Outpatient Behavioral Health Services Audit Tool (Scoring)
Effective 7/1/2024

Section A: General Documentation
Information that must be documented for all clinical encounters submitted for reimbursement

Item	Requirement/Standard Description	Met	Partly Met	Not Met	NA	Comments / Recommendations
D1	Member's name or Medicaid ID is listed on each document within the record					
D2	Member or Guardian constent to participate in services is present					
D3	Member or Guardian's verbal or written consent to participate in Telehealth services is present (as appropriate)					
D4	Date of service is domumented					
D5	Start and end time of service or service duration is documented					
D6	Place of service is documented					
D7	Reason for the encounter is doumented					
D8	Description of service provided and/or interventions utilized is documented					
D9	Member's response to the service and/or progress towards treatment goals from the service provided (as appropriate) is documented					
D10	Notes address suicide risk as needed until risk is resolved (as appropriate) is documented					
D11	Plan for next contact/Care coordination and/or Referrals (as appropriate) is documented					
D12	Care Coordination and referral outcomes are documented (as appropriate) is documented					
D13	Provider's dated signature and relevant qualifying credential. A title should be included where no credential is held.					
D14	Interpretation/translation services are documented (as appropriate)					
D15	Documentation is legible					

Item		Requirement/Standard Description	Met	Partly Met	Not Met	NA	Comments / Recommendations
D16		Documentation supports use of CPT/HCPCS code billed for service					
D17		Evidence of documentation for no show appointments or drop out of services is present (as appropriate)					
D18		Clinical rationale and medical necessity for the service is documented					
Total for Section A=			0	0	0	0	0.00%

Medical Necessity Documentation Demonstrating medical necessity for assessment and treatment planning services includes generating an assessment and treatment plan in addition to documentation of the assessment or treatment planning service provided. These clinical documents include the following information.

Section B: Assessment

Item		Requirement/Standard Description	Met	Partly Met	Not Met	NA	Comments / Recommendations
A1	Assessment	Formal Risk Assessment/screen present, including Suicide question and Homicide quesiton, inlcuding Safety plan/crisis plan is present (if applicable)					
A2	Assessment	Chief Complaint/Problem Statement is present					
A3	Assessment	Psychiatric/Mental Health History is documented					
A4	Assessment	Complete Mental Status Evaluation is documented					
A5	Assessment	Client Strengths, skills, abilities, interests are documented					
A6	Assessment	Complete psychosocial history is documented including family, social history and cultural issues					
A7	Assessment	History including pre/perinatal events, physical/emotional/social/ intellectual growth & development, school adjustment & performance, typical activities & interests, behavior mgmt skills, social skills issues. Assessment includes review of developmental history, delays or disabilities, functional difficulties related to aging, etc.					
A8	Assessment	Medical/ dental history, symptoms, severity and necessity is documented.					
A9	Assessment	Substance Use/Abuse History is documented					

Item		Requirement/Standard Description	Met	Partly Met	Not Met	NA	Comments / Recommendations
A10	Assessment	Prescribed medication(s) is documented					
A11	Assessment	Behavioral Health Diagnoses with supporting evidence is documented					
Total for Section B=			0	0	0	0	0.00%

Section C: Treatment Plan

Item		Requirement/Standard Description	Met	Partly Met	Not Met	NA	Comments / Recommendations
T1	Treatment Plan	Treatment plan is individualized, stengths-based and culturally sensitive					
T2	Treatment Plan	Treatment plan includes short and long terrm goals in a manner understandable to the individual.					
T3	Treatment Plan	Treatment interventions include specific types and frequency of services					
T4	Treatment Plan	Risk/harm/SI concerns are addressed in plan					
Total for Section C=			0	0	0	0	0.00%

Score Summary	Percent	
Section A	0.00%	
Section B	0.00%	
Section C	0.00%	