Louisiana - Provider Quality Monitoring CORE 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

General

Question	
1	The record is accurate and clearly legible to someone other than the writer.
2	All entries in the record identifies the name of member.
3	Each record includes member's social security number. (Behavioral Health Service Provider (BHSP)
4	Each record includes member's address. (BHSP)
5	Each record includes member's employer and/or school, if applicable. (BHSP)
6	Each record includes member's home, school, and/or work telephone numbers. (BHSP)
7	Each record includes member's emergency contact information.
8	Each record includes member's date of birth. (BHSP)
9	Each record includes member's gender. (BHSP)
10	For members 0 to 17 years of age, documentation of authorized representative is included in the record, and proof of authorized representative, if applicable. (BHSP)
11	For members 0 to 17 years of age, there is evidence that services are in context of the family.
12	For members 0 to 17 years of age, there is evidence of ongoing communication with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
13	For members 0 to 17 years of age, there is evidence of ongoing coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.
14	Each member has a separate record.
15	All entries and forms completed by staff in member records include the name of the person making the entry's functional title, applicable educational degree and/or professional license of the person making the entry (including electronic signature for electronic medical record (EMR) systems).
16	All entries and forms completed by staff in member records include full date of documentation.
17	All entries and forms completed by staff in member records include signature (including electronic signature for EMR systems).

Telemedicine/Telehealth

Question	
18	Telehealth **does not include** the use of text, email, or fax for the delivery of healthcare services. (Licensed mental health professional (LMHP)s practicing independently & CMS has approved telehealth for CPST effective May 1, 2023. Telemedicine use documented, if applicable).
19	The member's record includes informed consent for services provided through the use of telehealth). (LMHPs practicing independently and crisis management services (CMS) has approved telehealth for Community Psychiatric Support and Treatment (CPST) effective May 1, 2023).
20	If assessments and/or re-evaluations are completed via telecommunication system, LDH has approved utilizing telemedicine/telehealth for conducting assessments conducted by licensed mental health practitioners. Exclusions: Methadone admission visits conducted by the admitting physician within Opioid Treatment Programs are not allowed via telecommunication technology. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

21 If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

22 If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

23 If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth.

24 If utilizing telemedicine/telehealth services, the consent form includes possible treatment alternatives as well as risks and benefits. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

25 If utilizing telemedicine/telehealth services, the consent form includes the risks and benefits of no treatment. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

26 For telemedicine/telehealth services, when possible (i.e., at the next in person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

27 For telemedicine/telehealth services, there is evidence in the record of a back-up plan (e.g., phone number where recipient can be reached) to restart the session or to reschedule it, in the event of technical problems. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

28 For telemedicine/telehealth services, there is evidence in the record of a safety plan that includes at least one emergency contact and the closest emergency room (ER) location, in the event of a crisis. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

29 For telemedicine/telehealth services, there is evidence in the record the member was informed of all persons who are present. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

30 For telemedicine/telehealth services, there is evidence in the record the member was informed of the role of each person. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

31 For telemedicine/telehealth services, there is evidence of documentation if recipient refused services delivered through telehealth or request that services be delivered in-person, the provider must provide an in-person service or refer to an equally qualified licensed practitioner. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

32 For members 0 – 17 years of age receiving telemedicine/telehealth services, providers need the consent of the recipient and/or the recipient's parent or legal guardian and their contact information prior to initiating a telemedicine/telehealth service with the recipient. (LMHPs practicing independently & CMS has approved telehealth for CPST effective May 1, 2023).

Member rights

Question

33 There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian. (BHSP/LMHP)

34 For members 18 years of age and older, the member is given information to create an advance directive or refusal is documented.

35 There is evidence of the member being given information regarding member's rights to confidentiality. (BHSP)

continued

Initial evaluation

Question	
36	An initial/Annual assessment is in the record and completed by a licensed mental health professional.
37	For members 0 to 17 years of age, there is evidence the Legal Guardian is involved in the assessment.
38	An initial primary treatment DSM diagnosis is present in the record. (BHSP)
39	The reasons for admission or initiation of treatment are appropriate to services being rendered.
40	A mental status exam is in the record.
41	A current behavioral health history is present.
42	The medical treatment history includes known medical conditions. (BHSP)
43	The medical treatment history includes allergies and/or adverse reactions and dates. (BHSP)
44	The medical treatment history includes current treating clinicians.
45	The medical treatment history includes family history.
46	Current medications are listed (physical health (PH) and behavioral health (BH)).
47	Prescriber of current medications are listed (primary care physician (PCP) and BH).
48	Medication dosage is listed.
49	Medication frequency is listed.
50	The initial history for members under the age of 21 includes prenatal and perinatal events, if information is available.
51	The initial history for members under the age of 21 includes a complete developmental history (physical, psychological, social, intellectual and academic).
52	Assessment of risk includes the presence or absence of current suicidal or homicidal risk, danger toward self or others.
53	Assessment of risk includes the presence or absence of previous suicidal or homicidal risk, danger toward self or others.
54	The record includes documentation of dates of previous suicidal or homicidal behaviors.
55	The record includes documentation of methods and lethality of previous suicidal or homicidal behaviors.
56	Documentation of any abuse the member has experienced.
57	Documentation of whether the member has been the perpetrator of abuse.
58	Substance use assessment documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use.
59	The record documents the presence or absence of relevant legal issues of the member and/or family.
60	There is documentation that the member was asked about community resources (family, support groups, social services, school-based services, educational groups, other social supports) that they are currently utilizing.
61	The record documents the assessment of the member's strengths.
62	The record documents the assessment of the member's needs.
63	The assessment documents any financial concerns.
64	The assessment documents any challenges related to transportation.
65	The member's desired outcomes of treatment are clearly documented in the record.
66	Indication and identification of any standardized assessment tool or comprehensive screening completed (i.e., a PHQ-9, GAD-7) as dictated by diagnosis. (BHSP)
67	An initial health screening, such as the Healthy Living Questionnaire or the Primary and Behavioral Health Care Integration (PBHCI), is included in the record. (Unless directed by the plan, this is for informational purposes and not counted against a provider in the compliance rating).

Treatment Plan

Question	
68	The treatment plan is in the record. NOTE: Based on most recent treatment plan; can review prior treatment plans to see progression and updates.
69	Treatment plan is signed by the member.
70	Treatment plan is signed by member's guardian, if applicable.
71	Treatment plan is developed by and signed by treating LMHP including credentials in signature.
72	Date of treatment plan.
73	Indication if it is an “initial” or an “updated” treatment plan.
74	The treatment plan is updated whenever goals are achieved or new problems are identified.
75	Progress on all goals are included in the update.
76	Treatment plan is based on and consistent with the assessment (initial or updated).
77	Treatment plan has individualized long term goals.
78	Treatment plan has individualized short term goals/objectives that are specific.
79	Treatment plan has individualized short term goals/objectives that are measurable.
80	Treatment plan has individualized short term goals/objectives that are action oriented.
81	Treatment plan has individualized short term goals/objectives that are realistic.
82	Treatment plan has individualized short term goals/objectives that are time limited.
83	Treatment plan reflects service locations for each intervention.
84	Treatment plan reflects staff providing the intervention.
85	Treatment plan reflects services to be provided in the duration.
86	Treatment plan reflects services to be provided in the frequency.
87	Individualized crisis plan is in the record.
88	Crisis plan signed by member and/or member's authorized representative as proof of participation in the development of crisis plan.
89	Peer Support Services (PSS): PSS are person-centered.
90	PSS: PSS are recovery focused.
91	PSS: Recovery planning assists members to set goals related to home.
92	PSS: Recovery planning assists members to set goals related to work.
93	PSS: Recovery planning assists members to set goals related to community.
94	PSS: Recovery planning assists members to set goals related to health.
95	PSS: Recovery planning assists members to accomplish goals related to home.
96	PSS: Recovery planning assists members to accomplish goals related to work.
97	PSS: Recovery planning assists members to accomplish goals related to community.
98	PSS: Recovery planning assists members to accomplish goals related to health.

continued

Progress Notes

Question	
99	Service/progress notes are present in the record.
100	There is evidence in the record that, regardless of the originating site, providers must maintain adequate medical documentation to support reimbursement of the visit.
101	Service/progress notes document specifically if service was provided through telemedicine/telehealth. (outpatient services.
102	Service/progress notes reference treatment plan goals.
103	Service/progress notes includes sufficient detail to support the length of the contact.
104	Service/progress notes includes service provider contact telephone number.
105	Service/progress notes includes documentation of treatment plan goals/objectives being referenced.
106	Service/progress notes includes documentation of specific interventions delivered.
107	Service/progress notes includes documentation of what materials were used when teaching a skill.
108	Service/progress notes includes documentation of observed behaviors.
109	Service/progress notes includes documentation of the member's response to intervention.
110	All service/progress notes includes documentation document clearly who is in attendance during each session (outpatient services).
111	Service/progress notes must include documentation of communication and coordination with the family and/or legal guardian/responsible party for services provided to children and youth.
112	Service/progress notes describe progress or lack of progress towards treatment plan goals.
113	Service/progress notes document continuous substance use assessment (if applicable).
114	Service/progress notes document on-going risk assessments (including but not limited to suicide and homicide).
115	Service/progress notes document monitoring of any at risk situations (including but not limited to suicide and homicide).
116	Service/progress notes document compliance or non-compliance with medications (if applicable).
117	Service/progress notes include date of service noted.
118	Service/progress notes include begin times of service noted.
119	Service/progress notes include end times of service noted.
120	Service/progress notes signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.
121	Service/progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.
122	Service/progress notes document the dates or time periods of follow up outpatient providers appointments.
123	Service/progress notes include when the member misses appointments, if applicable.
124	Services documented in the service/progress note reflect services billed. (BHSP)
125	There is evidence of progress summaries in the record.
126	There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.
127	Progress summaries document the start and end date for the time period summarized.
128	Progress summaries indicate who participated.
129	Progress summaries indicate where contact occurred.
130	Progress summaries indicate what activities occurred.

131	Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.
132	Progress summaries document any deviation from the treatment plan, if applicable.
133	Progress summaries document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.
134	Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.
135	Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.
136	Progress summaries are dated.
137	Progress summary is entered in the member's record when a case is transferred or closed.
138	Progress summaries shall be signed by the person providing the services.
139	PSS: PSS are face-to-face interventions with the member present.
140	PSS: PSS are therapeutic or have programmatic content.
141	PSS: PSS do not contain recreational, social, or leisure activities that do not have therapeutic or programmatic content.
142	PSS: PSS documented do not provide transportation.
143	PSS: PSS do not document general office/clerical tasks as part of rendered services.
144	PSS: PSS do not document attendance in meetings or sessions without a documented purpose/benefit from the peer’s presence in that meeting or session.

Continuity and Coordination of care

Question	
145	Services provided to children and youth must include communication and/or coordination with the PCP.
146	All coordination with other providers or agencies involved in the youth’s treatment must be documented within the record.
147	Release of Information signed or refusal noted for communications with other treating providers, if applicable.
148	The record documents that the member was asked whether they have a PCP.
149	PCP's name is documented in the record, if applicable.
150	PCP's address is documented in the record, if applicable.
151	PCP's phone number is documented in the record, if applicable.
152	If the member has a PCP, there is evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.
153	The record documents that the member was asked whether they are being seen by another behavioral health clinician.
154	Other behavioral health clinician's name is documented in the record, if applicable.
155	Other behavioral health clinician's address is documented in the record, if applicable.
156	Other behavioral health clinician's phone number is documented in the record, if applicable.
157	If the member is being seen by another behavioral health clinician, there is evidence of provider attempting or successfully communicating with primary behavioral health clinician or there is documentation that the member/guardian refused consent for the release of information to the behavioral health clinician.
158	Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.

Medication management (if applicable)

Question	
159	Each record indicates each medication name. (BHSP)
160	Each record indicates each medication type. (BHSP)
161	Medication start date is listed.
162	Each record indicates each medication frequency of administration. (BHSP)
163	Each record indicates the dosages of each medication. (BHSP)
164	Each record indicates the person who administered each medication. (BHSP)
165	Each record indicates each medication route. (BHSP)
166	There is evidence that lab work is ordered, if applicable. (BHSP)
167	There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.
168	Documentation of member education of prescribed medication.
169	Documentation of the member's guardian, and/or legal representative understanding and consenting to the medication used in treatment.
170	AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).
171	Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring.
172	There is evidence of medication monitoring in the treatment record, documenting adherence.
173	There is evidence of medication monitoring in the treatment record, documenting efficacy.
174	There is evidence of medication monitoring in the treatment record, documenting adverse effects.

Restraints and Seclusion

Question	
175	Documentation of alternatives/other less restrictive interventions were attempted. (only PRTF)
176	Documentation of restraint/seclusion order. (only PRTF)
177	Documentation of physician notification of restraint. (only PRTF)
178	Documentation of member face to face assessment by a physician or physician extender (e.g., physician assistant (PA), Nurse Practitioner (NP), Advanced Practice Registered Nurse (APRN) within one hour of restraint initiation/application. (only PRTF)
179	Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application. (only PRTF)
180	Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only). (only PRTF)

Patient Safety

Question	
181	If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken and monitoring occurred. (BHSP and Crisis Services)
182	If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable. (BHSP and Crisis Services)

Cultural Competency

Question	
183	There is evidence that services were appropriate for age of member.
184	There is evidence that services were appropriate to the developmental abilities of member.
185	There is evidence that services were appropriate to the education level of member.
186	Primary language spoken by the member is documented.
187	Any translation needs of the member are documented, if applicable.
188	Religious/Spiritual needs of the member were assessed.
189	Racial and/or Ethnic needs of the member were assessed, if applicable.
190	There is evidence that services are appropriate to individuals of diverse gender identities.
191	Identified gender needs of the member were incorporated into treatment, if applicable.
192	Sexual health related needs were assessed.

Adverse Incidents

Question	
193	For members 0 to 17 years of age, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery. (BHSP)
194	Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery. (BHSP)
195	Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery. (BHSP)
196	Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate. (BHSP)

Discharge Planning

Question	
197	Documentation of discussion of discharge planning/linkage to next level of care.
198	Discharge Summary is entered in the member's record when a case is transferred or closed.
199	A discharge summary details the recipient’s progress prior to a transfer or closure, when member is discharged or transitioned to a different level of care.
200	A discharge summary must be completed within 14 calendar days following a recipient’s discharge or transition to a different level of care.
201	Appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan. If not, barriers noted, when member is discharged or transitioned to a different level of care.
202	There is documentation that communication/collaboration occurred with the receiving clinician/program. If not, barriers noted, when member is discharged or transitioned to a different level of care.
203	PCP appointment date and/or time period of follow up documented if medical co morbidity present. If not, barriers noted, when member is discharged or transitioned to a different level of care.
204	Medication profile provided to outpatient provider during transition of care. If not, barriers noted, when member is discharged or transitioned to a different level of care.
205	Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.
206	Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.