

QI Spotlight

March 2004

Provider Treatment Record Review Audits

An important quality indicator for the CBHNP Provider Network is the quality of the written documentation of services by providers. Standards for treatment record documentation are defined by the Medical Assistance regulations for each level of care and by the National Committee for Quality Assurance (NCQA). These include such indicators as the timeliness of the beginning of service after authorization, provider clinical oversight, treatment plans, progress notes, provider training and adherence to training requirements, discharge planning, and billing accuracy.

CBHNP annually reviews the treatment records of high-volume providers in our network and is currently involved in completing that process. The high-volume services being reviewed include Behavioral Health Rehabilitation Services (BHRS), Family Based Mental Health Services, and Outpatient Mental Health Services. Individual results and recommendations are given to providers, and aggregate results will be distributed to both providers and Members.

The intent of the treatment record reviews is for provider treatment records to be maintained in a manner that is consistent, current, detailed and organized, and which permits effective and confidential care and quality review. As a result of the feedback provided, provider organizations examine problematic areas and institute appropriate quality improvement activities. CBHNP looks for potential areas of improvement across the provider network and sets performance goals to improve the overall quality of treatment record keeping.