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Behavioral Health Treatment Record Review Criteria and Scoring

Item	Biographical/Personal Data Documentation	Points
1	Patient name or patient ID number *Every page of the medical record has patient identification in the form of full name or some ID number. ID number may be a medical record number or insurance number.*	1.00
2	Patient date of birth *Must be documented at least once in the patient record either on the intake form or initial evaluation.*	0.14
3	Patient current address *May be kept in separate files or database.*	0.14
4	Patient home and work telephone numbers *A home telephone number should be listed for all patients. If the patient is a child, a parent's or guardian's home phone is appropriate. If there is no telephone in the home, the chart should indicate how the office contacts the patient in an emergency.*	0.14
5	Employer or school listed if applicable	0.14
6	Marital status if patient is more than 17 years of age	0.14
7	Patient legal status listed if patient is less than 18 years of age	0.14
8	Guardianship listed if patient is less than 18 years of age	0.14
	Sub-total	**1.84**

Item	General Chart Organization	Points
9	All entries in the medical record are signed or initialed. *Documentation includes the responsible clinician's name, professional degree and, if applicable, relevant identification number (provider ID #) for each visit. May be written or electronic signature.*	2
10	All entries in the treatment record are dated	2
11	All entries are in sequential order	1

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12	All records are legible *Several charts are reviewed before the reviewer deems them illegible. If charts are deemed illegible, you will be asked to send a copy of at least three charts to the Behavioral Health Department for review by an Associate Medical Director. The treatment record review will be scored as "unsatisfactory" if charts are subsequently judged to be illegible.*	***
	Sub-total	**5**

Item	Patient History Documentation	Points
13	Presenting problems are documented on a completed problem list	4
14	Current prescribed medications are listed (as applicable)	3
15	Dosage of each medication prescribed is documented (as applicable)	1
16	Dates of initial prescription and refills are documented (as applicable)	1
17	Allergies/adverse reactions *Medication allergies and adverse reactions/sensitivities must be recorded in a prominent location in the chart. If the patient does not have allergies, no known allergies (NKA) or no known drug allergies (NKDA) must be in the record.*	1
18	Imminent risk of harm (as applicable) *Includes to self or others*	3
19	Suicidal Ideation (as applicable) *Documentation should include severity of the suicidality.*	3
20	Premature termination of treatment (as applicable) *The reason for termination is documented which includes patient's who have refused further treatment, are lost to contact, transferred to an alternate provider, or have a level of care change.*	1
21	Present problems along with relevant psychological and social conditions affecting the patient's medical and psychiatric status. *For those without active medical problems, the list should either indicate "health maintenance" as the active issue or indicate "no problems."*	4
22	Previous treatment dates (as applicable) *Documentation includes all treatment experiences over the patient's lifetime.*	2

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23	Provider name and credentials are listed in conjunction with each previous treatment experience (as applicable)	2
24	Therapeutic interventions and responses to previous treatment experiences are documented (as applicable) *Outcome is documented for each treatment experience.*	3
25	Relevant family information is documented *Includes genogram or written documentation of family health and family illnesses.*	3
26	Sexual and physical abuse (as applicable) *Includes written documentation of abuse over the patient's lifetime*	3
27	Laboratory tests and consultation reports are present (as applicable) *Consultation reports include medication evaluations, neurological or psychological studies, UA or BA.*	3
28	For children and adolescents less than 18 years of age, prenatal and perinatal events are documented *Documentation includes a complete developmental history (physical, psychological, social, intellectual, and academic) (as applicable)*	4
29	Smoking history *For patients 12 and older, documentation of the following: Is the patient a current smoker? If so, current rate of use? For current smokers, indication that counseling about smoking cessation has occurred including mentioning health hazards of tobacco use.*	1
30	Alcohol use *For patient's 12 and older, documentation of the following: Is there indication of alcohol abuse/addiction or problem drinking? A careful history of alcohol use should be obtained. If indicated, counseling/referral should be documented.*	3
31	Illicit drug use *For patient's 12 and older, documentation of the following: Is there any indication of drug use or addiction to illicit drugs? If so, is a referral to a treatment program indicated?*	3
32	Prescription and over the counter drug use *For patient's 12 and older, documentation of the following: Is there any indication of drug use or addiction to either prescription medications or over the counter drugs? If so, is a referral to a treatment program indicated?*	1

33	For other family members past and present use of cigarettes, alcohol, illicit, prescribed and other over the counter drug use is documented. *Family members include both immediate and biological*	1
	Sub-total	**50**

Item	Mental Status Documentation	Points
34	Affect *examples include: appropriate, constricted, blunted, flat*	0.5
35	Speech *examples include: normal, pressured, excessive*	0.5
36	Mood *examples include: normal, inappropriate, dysphoric*	0.5
37	Thought content *examples include: normal, delusional, paranoid*	0.5
38	Judgment *examples include: good, fair, poor*	0.5
39	Insight *examples include: good, poor*	0.5
40	Attention or concentration *examples include: relaxed, maintains focus, distractible, inattentive*	0.5
41	Memory *Includes long and short term memory*	0.5
42	Impulse control *examples include: over controlled, tolerant, volatile, aggressive*	0.5
	Sub-total	**4.5**

Item	Treatment Plans	Points
43	A DSM-IV diagnosis is documented *Diagnosis must be consistent with the presenting problems, history, MSE, and or other assessment data.*	***
44	Treatment plans are consistent with the diagnosis	4
45	Treatment plans must contain objective, measurable goals and estimated time frames for goal attainment or resolution. *Measurable goals include identified tasks or actions that are documented in conjunction with the anticipated results.*	1
46	Interventions are consistent with treatment plan goals and objectives	4
47	Informed consent for medication is documented (as applicable) *Documentation includes medication options, side effects, and delayed or prolonged reactions. If child, documentation shows parent/guardian informed.*	4
48	Patient’s understanding of treatment plan is documented. *Documentation includes practitioner’s initials and statement of patient’s understanding of plan or by signature of patient or if child, signature of parent or guardian on treatment plan.*	4
49	Progress notes describe the patient’s strengths and limitations in achieving their treatment plan goals and objectives.	3
50	Patient’s who become suicidal, homicidal or unable to care for themselves documentation indicates a referral to higher level of care (as applicable)	4
51	Preventive services are documented (as applicable) *Services include: relapse prevention, stress management, wellness programs, lifestyle changes, referrals to community resources.*	3
52	Signed releases of information. *Record contains specific written release forms for each caregiver to whom information will be shared or a note of the patient’s refusal to have information released. **Note**: This includes a written release of information for the patient’s primary care physician (required by the New York State Department of Health).*	2

53	Evidence of continuity of care (exchange of information) between Primary Behavioral Health Provider and consultants, ancillary providers, and health care institutions exists *Evidence includes previous treatment records or documented efforts to obtain or sending written communications and/or documentation of telephone conversations.*	4
54	Evidence of continuity of care (exchange of information) between the behavioral health provider and the primary care physician (PCP) *Evidence includes written communications and/or documentation of telephone conversations.*	4
55	Date/time frames for follow-up visit are recorded in the chart if treatment is complete, discharge plan is documented.	2
	Sub-total	**39**
	Total Score	**100.34**

*** Always results in further review