January-22

UnitedHealthcare Community Plan (UHCCP)

NY Treatment Record Tool

	Rating Scale: NA = Not Applicable Y = Yes N = No	Yes	No	NA
General Documentation				
001	Each member has a separate record.			
002	Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information, if relevant.			
003	All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
004	For children and adolescents the record includes legal documents (court mandates, parental custody, ACS/CPS custody, orders of protection, termination of parental rights etc.) confirming a child's legal custodian AND legal guardian (if different).			
Initial Assessment				
005	The initial assessment for outpatient services is completed within 30 days of the member's request for services; any exceptions to this time frame are clearly documented (must be scored for all outpatient services).			
006	A complete clinical case formulation is documented in the record (e.g., DSM primary treatment diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).			

007	The member's reasons for seeking treatment are documented.			
008	A behavioral health history is in the record and includes the following information: dates and providers of previous treatment, family behavioral health history information and therapeutic interventions and responses.			
009	There is documentation that recent providers of services have been contacted to obtain discharge summaries and other pertinent information.			
010	A medical history is in the record and includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses and family medical history inf			
011	Was a current medical condition identified? This is a non-scored question.			
012	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.			
013	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. This is a non-scored question.			
014	A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
015	The record documents a risk assessment appropriate to the level of care and population served which may include the presence or absence of suicidal or homicidal risk and any behaviors that could be considered a danger toward self or others.			

016	If a risk issue is identified, a safety plan is documented in the record.			
017	The record includes documentation of previous suicidal or homicidal behaviors, (dates, method, and lethality) as well as any behaviors that could be considered a danger toward self or others.			
018	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.			
019	For children and adolescents the assessment includes and assessment of bullying the member has experienced or if the member has been the perpetrator of bullying.			
020	The behavioral health history includes an assessment of any trauma the member has experienced.			
021	For Adolescents: The assessment documents a sexual behavior history to include sexual identity, orientation, activity status, unsafe/risky situations and practices.			
022	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, living arrangements, custody, and academic), are documented.			
023	The initial screen includes an assessment for depression.			
024	For members 12 and older, a substance abuse screening occurs using a standardized screening instrument and clinical assessment as needed. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-cou			

025	For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
026	For active smokers, the substance abuse screening includes documentation of the member's readiness to reduce or quit using tobacco.			
027	For active smokers, every 3 months the member's nicotine use is reassessed.			
028	For members under the age of 18, the substance abuse screening includes documentation of nicotine, alcohol or subatance use by anyone living in the member's place of residence.			
029	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
030	The substance identified as being misused was alcohol. This is a non-scored question.			
031	The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.			
032	The substances identified as being misused were alcohol and other substance(s). This is a non-scored question.			
033	The assessment documents the spiritual and cultural variables that may impact treatment			

034	An educational assessment appropriate to the member's age is documented (including identification of any literacy needs).			
035	The record documents the presence or absence of relevant legal issues of the member and/or family.			
036	There is documentation that the member was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
037	There is documentation that indicates the member understands and consents to the medication used in treatment.			
038	For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.			
039	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			
040	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
041	The member's previous medication history is documented in the record.			
042	The clinician uses a Consent for Treatment or Informed Consent form with all members; this document should be signed by the member and/or legal guardian.			

043	For children and adolescents, there is documentation that the legally authorized decision maker for the child understands and consents to treatment.			
Coordination of Care				
044	Does the member have a medical physician (PCP)? This is a non-scored question.			
045	The record documents that the member was asked whether they have a PCP. Y or N Only			
046	If the member has a PCP there is documentation that communication/collaboration occurred.			
047	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.			
048	Is the member being seen by another behavioral health provider (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). This is a non-scored question.			
049	The record documents that the member was asked whether they are being seen by another behavioral health provider. Y or N Only			
050	If the member is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.			

051	If the member is being seen by another behavioral health provider, there is documentation that the member/guardian refused consent for the release of information to the behavioral health provider.			
Treatment Planning				
052	For Outpatient Services Only: The treatment plan is completed within 30 days of admission or prior to the 4th visit.			
053	An initial treatment plan with goals, treatment priorities, and milestones for progress is in the record.			
054	There is evidence that the assessment is used in developing the treatment plan and goals.			
055	At the time of the initial assessment and throughout treatment, potential barriers or difficulties to participating in treatment are identified and addressed.			
056	If member receiving services from collateral organizations or providers (such as: probation, family court, domestic violence support, etc.) there is evidence that, when agreed upon by the member, that communication occurs as needed.			
057	The member and the primary clinician sign the treatment plan and any treatment plan reviews.			
058	For children and adolescents, the legally authorized decision maker signs the treatment plan and any treatment plan reviews.			

059	The treatment plan is consistent with the diagnosis.			
060	The treatment plan includes a recovery goal in the member's own words.			
061	Measurable and attainable steps toward the achievement of goals are identified.			
062	The treatment plan has estimated time frames for goal attainment.			
063	Treatment plan goals, objectives, and services reflect the assessment and include the individual’s/family’s preferences and priorities.			
064	The treatment plan is updated when goals are achieved or new goals are identified.			
065	For Outpatient Services Only:The treatment plan is reviewed and updated as needed as determined by the individual/family and the treating clinician, but no less than annually.			
066	When applicable, the treatment record, including the treatment plan, reflects discharge planning.			
067	If a member is receiving services in a group setting, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member needs.			

068	The treatment record documents and addresses biopsychosocial needs.			
069	The treatment record indicates the member's involvement in care and service.			
070	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.			
Progress Notes				
071	For all Outpatient Services: All progress notes document the start and stop times or duration for each session when a timed code is used.			
072	For all Outpatient Services: All progress notes document clearly who is in attendance during each session.			
073	For all Outpatient Services: All progress notes include documentation of the billing code that was submitted for the session.			
074	The progress note indicates the type of intervention that was used for the session			
075	The progress notes reflect reassessments when necessary.			

076	The progress notes reflect on-going risk assessments (including but not limited to suicide, homicide, and dangerous behaviors) and monitoring of any at risk situations.			
077	Documentation in the record reflects that safety plans are reviewed and updated when clinically indicated.			
078	Documentation in the record includes the reason(s) for continued services.			
079	The progress notes describe/list member strengths and limitations and how those impact treatment.			
080	Progress notes are linked to goals and objectives by summarizing services provided, the interventions utilized, the recipient's response, and progress toward goals.			
081	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.			
082	The progress notes document the use of any preventive services (relapse prevention, stress management, wellness programs and referrals to community resources).			
083	If the member is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)			
084	When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication. This is a non-scored question.			

085	When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing clinician.			
086	When lab work is ordered, there is evidence that the provider reviewed the results with the member.			
087	The progress notes document the dates of follow up appointments AND when members miss appointments.			
088	When a member misses an appointment, there is documentation of outreach efforts (phone calls, missed appointment letters) the provider makes to reengage the member in treatment.			
Transitions Planning				
089	Was the member transferred/discharged to another clinician or program? This is a non-scored question.			
090	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
091	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.			
092	The reason for discharge is clearly identified.			

093	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
094	The discharge/aftercare plan describes specific follow up activities.			
095	When a member discontinues services, a full review of the case, including an assessment of the level of risk, is completed and efforts are made to reengage the member in services.			
096	When a case is closed as a result of the member discontinuing services, written correspondence is sent to the member indicating they are encouraged and welcome to reengage in services at any time.			
Treatment Records				
097	Treatment records are completed within 30 days following discharge from services.			
098	The record is clearly legible to someone other than the writer.			
099	When appropriate there is evidence of supervisory oversight of the treatment record.			
Medical Necessity				

100	The documentation in the treatment record includes the onset, duration, and frequency of the symptoms the member is experiencing.			
101	The documentation in the treatment record identifies functional deficits the member is experiencing.			
102	The documentation in the record indicates how the services that are rendered will address the functional deficits.			
103	The documentation in the record indicates that a lack of treatment could result in increased impairment for the member.			
104	The documentation in the record indicates that the services the member needs cannot be effectively rendered at a lower level of care (example, a PCP office).			
105	The documentation in the record indicates that not receiving the treatment could result in decompensation and a need for treatment at a high level of care or service type (example, inpatient).			
Education				
106	There is documentation that the provider offers education to members/families about care options, participation in care, coping with behavioral health problems, prognosis and outcomes.			
107	There is documentation that the risks of not participating in treatment are discussed with the member.			

Interpreter Services				
108	If the member has limited English proficiency, there is documentation that interpreter services were offered.			
Recovery and Resiliency				
109	The member is given information to create psychiatric advance directives. This is a non-scored question.			