Placer/Sierra County Provider Audit Tool

Provider/Agency: _____ **Date of Review:** _____
Review Period: _____ **Auditor Name:** _____

Client Name: _____ **Avatar #:** _____

Item #	Charting Standards	Yes	No	n/a
1.	*Provider Pre-Authorization* in file? (*required for IHBS, TBS, and TFC)*	☐	☐	☐
2.	Assessment dated within 1 year for children, 2 years for adults	☐	☐	☐
a.	Presenting Problem	☐	☐	☐
b.	Developmental history, including pre-natal and perinatal events	☐	☐	☐
c.	Relevant family history	☐	☐	☐
d.	Social supports	☐	☐	☐
e.	Substance abuse history	☐	☐	☐
f.	Mental health services history	☐	☐	☐
g.	Medical history, including allergies	☐	☐	☐
h.	Medication history, including medication allergies, adverse reactions to medications, or lack of known allergies/sensitivities	☐	☐	☐
i.	Mental status	☐	☐	☐
j.	Assessment of risk	☐	☐	☐
k.	Client strengths	☐	☐	☐
l.	Signature and Licensure	☐	☐	☐
m.	DSM IV-TR 5 axis diagnosis	☐	☐	☐
o.	Changes/corrections have been initialed by worker	☐	☐	☐

Auditor Comments:

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Provider Corrections/Copies of the completed corrections or missing notes have been attached for review:

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Item #	Charting Standards	Yes	No	N/A
4.	**Treatment Plan in file for entire review period**	☐	☐	☐
a.	Specific observable and/or specific quantifiable treatment goals related to the client's mental health needs and functional impairments as a result of the mental health diagnosis	☐	☐	☐
b.	Description of the proposed types of interventions *Must include all proposed interventions, such as Plan Development, Therapy, Collateral, Targeted Case Management, and Medication Support. All services that the client is planned to receive must be included.* *Must include specific interventions/modalities, as appropriate. For example, CBT, role-modeling, etc.*	☐	☐	☐
c.	Proposed frequency and duration for each intervention *Cannot use terms such as "As needed" or "Ad hoc." The proposed frequency may be a range.*	☐	☐	☐
d.	Interventions focus and address the identified functional impairments as a result of the mental disorder	☐	☐	☐
e.	Focus of intervention consistent with client plan goals	☐	☐	☐
f.	Interventions consistent with the qualifying diagnosis	☐	☐	☐
g.	Signed by LPHA/LPHA-waived staff	☐	☐	☐
h.	Signed by client or parent/guardian	☐	☐	☐
i.	Description of client's degree of participation in development of the plan *(n/a if client signs the plan)*	☐	☐	☐
j.	Description of client's agreement with the plan *(n/a if client signs the plan)*	☐	☐	☐
k.	Statement describing client's unavailability to sign plan *(n/a if client signs the plan)* *This must include a statement as to why the client did not sign the plan electronically. "Plan was completed over the phone with the client and they were not able to sign the plan electronically."*	☐	☐	☐
l.	Documentation that a copy of the plan was offered to the client	☐	☐	☐
m.	Plan is completed prior to expiration of previous plan, and at least yearly or within 60 days of client entering into client services *If services have been provided without a treatment plan in place, please indicate the service that should be backed-out*	☐	☐	☐
n.	Updated when clinically necessary			
5.	**Other documents**			
a.	Consent for treatment of minor	☐	☐	☐
6.	**Progress Notes**			
a.	Are the CARE041 and CARE041g Progress Notes being used *(n/a if provider has their own EHR)*	☐	☐	☐
b.	Date service was provided	☐	☐	☐
c.	Date service was entered into the clinical record			
d.	Location of service	☐	☐	☐
e.	Time units (in minutes) recorded in progress notes as reflected in billing statements	☐	☐	☐
f.	Type of service	☐	☐	☐
g.	Name of client	☐	☐	☐
h.	A clear but brief synopsis of services and specific intervention (i.e. problem solving	☐	☐	☐
i.	Signature of service provider and their degree, license, or job title	☐	☐	☐

CONFIDENTIAL PATIENT INFORMATION: See California Welfare & Institutions Code Section 5328 and Health Insurance Portability and Accountability Act Privacy and Security Rules

j.	Changes/corrections have been initialed by worker (no sticky notes or white-out used)	☐	☐	☐
k.	For group services, the group billing formula has been completed correctly	☐	☐	☐

Auditor Comments:

Provider Corrections/Copies of the completed corrections or missing notes have been attached for review:

Item #	Required Posted Materials	Yes	No	N/A
7.	**POSTED MATERIALS IN ENGLISH AND SPANISH**	☐	☐	☐
a.	Guide to Medi-Cal MH Poster	☐	☐	☐
b.	Grievance Appeal Forms	☐	☐	☐
c.	Envelopes on display	☐	☐	☐
d.	Grievance/Appeal Poster	☐	☐	☐
e.	Patients' Rights Poster	☐	☐	☐
f.	Cleanliness	☐	☐	☐
g.	Safety	☐	☐	☐
h.	Handicapped Access	☐	☐	☐

Auditor Comments:

Provider Corrections/Copies of the completed corrections or missing notes have been attached for review:

Reviewer Signature:	Date:

☐ Marie Osborne (530) 886-2937	☐ Derek Holley (530) 886-5407	☐ Julia Soto (530) 889-7272
☐ Danielle Gold (530) 886-3415	☐ Debbie DiIanni (530) 886-2981	☐ Jeff Steer (916) 784-6431
☐ April Carew (916) 780-3215		