceptable electronic signatures are “Electronically signed by,” “Authenticated by,” “Approved by,” “Completed by,” “Finalized by,” or “Validated by,” and include the practitioner’s name, including credentials, and date signed.	CMS Manual System, Pub 100-08, CR 5971; MN Stat. sec 221.173; MN Rules part 9505.0323, subp. 26; MN Rules part 9505.2175, subp. 2 C (4); NCQA QI-12
4.All entries are dated.	Each entry in the treatment record must contain the date on which the entry was made and/or the date on which the health service was provided.	MN Rules part 9505.0323, subp. 26; MN Rules part 9505.2175, subp. 2 C (1) (2); NCQA QI-12
5.All entries are legible to someone other than author.	There is a system in place to assure that all entries in the treatment record are legible to someone other than the author. Content of the record is presented in a standard format that allows a reader to review without the use of separate legend/key.	MN Rules part 4685.1110, subp.13 A; MN Rules part 9505.2175, subp. 2 A; NCQA QI-12

ELEMENT	STANDARD	REGULATORY REQUIREMENT
6. Each entry in health record contains the length of time spent with member if the amount paid for the service depends on time spent.	If level of service is based on face time with the member, time spent must be documented in the treatment record entry.	MN Rules part 9505.0323, subp. 26; MN Rules part 9505.2175, subp. 2 (C) (3)
B. RECORD CONTENT		
1. Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information.	Personal biographical data is documented in a prominent location in each treatment record and includes member's address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if applicable.	NCQA QI-12
2. Health Care Directives are documented in the treatment record for members 18 years and older.	Documentation is in a prominent part of the member's current treatment record whether or not the member has executed a healthcare directive. If not executed, there is documentation that health care directive information was offered.	42 CFR 422.128 (b) (1) (i) (E); MN Stat. secs. 145C.01, 145C.02, 145C.03
3. Member authorization to release private information and member information obtained from outside sources must be documented.	There must be a signed authorization for all external persons with whom treatment information is exchanged. The period of authorization must not exceed one year. For a minor or adult unable to give consent, the parent or legal representative has signed. No treatment information can be exchanged without member authorization or court order.	45 CFR 164.510; 45 CFR 164.522; MN Stat. sec. 144.292-4; MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, subp. 19-20; MN Rules part 9520.0790, subp. 5 (G)
4. Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.	Documentation of presence of medication allergies, including adverse reactions, must be consistently and clearly documented in a prominent location of all treatment records. If the member has no known allergies or history of adverse reactions, this is also prominently noted in the treatment record. Allergies to environmental allergens, food, pets, etc., should also be noted.	NCQA QI-12

ELEMENT	STANDARD	REGULATORY REQUIREMENT
C. ASSESSMENT AND TREATMENT PLAN		
<p>1. A medical history is easily identified and includes relevant illnesses and medical conditions.</p>	<p>A medical history must be documented which includes current and/or past major or chronic medical conditions, serious accidents, operations and illnesses.</p>	<p>MN Rules part 9505.0323, subp. H; MN Rules part 9505.2175, subp. 2 (D) (1); MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>
<p>2. A developmental history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.</p>	<p>For members under the age of 18, a comprehensive developmental history must be documented that includes relevant prenatal and perinatal events, achievement of developmental milestones, and psychological, social, intellectual, and academic history.</p>	<p>MN Rules part 9505.0323, subp. H; MN Rules part 9505.2175, subp. 2 (D) (1); MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>
<p>3. For members 10 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs, and present caffeine use.</p>	<p>A substance use history must be documented for members 10 years and older. The history must include past and present use of tobacco, alcohol, illicit drugs and any misuse of prescription or over-the-counter drugs. Present caffeine use should also be noted. Additionally, negative consequences of use and history of assessment and/or treatment should be documented.</p>	<p>MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12; PrimeWest Health Standard</p>
<p>4. Standardized co-occurring mental illness screening questionnaire results are incorporated in the initial assessment of members age 12 and older.</p>	<p>A nationally recognized tool of the provider's choice is utilized upon initial access of behavioral health services to screen members for the presence of co-occurring mental illness. The State recommends sections 1 and 2 (Internalizing Disorder and Externalizing Disorder Screeners) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the K-6.</p>	<p>MN Rules part 9505.0323, subp. 4; PMAP Contract 6.1.20; MSHO Contract 6.1.22; SNBC Contract 6.20, 6.20.2</p>
<p>5. Standardized substance use screening questionnaire results are incorporated in the initial assessment of members age</p>	<p>A nationally recognized tool of the provider's choice is utilized upon initial access of behavioral health services to screen members for the presence of substance use</p>	<p>MN Rules part 9505.0323, subp.4; PMAP Contract</p>

<p>12 and older.</p>	<p>disorder. The State recommends section 3 (Substance use Disorder Screener) of the Global Assessment of Individual Needs-Short Screener (GAIN-SS) or the CAGE-AID.</p>	<p>6.1.20; MSHO Contract 6.1.22; SNBC Contract 6.20, 6.20.2</p>
<p>6.A social history must be documented.</p>	<p>There is documentation of a social history that includes family history, current family status, history of physical, sexual, or mental abuse or trauma, current social network, and academic or vocational status.</p>	<p>MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>
<p>7.A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.</p>	<p>A psychiatric history must be documented and should include, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, relevant family information, lab test results and consultation reports.</p>	<p>MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>
<p>8.Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.</p>	<p>Presenting problem(s), as well as relevant psychological and social conditions affecting the member's medical and psychiatric status. Presenting symptoms must be clearly identified and documented, including the onset, duration, and intensity of symptoms.</p>	<p>MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, subp. H; MN Rules part 9505.2175, subp. 2 (D) (1); MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>
<p>9.Results of a mental status exam are documented.</p>	<p>A mental status examination must be documented which describes, at a minimum, the member's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude towards his or her symptoms. Comments on affect, thought content, thought process, judgment, insight, orientation status X3, attention, concentration, memory, intelligence level, and impulse control should also be documented when appropriate. Continued assessment should be documented in subsequent progress notes or follow-up visits, to include, at a minimum,</p>	<p>MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, Subp. H; MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12</p>

	thought content, specifically, imminent risk of harm to self or others. All notes should reference suicidal and homicidal ideation.	
10. Special status situations are prominently noted.	Special status situations, such as imminent risk of harm to self or others, suicidal and homicidal ideation are prominently noted. Continued assessment should be documented in subsequent progress notes or follow-up visits.	MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, Subp. H; MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12
11. Member strengths and vulnerabilities that enable or inhibit the member's ability to achieve treatment goals are documented.	Member strengths and vulnerabilities must be documented during the initial assessment and considered in the development of the treatment plan. Treatment plan notes detail member strengths and vulnerabilities in achieving treatment plan goals.	MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, subp. H; MN Rules part 9520.0790, subp. 3, 5 (B)
12. Laboratory and other studies are ordered, as appropriate.	The results of all diagnostic tests and examinations, consistent with the exam and assessment, must be documented in the treatment record. Documentation of the order for laboratory or x-ray service must also be in the record.	MN Rules part 9505.2175, subp. 2 (D) (2) (I); MN Rules part 9520.0790, subp. 5 (F); NCQA QI-12
13. A DSM-IV diagnosis is documented.	A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data. All five axes must be documented according to the DSM-IV-TR multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses must be listed when applicable.	MHCP Provider Manual, Chapter 16; MN Rules part 9505.0323, subp. H; MN Rules part 9505.2175, subp. 2 (D) (3) (H); MN Rules part 9520.0790, subp. 3, 5 (B); NCQA QI-12
14. Treatment plans are consistent with diagnoses.	Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated timeframes for goal attainment or problem resolution, and	MN Rules part 9505.0323, subp. 1 (W), 21; MN Rules part

	include a preliminary discharge plan, if applicable. Treatment plans must be developed no later than the end of the first psychotherapy session after the completion of the member’s diagnostic assessment. There is evidence of provider consideration of member input into the proposed treatment plan; and in consultation with any specialists caring for the member.	9505.2175, subp. 2 (G) (H); MN Rules part 9520.0790, subp. 4, 5 (D); NCQA QI-12
15. Informed consent for individual treatment plan is documented.	The member must participate in the development of the treatment plan and should sign the initial plan and sign or initial all updates or revisions. The plan must be reviewed and signed at least once every 90 days, and if necessary revised. For a minor or adult unable to give consent, the parent or legal representative has signed.	MN Rules part 9505.0323, subp. 1 (J), 25; MN Rules part 9520.0790, subp. 4; NCQA QI-12
16. Current medications prescribed by all prescribing practitioners, as well as over the counter and herbal preparations, are documented.	Ongoing documentation and medication reconciliation of prescribed medications, including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions, is clearly visible in the treatment record and listed in a composite form. Over the counter and herbal preparations should also be clearly noted.	MN Rules part 9505.2175, subp. 2 (E); MN Rules part 9520.0790, subp. 5 (E); NCQA QI-12
17. Evidence of informed consent for medication is documented.	The member must participate in the development of the medication treatment plan. Informed consent for medication and the member’s understanding of treatment should be documented to include use, treatment alternatives, risks, and possible outcomes and side effects of treatment. For a minor or adult unable to give consent, the parent or legal representative has signed.	MN Rules part 9505.0323, subp. 1 (J), 25; MN Rules part 9520.0790, subp. 4; NCQA QI-12
18. Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.	As required for continuity and coordination of care, all behavioral health providers shall, when appropriate, convey pertinent information to members’ primary care provider, consulting practitioner, ancillary provider, or health care institution. This shall include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical test, and any summary of the following items: Diagnosis, functional status, the treatment	45 CFR 164.501; 45 CFR 164.506; 45 CFR 164.508; MN Stat. sec. 144.293; MHCP Provider Manual, Chapter 16; MN Rules part 9520.0790, subp. 1, 5 (G) (I); NCQA QI-11;

	<p>plan, symptoms, prognosis, and progress to date. It is expected that timely updates will be provided regarding member’s progress under continuing care. This standard excludes “psychotherapy notes” which are defined as notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session. Psychotherapy notes must be separated from the rest of the individual’s medical record to qualify as psychotherapy notes. Member authorization must be obtained prior to the release of any psychotherapy notes. If the member does not wish to have treatment information exchanged, member refusal must also be documented.</p>	NCQA QI-12
ELEMENT	STANDARD	REGULATORY REQUIREMENT
D. PROGRESS NOTES AND FOLLOW-UP		
<p>1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.</p>	<p>Relevant updates to the member strengths, weakness and barriers that enable or inhibit the member’s ability to achieve treatment goals and objectives should be noted and reflect treatment interventions that are consistent with those goals and objectives. Any education interventions, including medication and preventive education should also be noted.</p>	<p>MN Rules part 9505.2175, subp. 2 (G), (H); MN Rules part 9520.0790, subp. 5 (D) (F); NCQA QI-12</p>
<p>2. Progress notes reflect current treatment interventions and mental status including special status situations.</p>	<p>There is documentation in progress notes to reflect treatment interventions that are consistent with current treatment plans and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Assessment of current mental status and special status situations to include, at a minimum, thought content, specifically, imminent risk of harm to self or others are documented. All notes should reference suicidal and homicidal ideation.</p>	<p>MN Rules part 9505.2175, Subp. 2 (G), (H); MN Rules part 9520.0790, subp. 5 (D) (F); NCQA QI-12</p>
<p>3. Encounter forms or notes include information about follow-up care, visits, calls, or</p>	<p>There must be notation in each entry about need for follow-up care, plans for a return visit or termination of treatment. Telephone</p>	<p>MN Rules part 9505.2175, subp. 2 C (2), (H);</p>

as applicable, discharge plans. Specific time of return is noted in weeks, months or as needed.	encounters (phone contact) with persons relevant to treatment, (e. g. referral sources, physicians, or parents) must be documented in the treatment record and reflect practitioner review. The specific date or timeframe of a return visit must be noted.	MN Rules part 9520.0790, subp. 5 (D) (F) (I); NCQA QI-12
4. Unresolved problems from previous visits are addressed in subsequent visits.	Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits are documented in subsequent visit notes. The record must report the member's progress or response to treatment, and changes in the treatment or diagnosis.	MN Rules part 9505.2175, subp. 2.H; MN Rules part 9520.0790, subp. 5 (D) (F); NCQA QI-12
5. Preventive services are utilized in the treatment plan.	Recommendations or referrals for preventive or other external services, as appropriate, such as stress management, relapse prevention, wellness programs, lifestyle changes, or community services, must be documented.	42 CFR 438.236; MN Rules part 9505.0355; MN Rules part 9520.0790, subp. 5 (F) (I); NCQA QI-12
6. Note from consultant is present for each consultation requested.	Treatment records include consultation reports/summaries that correspond to specialist referrals, or documentation that practitioner attempted to obtain reports that were not received.	MN Rules part 9505.2175, subp. 2.F; MN Rules part 9520.0790, subp. 5 (F) (I)
7. Consultation, lab, and imaging reports filed in the treatment record are initialed by the practitioner who ordered them, to signify review.	All reports of consultation, lab, and imaging studies ordered are filed in the treatment record and are initialed by the practitioner who ordered them to signify review. Documentation of the order for service must also be in the treatment record. If reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Review and signature by professionals other than the ordering practitioner do not meet this requirement.	MN Rules part 9505.0175, subp. 35.B; MN Rules part 9520.0790, subp. 5 (F) (I)
8. Clinically significant consultation, abnormal lab, and imaging reports have an explicit notation of follow-up plans.	Follow-up care, communication of test results, and call/visits should be documented to indicate continuity of care. Subsequent visit notes and treatment plans reflect results of the reports as may be pertinent to ongoing care.	MN Rules part 9505.0175, subp. 35 (A) (B); MN Rules part 9520.0790, subp. 5 (F) (I)
9. Discharge summaries are filed in the member's record.	Discharge summaries for diagnostic and therapeutic services for which a member	NCQA QI-12

	was referred, such as hospital discharge reports, specialty physician reports, home health nursing reports, and physical therapy reports, are found in member's record when applicable.	
10. At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.	A statement of the reason for termination, current client condition, and the treatment outcome must be documented at the closing of the case.	MN Rules part 9520.0790, subp. 5 (H)

Medical Record Audit Tool

Facility Name: _____ Provider ID: _____ Date: _____

Member Name: _____ Member ID: _____ DOB: _____

A. RECORD FORMAT	YES	No	N/A
1. Elements in the medical record are organized in a consistent manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Member name present on every page.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Author identification present for every entry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. All entries dated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. All entries legible to someone other than author.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. BASIC RECORD CONTENT	YES	No	N/A
1. Personal biographical data includes member address, employer, home and work phone numbers, and marital status.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Health Care Directives are documented in the medical record for those 18 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Significant illnesses and medical conditions are indicated on problem list.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Absence or presence of medication allergies and adverse reactions are prominently noted in medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Past medical history (for members seen three or more times) is easily identified and includes serious accidents, operations and illnesses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Past medical history for members under the age of 18 (seen three or more times) includes information such as prenatal care, birth, operations and childhood illnesses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. For members 10 years and older, there is appropriate notation concerning the use of tobacco, alcohol and substances (for members seen three or more times or if indicated, query substance abuse history).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. PREVENTIVE SCREENING AND SERVICES	YES	No	N/A
1. Immunization status information for all ages is recorded on a single page location.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Body Mass Index (BMI) is documented annually for members 2 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. There is evidence that preventive screening and services are offered in accordance with PrimeWest Health's clinical practice guidelines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. ASSESSMENT, PLAN AND FOLLOW-UP	YES	No	N/A
1. History and physical exam identifies appropriate subjective and objective information pertinent to member's presenting complaints.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Laboratory and other studies are ordered, as appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Working diagnoses are consistent with findings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Treatment plans are consistent with diagnoses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. There is no evidence the member is placed at inappropriate risk by a diagnostic or therapeutic procedure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Prescribed medications are clearly visible in medical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Unresolved problems from previous visits are addressed in subsequent visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Encounter forms or notes include information about follow-up care, calls, or visits when indicated. Specific time of return is noted in weeks, months or as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Note from consultant is present for each consultation requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Consultation, lab, and imaging reports filed in the medical record are initialed by the practitioner who ordered them, to signify review.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Clinically significant consultation, abnormal lab, and imaging reports have an explicit notation of follow-up plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Discharge summaries are filed in the member's record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS SECTION:

Section:	Question Number:
Section:	Question Number:
Section:	Question Number:
Section:	Question Number:
Section:	Question Number:

Elements Met: _____% (90% Performance Threshold)

Audit meets PrimeWest Health standards: Yes

Forward to QCCC for review: Yes

Reviewer

Date

Clinic Representative

Behavioral Health Treatment Record Audit Tool

Facility Name: _____ Provider ID: _____ Date: _____

Member Name: _____ Member ID: _____ DOB: _____

A. RECORD FORMAT	YES	No	N/A
1. Elements in the treatment record are organized in a consistent manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Member name present on every page.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Author identification present for every entry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. All entries are dated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. All entries are legible to someone other than author.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. RECORD CONTENT	YES	No	N/A
1. Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Health Care Directives are documented in the treatment record for members 18 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Member authorization to release private information and member information obtained from outside sources must be documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. ASSESSMENT AND TREATMENT PLAN	YES	No	N/A
1. A medical history is easily identified and includes relevant illnesses and medical conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A developmental history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. For members 10 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Standardized co-occurring mental illness screening questionnaire results are incorporated in the initial assessment of members age 12 and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Standardized substance use screening questionnaire results are incorporated in the initial assessment of members age 12 and older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. A social history must be documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Results of a mental status exam are documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Special status situations, when present, are prominently noted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Member strengths and vulnerabilities that enable or inhibit the member's ability to achieve treatment goals are documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Laboratory and other studies are ordered, as appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. A DSM-IV diagnosis is documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Treatment plans are consistent with diagnoses.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Informed consent for individual treatment plan is documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Current medications prescribed by all prescribing practitioners, as well as over the counter and herbal preparations, are documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Evidence of informed consent for medication is documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. PROGRESS NOTES AND FOLLOW-UP	YES	No	N/A
1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Progress notes reflect current treatment interventions and mental status including special status situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months or as needed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Unresolved problems from previous visits are addressed in subsequent visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Preventive services are utilized in the treatment plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Note from consultant is present for each consultation requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Consultation, lab, and imaging reports filed in the treatment record are initialed by the practitioner who ordered them, to signify review.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Clinically significant consultation, abnormal lab and imaging reports have an explicit notation of follow-up plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Discharge summaries are filed in the member's record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS SECTION:

Section:	Question Number:
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Elements Met: _____% (90% Performance Threshold)

Audit meets PrimeWest Health standards: Yes

Forward to QCCC for review: Yes

Reviewer

Date

Clinic Representative