Louisiana - Clinical Practice Guidelines Record Tool

Effective Date: August 5, 2024

These audit tools can be used for various types of audits that a provider may require. They ensure you are meeting state regulatory requirements.

Major depressive disorder (MDD)

Question

1. The provider found sufficient evidence to support the diagnosis of MDD by ruling out medical conditions that might cause depression and/or complicate the treatment.
2. The provider delivered education about MDD and its treatment to the member, and if appropriate, to the family.
3. If psychotic features were found, the treatment plan included the use of either antipsychotic medication or ECT, or clear documentation why not.
4. If MDD was of moderate severity or above, the treatment plan used a combination of psychotherapy and antidepressant medication, or clear documentation why not.
5. The psychiatrist delivered education about the medication, including signs of new or worsening suicidality, and the high-risk times for this side effect.
6. If provider was not an MD, there was documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above.

Attention deficit hyperactivity disorder (ADHD)

Question

7. Diagnosis was determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life.
8. Record indicated that the medical evaluation was reviewed to rule out medical causes for the signs and symptoms.
9. Psychoeducation was delivered to all members with ADHD and in the case of minors, to the parents/caregivers.
10. The treatment plan and rationale as well as available treatments, including medications and their benefits, risks, side effects, were discussed with the member and the parent/caregiver in the case of minors.
11. Record indicated the use of family interventions that coach parents on contingency management methods.
12. Record indicated a comprehensive assessment for comorbid psychiatric disorders was conducted.

Substance use disorder (SUD)

Question

13. Education was delivered about substance-use disorders.
14. A plan for maintaining sobriety, including strategies to address triggers was developed, and the role of substance use in increasing suicide risk was discussed.
15. The treatment plan included a referral to self-help groups such as Alcoholics Anonymous (AA), Al-Anon, and Narcotics Anonymous (NA).
16. Evaluation included the consideration of appropriate psychopharmacotherapy.
17. For MD providers, evidence that abstinence-aiding medications were considered.
18. If provider was not an MD, there was evidence that a referral for abstinence-aiding medication or a diagnostic consultation was considered.

Schizophrenia

Question

19. Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment was completed.
20. Education was delivered regarding schizophrenia and its treatment to the member and the family.
21. If significant risk was found, the provider implemented a plan to manage the risk, including a plan for diminishing access to weapons/lethal means.
22. If provider was a not an MD, documentation of a referral for a psychiatric evaluation was included in the record.
23. If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan.
24. If provider was an MD, and if there was several unsuccessful medication trials and/or severe suicidality, then the member was considered for electroconvulsive therapy (ECT) and/or Clozapine.

Generalized Anxiety Disorder (GAD)

Question

25. Diagnosis for GAD based on DSM-5 criteria.
26. Member received education from physician about GAD, options for treatment and general prognosis.
27. CBT based psychotherapy and/or psychopharmacotherapy considered as first line treatment.
28. Ongoing monitoring of symptoms that are accessed for severity.

Bipolar Disorder

Question

29. Diagnosis is documented by type (acute manic, hypomania, mixed, or acute depressive episode).
30. Complete psychological assessment documented First-line treatment: psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy.
31. Psychoeducation, psychotherapy and family intervention provides as indicated.
32. Evidence of monitoring medication and managing adverse effects.

Suicide Risk

Question

33. High to intermediate level of acute risk for suicide and Risk Assessment documented.
34. Psychosocial evaluation completed.
35. Assessment of lethal means and limited access to lethal means if needed.
36. Assessment for indications for inpatient admission.
37. Safety plan development if risk is not imminent including social support.
38. Continued monitoring of patient status and reassessment of risk in follow-up contacts.

(continued)

Post Traumatic Stress Disorder (PTSD)

Question

39. Therapeutic approach is trauma-informed and evidence-based (Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Cognitive Therapy (CT), Brief Eclectic Psychotherapy (BEP), Eye Movement Desensitization and Reprocessing (EMDR), Prolonged Exposure Therapy (PE), Seeking Safety for adults, or Parent Child Interaction Therapy (PCIT), Preschool PTSD Treatment (PPP), Child Parent Psychotherapy (CPP) for children).
40. There is evidence the member was assessed for appropriate pharmacotherapy approach to treatment.
41. Psychotherapist rendering services has training and certification in trauma-informed therapy.
42. There is evidence the treatment plan is individualized to the needs of the member.
43. Treatment includes teaching member/caregivers coping skills.
44. There is evidence the treatment plan addresses socio-economic, cultural, or other diversity or contextual issues.
45. There is evidence that member and/or caregivers were given resources to address PTSD (educational materials, referral to web sites, community support groups, organizations, etc.).

Oppositional Defiant Disorder (ODD)

Question

46. There is evidence of a thorough assessment prior to the diagnosis, including clinical interviewing, with evidence of differential diagnostic considerations, in the record.
47. There is evidence of that information used in the assessment was obtained from multiple outside informants.
48. There is evidence of completion of a physical examination and appropriate supportive tests to rule out any medical reason for symptoms.
49. There is evidence in the assessment and treatment plan that cultural issues were considered in the diagnosis and the plan.
50. There is evidence that parent/caregiving (including schoolteachers when appropriate) training is included in the treatment plan.
51. There is evidence that treatment plan is appropriate to the severity of the symptoms, and ability.
52. There is evidence that evidence-based practices (EBP)s, such as parent-management training programs and family therapy, cognitive problem-solving skills training, social skills programs, and/or school-based programs, were used in treatment.
53. When appropriate, member was referred to and seen by a prescriber for medication treatment.
54. There is evidence that member/family/caregiver were given resource educational material, referred to community groups, and/or national organization, for additional supports.