COMMUNITY MENTAL HEALTH CLINIC
AUDIT CHECKLIST

Beneficiary's Name _____

Beneficiary's Medicaid # _____DOB_____

Service Dates FROM: _____TO _____

Provider Name _____Provider Medicaid ID # _____

Provider Contact Person/ph/email: _____

Itemized below is documentation that is related to the type of services provided by a Community Mental Health Center . The requested documentation depends upon the nature of the service rendered.

1. Documentation contains a comprehensive assessment that identifies mental health problems, includes DSM IV diagnosis and establishes eligibility for services
2. Assessment includes recommendations for treatment and services, both clinical and rehabilitation
3. A functional assessment must be completed prior to providing rehabilitation services, include the functional in the audit request
4. Beneficiary's record contains a treatment plan that includes a prioritized summary of problems and needs based on the information in the intake and functional assessments.
5. Treatment plan contains all required signatures
6. Treatment plan contains specific treatment recommendations including interventions, frequency, location, duration of services, and estimated length of entire treatment process
7. Treatment plans contain clearly stated individualized goals and measurable objectives, with a specific time period for attainment of each goal or objective
8. Treatment plan is reviewed every 3 months for children (under 21) and every six months for adults
9. For SED children, interdisciplinary team member signatures are required on treatment plans and reviews
10. The progress note includes the goal addressed, the active staff intervention, the beneficiary's progress toward goal addressed and total duration of service
11. The progress note supports the number of units rendered to the beneficiary and matches the number of units billed
12. Prior authorization submitted as required, if service limits are exceeded
13. Correct ICD-9 and CPT codes have been documented on claim and billed.
14. Record has beneficiary's name, DOB, other identifying information, and Medicaid # on it
15. Beneficiary's name and Medicaid # matches the ID on the record
16. Provider name and Provider Medicaid # matches the name/number on record

Please be sure that:

- Documentation in the record is legible
- Both sides of a document are copied using two sides of a document
- Page edges or bottoms are not cut off when copying
- Applicable agency Policies/Procedures are submitted as needed

AUDIT CHECKLIST TOOL

This tool can be used to compile information when an auditor requests documentation. It is not meant to be exhaustive, but will help the provider determine if he/she is considering all the information needed for an audit request.

CHECKLIST	Yes	N/A
1. Documentation on record is legible.		
2. Record has beneficiary's name, DOB, and other identifying information		
3. Beneficiary's name matches the record name.		
4. Beneficiary's ID matches the ID on record.		
5. Provider name matches the name on record.		
6. Provider ID matches the ID on record.		
7. Documentation contains a comprehensive assessment that identifies mental health problems, includes DSM IV diagnosis and establishes eligibility for services		
8. A functional assessment must be completed prior to providing rehabilitation services, please include the functional in the documentation		
9. Assessment includes recommendations for treatment and services		
10. Beneficiary record contains a treatment plan that includes a prioritized summary of problems and needs based on the information in the intake and functional assessments. Treatment plan contains all required signatures		
11. Treatment plan contained specific treatment recommendations including interventions, frequency, location, duration of services,		

and estimated length of entire treatment process		
12. Treatment plans contained clearly stated individualized goals and measurable objectives. Each goal and objective has a specific time period for attainment		
13. Treatment plan was reviewed every 3 months for children (under 21) and every six months for adults		
14. For SED children, interdisciplinary team member signatures are present		
15. A progress note is included for each day each service was provided. Note was signed, dated, and credentialed by staff providing the service		
15. The progress note included the goal addressed, the active staff intervention, the beneficiary's progress toward goal addressed and total duration of service		
16. The progress note supported the number of units rendered to beneficiary and matches the number of units billed.		
17. Prior authorization was obtained as required		
18. Correct ICD-9 and CPT codes are documented on claim and billed.		