OP (Outpatient) Clinical Record Review Tool

	Facility or Provider:		
	Pt. File ID#_____	**Date:**	**Auditor:**
	Outpatient:		
	IOP:		
	Partial Hospitalization:		
	Child: Adult:		
	Contract Requirements	**Scoring (M=Met PM=Partially Met NM=Not Met)**	**Comments**
	Demographic and Intake Information		
1	1. Member's name listed on each page of the clinical record		
2	2. Member's date of birth documented		
3	3. Member's gender documented		
4	4. Legal guardianship addressed, if applicable		
5	5. Address and phone number listed		
6	6. Identified primary language spoken		
7	7. Record was legible and maintained in detail		
8	8. Evidence of efforts to collect PCP information		
9	9. Communication with PCP is documented, if applicable.		
10	10. Consent for treatment signed by member and/or legal guardian		
11	11. Confidentiality statement signed by member and /or legal guardian		
12	12. Patient rights and responsibilities		
13	13. Documentation of service eligibility		
14	14. Documentation of informed consent was located in the child's clinical record		
	Service Documentation Requirements		
1	1. Date the service occurred		
2	2. Start and end times for services billed on a per unit basis		
3	3. Identification of the setting where service occurred		
4	4. Identification of the specific problem, behavior, or skill deficit for which the service was provided		

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5	5. Documentation included the type of service provided including the specific intervention used		
6	6. Progress notes reflected updates on the member's progress towards meeting the goals and objectives identified in the treatment plan		
7	7. Documentation included the original, legible signature and credentials or title of the person rendering the service.		
8	8. Documentation included the signature of supervisor, if applicable		
9	9. Documentation included referrals to other services, if applicable		
	Individualized Treatment Plan		
1	1. The treatment plan was recovery-oriented and promoted resiliency		
2	2. The ICD-9-CM / DSM IV TR diagnosis code(s) were consistent with the assessment(s)		
3	3. Goals were appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and expressed needs		
4	4. The treatment plan included measurable objectives and target dates		
5	5. The treatment plan included a list of services to be provided		
6	6. The treatment plan included the amount, frequency and duration of each service for the 6 month duration of the treatment plan (e.g., no references to "p.r.n" or "x to y times per week")		
7	7. The treatment plan included the signature of the recipient		
8	8. If recipient was unable to sign, an explanation of the reason for the inability to sign was documented		
9	9. The treatment plan included the signature of the recipient's parent, guardian, or legal custodian, if a minor		

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8	8. Clinical reports and assessments included FARS/CFARS **(Applies to Florida only)**		
9	9. Clinical reports and assessments included a current medical history including immunizations for members 0-18		
10	10. Clinical reports and assessments included previous treatment (MH/SA; IP/OP; last use [SA cases])		
11	11. Clinical reports and assessments included lethality (suicidality, homicidality, assaultiveness, violence)		
12	12. Clinical reports and assessments included a mental health out-of-home risk		
13	13. Clinical reports and assessments included documentation of the support system		
14	14. Clinical reports and assessments included strengths and barriers to treatment		
15	15. Clinical reports and assessments included evidence of treatment plan reviews		
16	16. Clinical reports and assessments included evidence of medication monitoring		
17	17. Clinical reports and assessments included documentation of a developmental history, if the member was an adolescent or child		
18	18. Clinical reports and assessments included consultation reports, if applicable		
19	19. Clinical reports and assessments included documentation of denial of services		
20	20. Clinical reports and assessments included physician's orders and results of diagnostic and laboratory tests, medication assessment, prescriptions, and management		
	Discharge Planning		
1	1. Discharge planning included documentation that the member agreed/and supported the discharge plans (signed by the member/ appropriate guardian)		
2	2. Discharge planning included a discharge summary		
3	3. The discharge summary included referrals to supportive services		
4	4. The discharge summary included referrals to other providers (PCP, etc.)		

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5	5. The documentation of transfers or discharges indicated individualized information related to the member's condition, current living situation, and community resources		
	Kentucky Specific Items		
1	1. Member's age is documented		
2	2. Marital status, for adults, is documented		
3	3. Member's race or ethnicity is documented		
4	4. Employer, if applicable		
5	5. Employer address and phone number		
6	6. Name of school, if school aged		
7	7. Name and telephone information for emergency contact(s)		
8	8. Allergies, adverse reations and any known allergies are noted in a prominent location in the record.		
9	9. Identification and history of nicotine, alcohol use or substance abuse		
10	10. Advanced medical directives for adults		
11	11. All written denials of service and the reason for the denial as applicable		
12	12. If the record is judged illegible, record legibility is evaluated by another reviewer		
	Score:	**# of Elements**	
	Met:	0	
	Partially Met:	0	
	Not Met:	0	
	Total Possible:	0	
	Total Score:	#DIV/0!	
	Signature:	**Date:**	