Behavioral Health Provider Audit Tool Elements	
General Requirements	*Yes, No, N/A*
The record is accurate and clearly legible to someone other than the writer.	
Each page of record identifies the member.	
All entries in the record include the responsible service provider's name.	
All entries in the record include the responsible service provider's professional degree and relevant identification number, if applicable.	
All entries in the record include date where appropriate.	
All entries in the record include signature (including electronic signature for EMR systems) where appropriate.	
Each record includes member's address.	
Each record includes employer and/or school address and telephone number, if applicable.	
Each record includes home and/or work telephone numbers.	
Each record includes emergency contact information.	
Each record includes date of birth.	
Each record includes gender.	
Each record includes relationship and/or legal status, if applicable.	
For members 0 to 18, documentation of guardianship is included in the record, and proof of guardianship, if applicable.	
For members 0 to 18, there is evidence that services are in context of the family.	
For members 0 to 18, 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.	
For members 0 to 18, 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.	
Each member has a separate record.	
For telemedicine/telehealth services, there is evidence in the record of verification of recipient's identity.	
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.	
Member Rights	*Yes, No, N/A*

There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.	
The Patient Bill of Rights is either signed or refusal is documented.	
There is evidence of the member being given information regarding member's rights to confidentiality.	
For members over the age of 18 years of age, the member is given information to create psychiatric advance directives or refusal is documented.	
If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services	
If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks.	
If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth, including privacy related risks.	
If utilizing telemedicine/telehealth services, the consent form includes possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes risks of possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes benefits of possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes the risks and benefits of no treatment	
For telemedicine/telehealth services, there is consent signed by the recipient or authorized representative in the record authorizing recording of the session.	
For 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 if the recipient is 18 years old or under.	
Initial Evaluation	*Yes, No, N/A*
An initial/Annual assessment is in the record.	
An initial/Annual assessment is completed by a licensed mental health professional.	
For members 0 to 18, there is evidence the primary care giver is involved in the assessment.	
Any standardized assessments are clearly documented, if applicable.	
Presenting problem(s) are identified.	

An initial primary treatment DSM diagnosis is present in the record.	
The reasons for admission or initiation of treatment are indicated.	
The reasons for admission or initiation of treatment are appropriate to services being rendered.	
A complete mental status exam is in the record, documenting the member's affect.	
A complete mental status exam is in the record, documenting the member's speech.	
A complete mental status exam is in the record, documenting the member's mood.	
A complete mental status exam is in the record, documenting the member's thought content.	
A complete mental status exam is in the record, documenting the member's judgement.	
A complete mental status exam is in the record, documenting the member's insight.	
A complete mental status exam is in the record, documenting the member's attention or concentration.	
A complete mental status exam is in the record, documenting the member's memory.	
A complete mental status exam is in the record, documenting the member's impulse control.	
The behavioral health treatment history includes family history information, if available.	
A behavioral health history is in the record, including any previous providers, if applicable.	
A behavioral health history is in the record, including treatment dates, if applicable.	
A behavioral health history is in the record, including treatment modality, if applicable.	
A behavioral health history is in the record, including member response, if applicable.	
The medical treatment history includes known medical conditions, if applicable.	
The medical treatment history includes allergies and/or adverse reactions and dates, if applicable.	
The medical treatment history includes providers of previous treatment, if applicable.	
The medical treatment history includes current treating clinicians, if applicable.	
The medical treatment history includes current therapeutic interventions and responses, if applicable.	

The medical treatment history includes family history, if available.	
Current medications are listed (PH & BH), if applicable.	
Prescriber of current medications are listed (PCP & BH), if applicable.	
Medication dosage is listed, if applicable.	
Medication frequency is listed, if applicable.	
Medication start date is listed, if applicable.	
Response to medication and other concurrent treatment (successful/unsuccessful) is documented, if applicable.	
Problems/side effects are documented, if applicable.	
The initial history for members under the age of 21 includes prenatal and perinatal events, if information is available.	
The initial history for members under the age of 21 includes a complete developmental history (physical, psychological, social, intellectual and academic).	
Assessment of risk includes the presence or absence of current and past suicidal or homicidal risk, danger toward self or others.	
The record includes documentation of previous suicidal or homicidal behaviors, if applicable.	
The record includes documentation of dates of previous suicidal or homicidal behaviors, if applicable.	
The record includes documentation of methods of previous suicidal or homicidal behaviors, if applicable.	
The record includes documentation of lethality of previous suicidal or homicidal behaviors, if applicable.	
Documentation of any abuse the member has experienced or if the member has been the perpetrator of abuse.	
Substance use assessment was conducted.	
Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use, if applicable.	
The record documents the presence or absence of **relevant** legal issues of the member and/or family.	
There is documentation that the member was asked about community resources (family, support groups, social services, school based services, other social supports) that they are currently utilizing.	
The record documents the assessment of the member's strengths.	
The record documents the assessment of the member's needs.	
The assessment documents the spiritual variables that may impact treatment.	
The assessment documents any financial concerns.	

The assessment documents any challenges related to transportation.	
Telemedicine use documented, if applicable.	
The member's desired outcomes of treatment are clearly documented in the record.	
There is evidence of preliminary discharge planning.	
Indication and identification of any standardized assessment tool or comprehensive screening completed (i.e. a PHQ-9, GAD-7) as dictated by diagnosis.	
Documentation of referrals, if applicable.	
An initial health screening, such as the Healthy Living Questionnaire or the 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.)	
Agency Specific Requirements	
CPST/PSR	
Medical necessity is documented by a LMHP or physician, for adults, as evidenced by individuals exhibiting impaired emotional, cognitive or behavioral functioning that is the result of mental illness in order to meet the criteria for disability.	
Evidence the individual's impairment substantially interferes with role functioning.	
Evidence the individual's impairment substantially interferes with occupational functioning.	
Evidence the individual's impairment substantially interferes with social functioning.	
Services are recommended by an LMHP or physician.	
Assessments must be performed at least every 365 days or as needed anytime there is significant change to the member’s circumstance.	
For members 6 - 18 years of age, there is evidence of the CALOCUS being utilized as part of the assessment.	
For members 19 years of age and over, has at least a score of three on the level of care or a composite score of 17-19 on the level of care utilization system (LOCUS) or documented why not.	
For members 19 years of age and over, member must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating.	

The assessment documents that in addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as: • Basic daily living (for example, eating or dressing); • Instrumental living (for example, taking prescribed medications or getting around the community); and • Participating in a family, school, or workplace.	
There is evidence of medical necessity, if applicable, for members 19 years of age and over, with longstanding deficits who do not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR.	
TGH	
The assessment protocol must differentiate across life domains.	
The assessment protocol must differentiate between risk factors.	
The assessment protocol must differentiate between protective factors.	
The assessment protocol must track progress over time.	
Requirements for pretreatment assessment are met prior to treatment commencing.	
Screening is required upon admission.	
Assessment is required upon admission.	
The assessment protocol documents less intensive levels of treatment have been determined to be unsafe, unsuccessful or unavailable.	
PRTF Requirements	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the youth.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the parents/legal guardian.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the medical aspects of the recipient's situation.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the psychological aspects of the recipient's situation.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the social aspects of the recipient's situation.	

Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the behavioral aspects of the recipient's situation.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the developmental aspects of the recipient's situation.	
Evidence of a diagnostic evaluation must be conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care.	
SUD Requirements	
Triage screening to determine eligibility and appropriateness (proper member placement) for admission and referral.	
ASAM 6 Dimensional risk evaluation must be completed prior to admission, which substantiates member placement at the appropriate ASAM level of care.	
A comprehensive bio-psychosocial evaluation must be completed prior to admission, which substantiates appropriate member placement. *(Except 4-WM - comprehensive bio-psychosocial assessments are not required for this level of care.)*	
The comprehensive bio-psychosocial evaluation shall contain circumstances leading to admission.	
The comprehensive bio-psychosocial evaluation shall contain past behavioral health concerns, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain present behavioral health concerns, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain past psychiatric treatment, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain present psychiatric treatment, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain past addicitive disorders treatment, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain present addicitive disorders treatment, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain significant medical history.	
The comprehensive bio-psychosocial evaluation shall contain current health status.	
The comprehensive bio-psychosocial evaluation shall contain family history, if available.	
The comprehensive bio-psychosocial evaluation shall contain social history.	
The comprehensive bio-psychosocial evaluation shall contain current living situation.	

The comprehensive bio-psychosocial evaluation shall contain relationships with family of origin, nuclear.	
The comprehensive bio-psychosocial evaluation shall contain family and/or significant others.	
The comprehensive bio-psychosocial evaluation shall contain education, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain vocational training, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain employment history.	
The comprehensive bio-psychosocial evaluation shall contain employment current status.	
The comprehensive bio-psychosocial evaluation shall contain military service history, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain military service current status, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain legal history, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain current legal status, if applicable.	
The comprehensive bio-psychosocial evaluation shall contain past emotional state.	
The comprehensive bio-psychosocial evaluation shall contain present emotional state.	
The comprehensive bio-psychosocial evaluation shall contain past behavioral functioning.	
The comprehensive bio-psychosocial evaluation shall contain present behavioral functioning.	
The comprehensive bio-psychosocial evaluation shall contain strengths.	
The comprehensive bio-psychosocial evaluation shall contain weaknesses.	
The comprehensive bio-psychosocial evaluation shall contain needs.	
The evaluation must be reviewed and signed by an LMHP.	
A physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process, except for 3.7-WM and 4-WM.	
A drug screening is conducted when the member's history is inconclusive or unreliable.	
An appropriate assignment to level of care with referral to other appropriate services as indicated shall be made.	

For residential facilities, diagnostic laboratory tests or appropriate referral shall be made as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.	
Evaluations shall include the consideration of appropriate psychopharmacotherapy.	
Admission Criteria ASAM Level 3.2-WM	
For 3.2-WM: Medical clearance and screening - Medical screening is performed upon arrival by staff with current CPR and first aid training, with telephone access to RN physician for instructions for the care of the individual.	
For 3.2-WM:Individuals who require medication management must be transferred to medically monitored or medical withdrawal management program until stabilized.	
Admission Criteria ASAM Level 3.7 Adolescent -PRTF	
For 3.7 Adolescent -PRTF: A comprehensive bio-psychosocial assessment must be completed within seven days, which substantiates appropriate patient placement.	
For 3.7 Adolescent -PRTF:The assessment must be reviewed as evidenced by being signed by a LMHP.	
The medical section of the bio-psychosocial assessment was completed prior to seven days of admission.	
The psychological section of the bio-psychosocial assessment was completed prior to seven days of admission.	
The alcohol section of the bio-psychosocial assessment was completed prior to seven days of admission.	
The drug/substance use section of the bio-psychosocial assessment was completed prior to seven days of admission.	
Admission Criteria ASAM Levels 3.7-WM and 4-WM	
For 3.7-WM and 4-WM: A physical examination must be performed by a physician, PA or NP within 24 hours of admission, if not, barriers noted. A physical examination conducted within 24 hours prior to admission may be used if reviewed and approved by the admitting physician.	
For 3.7-WM and 4-WM: appropriate laboratory tests were ordered.	
For 3.7-WM and 4-WM: appropriate toxicology tests were ordered.	
Treatment Plan	*Yes, No, N/A*
The treatment plan is in the record.	
Treatment plan is signed by the member.	
Treatment plan is signed by member's guardian, if applicable.	

Treatment plan signed by treating LMHP including credentials in signature.	
Treatment plan signed by caregiver or other treating professionals or paraprofessionals involved in tx team.	
Date of treatment plan.	
Indication if it is an “initial” or an “updated” treatment plan.	
Member signature with a statement that they participated in the treatment plan development and agree to participate in the care/treatment with member signature date.	
The treatment plan is updated whenever goals are achieved or new problems are identified.	
Progress on all goals are included in the update.	
Treatment plan is based on the assessment (initial or updated).	
Member's strenghts are included in the treatment plan.	
Member's needs are included in the treatment plan.	
Treatment plan utilizes input from the member, family, natural supports, and/or treatment team.	
Treatment plan is developed by an LMHP.	
Treatment plan is consistent with diagnosis.	
Treatment plan has long term goals.	
Treatment plan has short term goals/objectives/interventions.	
Treatment plan goals/objectives/interventions are specific.	
Treatment plan goals/objectives/interventions are measurable.	
Treatment plan goals/objectives/interventions are action-oriented.	
Treatment plan goals/objectives/interventions are realistic.	
Treatment plan goals/objectives/interventions are time-limited.	
There is evidence the treatment has been revised/updated to meet the changing needs of the member, if applicable.	
Treatment plan reflects services to be provided in the amount.	
Treatment plan reflects services to be provided in the type.	
Treatment plan reflects services to be provided in the duration.	
Treatment plan reflects services to be provided in the frequency.	
Individualized Crisis Plan is in the record, including any changes related to COVID-19 risks.	
Member signature with a statement that they participated in the crisis plan development.	
Crisis plan is updated as needed to meet participant's needs.	
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.	

For telemedicine/telehealth services, there is evidence in the record of a a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.	
Agency Specific Requirements	
Mental Health Rehabilitation	
Treatment plan has recovery focused goals targeting areas of risk identified in the assessment.	
Treatment plan has recovery focused objectives/interventions targeting areas of risk identified in the assessment.	
Treatment plan has recovery focused goals targeting areas of need identified in the assessment.	
Treatment plan has recovery focused objectives/interventions targeting areas of need identified in the assessment.	
Treatment plan clearly identifies actions to be taken by provider.	
Treatment plan clearly identifies actions to be taken by member/guardians.	
Treatment plan clearly identifies specific interventions that will address specific problems/needs identified in the assessment.	
Transition plan describes how member will transition from adolescence to adulthood in the record for members ages 15 to 21.	
The treatment plan review is in consultation with provider staff at least once every 180 days or more often if indicated.	
The treatment plan review is in consultation with the member/caregiver at least once every 180 days or more often if indicated.	
The treatment plan review is in consultation with other stakeholders at least once every 180 days or more often if indicated.	
Documentation of the treatment plan review.	
Evidence the member received a copy of the plan upon completion.	
PRTF	
The plan must be developed no later than 72 hours after admission	
The plan must be implemented no later than 72 hours after admission	
The plan must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis	

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.	
TGH	
There is evidence of a standardized assessment and treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.	
Member's plan of care was developed no later than 72 hours after admission unless clinical documentation notes member's refusal or unavailability.	
The treatment plan must include behaviorally measurable discharge goals.	
SUD General Requirements	
Treatment plans are based on evaluations.	
Treatment plans include person centered goals.	
Treatment plans include person centered objectives.	

Treatment plan shall include other medical/remedial services intended to reduce the identified condition.	
The treatment plan should include anticipated outcomes of the individual.	
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).	
The treatment plan specifies the frequency.	
The treatment plan specifies the amount.	
The treatment plan specifies the duration.	
The treatment plan is signed by the LMHP or physician responsible.	
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).	
Treatment plans re-evaluations involve the individual.	
Treatment plan re-evaluations involve the family, if available.	
Treatment plan re-evaluations involve the provider.	
Re-evaluations determine if services have contributed to meeting the stated goals.	
If no measurable reduction has occurred, a new treatment plan will be developed.	
If a new treatment plan is developed it includes a different rehabilitation strategy.	
If a new treatment plan is developed it includes revised goals.	
If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.	
ASAM Level Specific Requirements	
ASAM Level 1	
The treatment plan is reviewed/updated in collaboration with the member, as needed, at a minimum of every 90 days or more frequently if indicated by the member's needs.	
ASAM Level 2-WM	
The treatment plan is reviewed and signed by the physician within 24 hours of admission.	
The treatment plan is reviewed and signed by the individual within 24 hours of admission or documentation of why not.	
Treatment plan is updated at least every 30 days.	
ASAM Level 2.1	
The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs.	
ASAM Level 3.1 Adult/Adolescent	

Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 90 days or as indicated by member needs.	
ASAM Level 3.2-WM Adult/Adolescent	
The treatment plan is developed in collaboration with the member within 24 hours or documentation of why not.	
The treatment plan is reviewed and signed by the qualified professional within 24 hours of admission.	
The treatment plan is reviewed and signed by the individual within 24 hours of admission.	
The signed treatment plan must be filed in the individual's record within 24 hours of admission.	
ASAM Level 3.3	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 90 days or as indicated by member needs.	
ASAM Level 3.5 Adult/Adolescent	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 30 days or as indicated by member needs.	
There is evidence in the record of an in-house education/vocational component if serving adolescents.	
ASAM Level 3.7-WM	
A qualified professional creates a plan of action until individual is physically stable.	
The treatment plan is reviewed by physician within 24 hours of admission as evidenced by date and signature.	
The treatment plan is reviewed by the individual within 24 hours of admission as evidenced by date and signature or documentation of why not.	
The signed treatment plan is filed in the individual's record within 24 hours of admission.	
ASAM 3.7 Adolescent PRTF	
The treatment plan is reviewed/updated in collaboration with the member, as needed, or at a minimum of every 30 days.	

ASAM Level 3.7 Adult	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 30 days or as indicated by member needs.	
ASAM Level 4-WM	
The treatment plan is reviewed by physician within 24 hours of admission as evidenced by date and signature.	
The treatment plan is reviewed by the individual within 24 hours of admission as evidenced by date and signature or documentation of why not.	
The signed treatment plan is filed in the individual's record within 24 hours of admission.	
Progress Notes	*Yes, No, N/A*
Progress notes reference treatment goals.	
All progress notes document clearly who is in attendance during each session (outpatient services).	
The progress notes describe progress or lack of progress towards treatment plan goals.	
The progress notes describe/list member strengths.	
The progress notes describe/list how strenghts impact treatment.	
The progress notes describe/list limitations.	
The progress notes describe/list how limitations impact treatment.	
The progress notes document continuous substance use assessment (if applicable).	
The progress notes document on-going risk assessments (including but not limited to suicide and homicide).	
The progress notes document (including but not limited to suicide and homicide) monitoring of any at risk situations.	
Compliance or non-compliance with medications is documented (if applicable).	
Indication of ongoing discussion of discharge planning to alternative or appropriate level of care.	
Progress notes include date of service noted.	
Progress notes include begin times of service noted.	
Progress notes include end times of service noted.	
Progress notes include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.	

Progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.	
The progress notes document the dates or time periods of follow up appointments.	
Provider documents when the member misses appointments, if applicable.	
When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)	
Progress notes document specifically if service was provided through Telemedicine/Telehealth. (outpatient services)	
All progress notes include documentation of the billing code that was submitted for the session.	
Services documented in the progress note reflect services billed.	
The progress notes reflect reassessments, if applicable.	
There is evidence of progress summaries in the record.	
There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.	
Progress summaries document the start and end date for the time period summarized.	
Progress summaries indicate who participated.	
Progress summaries indicate where contact occurred.	
Progress summaries indicate what activities occurred.	
Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.	
Progress summaries document any deviation from the treatment plan, if applicable.	
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.	
Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.	
Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.	
Progress summaries are dated.	
Progress summaries shall be signed by the person providing the services.	

For telemedicine/telehealth services,There is evidence in the record the member was informed of all persons who are present.	
For telemedicine/telehealth services,There is evidence in the record the member was informed of the role of each person.	
For telemedicine/telehealth services, evidence in the record that, regardless of the originating site, providers must maintain adequate medical documentation to support reimbursement of the visit.	
For telemedicine/telehealth services, documentation if recipient refused services delivered through telehealth.	
Agency Specific Requirements	
Mental Health Rehabilitation	
Services are provided at the provider agency, in the community, in the member's place of residence, and/or via telehealth/telemedicine as outlined in the treatment plan.	
Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the Department. Services shall not be provided in an IMD, if applicable.	
Services are documented as being provided individually or in a group setting.	
Services are documented as being provided face-to-face and/or via telehealth as per LDH guidelines.	
Services are appropriate for age.	
Services are appropriate for development level.	
Services are appropriate for education level.	
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and not be provided at a work site which is job tasks-oriented and not directly related to the treatment of the member's needs.	
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and must not contain Service or service components in which the basic nature is to supplant housekeeping, homemaking or other basic services for the convenience of the individual receiving services.	
Progress notes for PSR services document restoration, rehabilitation and/or support to develop social and interpersonal skills to increase community tenure in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to enhance personal relationships in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	

Progress notes for PSR services document restoration, rehabilitation and/or support to establish support networks in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to increase community awareness in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to develop coping strategies and/or effective functioning in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living in accordance with the treatment plan.	
PSR progress notes for PSR services document implementing learned skills to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment in accordance with the treatment plan.	
Progress notes for CPST services document problem behavior analysis in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document emotional and behavioral management in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document developing and improving daily functional living skills in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing interpersonal goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	

Progress notes for CPST services document implementing self-care goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
ASAM Requirements Level 2-WM, 3.7-WM, 4-WM	
Progress notes document the implementation of the stabilization/treatment plan.	
Progress notes document the individual's response to and/or participation in scheduled activities.	
Progress notes document the individual's physical condition.	
Progress notes document the individual's vital signs.	
Progress notes document The individual's mood.	
Progress notes document the individual's behavior.	
Progress notes document statements about the individual's condition.	
Progress notes document statements about the individual's needs.	
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.	
ASAM Requirements Level 2.1	
Progress notes include documentation of evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and/or multidimensional family therapy.	
ASAM Requirements Level 3.2-WM	
Progress notes document the implementation of the stabilization/treatment plan.	
Progress notes document the individual's response to and/or participation in scheduled activities.	
Progress notes document the individual's physical condition.	
Progress notes document the individual's vital signs.	

Progress notes document The individual's mood.	
Progress notes document the individual's behavior.	
Progress notes document statements about the individual's condition.	
Progress notes document statements about the individual's needs.	
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.	
Daily assessment of progress through withdrawal management shall be documented in a manner that is person-centered.	
Daily assessment of progress through withdrawal management shall be documented in a manner that is individualized.	
Continuity and Coordination of Care	Yes, No, N/A
The record documents that the member was asked whether they have a PCP.	
PCP's name is documented in the record, if applicable.	
PCP's address is documented in the record, if applicable.	
PCP's phone number is documented in the record, if applicable.	
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.	
The record documents that the member was asked whether they are being seen by another behavioral health clinician.	
Other behavioral health clinician's name is documented in the record, if applicable.	
Other behavioral health clinician's address is documented in the record, if applicable.	
Other behavioral health clinician's phone number is documented in the record, if applicable.	
If the member is being seen by another behavioral health clinician, there is documentation that the member/guardian refused or granted consent for the release of information to the behavioral health clinician.	
Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.	
Release of Information signed or refusal noted for communications with other treating providers, if applicable.	
SUD	
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.	

SUD ASAM Level 2-WM	
Evidence of ambulatory withdrawal management [ASAM level 2-WM] is provided in conjunction with ASAM level 2.1 intensive outpatient treatment services.	

Medication Management (if applicable)	Yes, No, N/A
Each record indicates what medications have been prescribed.	
Each record indicates the dosages of each medication.	
Each record indicates the dates of initial prescription or refills.	
Documentation of member education of prescribed medication including benefits.	
Documentation of member education of prescribed medication including risks.	
Documentation of member education of prescribed medication including side effects.	
Documentation of member education of prescribed medication including alternatives of each medication.	
For members 18 and over, documentation of the member understanding and consenting to the medication used in treatment.	
For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	
Documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients for controlled substances or otherwise applicable.	
AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).	
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.	
There is evidence that lab work is ordered, if applicable.	
There is evidence the ordered lab work is received by the clinician ordering the lab work, if applicable.	
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.	
When a primary care physician is identified, there is evidence the prescriber attempted coordination of care within 14 calendar days after initiation of a new medication.	
There is evidence of medication monitoring in the treatment record, documenting adherence.	

There is evidence of medication monitoring in the treatment record, documenting efficacy.	
There is evidence of medication monitoring in the treatment record, documenting adverse effects.	
TGH	
Psychotropic medications should be used with specific target symptoms identification.	
Psychotropic medications should be used with medical monitoring.	
Psychotropic medications should be used with 24-hour medical availability when appropriate and relevant.	
SUD (All ASAM Levels)	
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis.	
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.	
SUD providers, when clinically appropriate, shall document member education in the progress notes.	
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.	
SUD providers, when clinically appropriate, shall document member response in the progress notes.	
Restraints and Seclusion (if applicable)	Yes, No, N/A
Documentation of alternatives/other less restrictive interventions were attempted.	
Documentation of restraint/seclusion order.	
Documentation of physician notification of restraint.	
Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application.	

Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application.	
Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).	
Member Safety	Yes, No, N/A
If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken and monitoring occurred.	
If the member was placed in restraints/seclusion, documentation of required monitoring. (A patient in seclusion or restraints shall be evaluated every 15 minutes and documentation of these evaluations shall be entered into the patient's record.)	
If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable.	
Cultural Competency	Yes, No, N/A
Cultural needs of the member were assessed.	
Identified cultural needs of the member were incorporated into treatment, if applicable.	
Primary language spoken by the member is documented.	
Any translation needs of the member are documented, if applicable.	
Language needs of the member were assessed (i.e. preferred method of communication), if applicable.	
Identified language needs of the member were incorporated into treatment, if applicable.	
Religious/Spiritual needs of the member were assessed.	
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.	
Racial needs of the member were assessed.(i.e. oppression, privledge, prejudice…etc.), if applicable.	
Identified racial needs of the member were incorporated into treatment, if applicable.	
Ethnic needs of the member were assessed.	
Identified ethnic needs of the member were incorporated into treatment, if applicable.	
Sexual health related needs were assessed.	
Identified sexual health related needs of the member were incorporated into treatment, if applicable.	

Adverse Incidents	Yes, No, N/A
For members 0 to 18, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.	
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.	
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.	
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.	

Discharge Planning	Yes, No, N/A
Documentation of discussion of discharge planning/linkage to next level of care.	
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.	
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.	
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.	
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.	
Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.	
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.	
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.	

A discharge summary must be completed within 14 calendar days following a recipient's discharge or transition to a different level of care.	
Additional SUD Requirements	
Documentation of discharge/transfer planning at admission.	
Documentation of referrals made as needed, if applicable.	
TGH	
Discharge planning within the first week of admission with clear action steps.	
Discharge planning with target dates outlined in the treatment plan.	
Clinical Practice Guidelines	Yes, No, N/A
The MCOs will review Clinical Practice Guidelines (CPGs) for the following diagnosis: Major Depressive Disorder, Attention Deficit Hyperactivity Disorder, Substance Use Disorder, Schizophrenia, Generalized Anxiety Disorder, Bipolar Disorder, Oppositional Defiant Disorder, Post Traumatic Stress Disorder, and Suicide Risk.	
PRTF AGENCY REQUIREMENTS	Yes, No, N/A
Members have access to education services.	
Member's health is maintained (e.g. dental hygiene for a child expected to reside in the facility for 12 months).	
TGH AGENCY REQUIREMENTS	Yes, No, N/A
Recreational activities are provided for all enrolled members.	
Members attend school, work and/or training.	
To enhance community integration, resident youth must attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution).	
The psychologist or psychiatrist must see the member at least once.	
The psychologist or psychiatrist must prescribe the type of care provided.	
If the services are not time-limited by the prescription, review the need for continued care every 28 days.	
The individualized, strengths-based services and supports are identified in partnership with the child or adolescent and/or the family and support system, to the extent possible, and if developmentally appropriate.	
The individualized, strengths-based services and supports are based on clinical assessments.	

The individualized, strengths-based services and supports are based on functional assessments.	
The individualized, strengths-based services and supports support success in community settings, including home and school.	
The TGH is required to coordinate with the child's or adolescent's community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.	
Additional SUD Core Requirements	Yes, No, N/A
Treatment services at all levels of care shall offer a family component.	
Adolescent substance use programs shall include family involvement as evidenced by parent education.	
Adolescent substance use programs shall include family involvement as evidenced by family therapy.	
Documentation of services provided to children and youth must include communication with the family and/or legal guardian.	
Documentation of services provided to children and youth must include coordination with the family and/or legal guardian.	
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in care conferences as evidenced by their signature on relevant documentation.	
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in treatment planning activities as evidenced by their signature on relevant documentation.	
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, attend and participate in discharge planning as evidenced by their signature on relevant documentation.	
The provider shall ensure that its clinical supervisor who, with the exception of opioid treatment programs, provide supervision of such activities as recreation, art/music or vocational education as evidenced by their signature on relevant documentation.	
Additional SUD Core Requirements Level 1	
Evidence of early intervention for those who have been identified as individuals suffering from addictive disorders.	
Evidence of referrals for education, activities or support services designed to prevent progression of disease if indicated.	

Additional SUD Core Requirements Level 2-WM	
Evidence of admission drug screen.	
Evidence of additional urine drug screens as indicated by the treatment plan.	
Evidence of physicians' orders for medical management.	
Evidence of physicians' orders for psychiatric management.	
Additional SUD Core Requirements Levels 3.2WM	
Evidence of physicians' orders for medical management.	
Evidence of physicians' orders for psychiatric management.	
Evidence of toxicology and drug screening – Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.	
ASAM Level 3.2-WM Adolescent TGH ASAM Requirement(In addition to the staffing required by TGHs)	
There is a physician on duty as needed for management/review/approval of psychiatric and/or medical needs of the client through course of stay as evidence by signature and/or relevant documentation.	
Additional SUD Core Requirements Levels 3.3	
ASAM Level 3.3 Women with Dependent Children Program Requirements	
Evidence of offering weekly parenting classes in which attendance is required.	
Evidence of addressing the specialized needs of the parent.	
Evidence of offering education for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.	
Evidence of offering rehabilitation services for its parent members that further addresses effects of chemical dependency on a women's health and/or pregnancy.	
Evidence of offering education for its parent members that further address parenting skills.	
Evidence of offering counseling for its parent members that further address parenting skills.	
Evidence of offering rehabilitation services for its parent members that further address parenting skills.	
Evidence of offering education for its parent members that further address health and/or nutrition.	
Evidence of offering counseling for its parent members that further address health and/or nutrition.	

Evidence of offering rehabilitation services for its parent members that further address health and/or nutrition.	
Evidence of regularly assessing parent-child interactions.	
Evidence of addressing any identified needs in treatment.	
Evidence of providing access to family planning services.	
The provider shall address the specialized needs and/or care for the dependent children.	
The provider shall address the therapeutic needs and/or care for the dependent children.	
The provider shall develop an individualized plan of care to address those needs to include target dates.	
The provider shall provide age-appropriate education for children.	
The provider shall provide age-appropriate counseling for children.	
The provider shall provide age-appropriate rehabilitation services for children.	
Additional SUD Core Requirements Levels 3.7-WM	
Evidence of physician approval for admission.	
Toxicology and drug screening – Toxicology and drug screenings are medically monitored. A physician may waive drug screening if and when individual signs list of drugs being used and understands that his/her dishonesty could result in severe medical reactions during withdrawal management process.	
Evidence of physicians' orders for medical management.	
Evidence of physicians' orders for psychiatric management.	
Additional SUD Core Requirements Levels 4WM	
Evidence of physician approval for admission.	
Toxicology and drug screening - Urine drug screens are required upon admission.	
Toxicology and drug screening - Urine drug screens are required as directed by the treatment plan.	
Evidence of physicians' orders for medical management.	
Evidence of physicians' orders for psychiatric management.	
Outpatient Treatment Providers (OTP)	Yes, No, N/A
A screening is conducted to determine eligibility for admission.	
A screening is conducted to determine eligibility for referral.	
A screening is conducted to determine appropriateness for admission.	
A screening is conducted to determine appropriateness for referral.	
A complete physical examination by the OTP's physician must be conducted before admission to the OTP.	

A drug screening test by the OTP's physician must be conducted before admission to the OTP.	
A full medical exam must be completed within 14 days of admission.	
Results of serology and other tests, must be completed within 14 days of admission.	
The physician shall ensure members have a Substance Use or Opioid Use Disorder.	
An OUD must be present for at least one year before admission for treatment, or meet exception criteria, as set in federal regulations.	
A comprehensive bio-psychosocial assessment must be completed within the first seven (7) days of admission, which substantiates treatment.	
For new admissions, the American Society of Addiction Medicine (ASAM) 6 Dimensional risk evaluation must be included in the assessment.	
There shall be evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis,	
There shall be evidence that the member was assessed to determine if an appropriate assignment to level of care was determined, with referral to other appropriate services as indicated.	
The treatment plan shall be developed within 7 days of admission by the treatment team.	
The treatment plan shall be updated and revised if there is no measureable reduction of disability or restoration of functional level.	
The medical necessity for substance use services must be determined by and/or recommended by a physician.	
Members who meet clinical criteria must be at least 18 years old, unless the member has consent from a parent or legal guardian, if applicable, and the State Opioid Treatment Authority.	
Members must also meet patient admission criteria for federal opioid treatment standards in accordance with CFR §8.12, as determined by a physician.	
Recording of medication administration in accordance with federal and state requirements;	
Recording of medication dispensing in accordance with federal and state requirements;	
Results of five most recent drug screen tests with action taken for positive results;	
Documentation of physical status	
Documentation of use of additional prescription medication;	

Documentation showing monthly or more frequently, as indicated by needs of client, contact notes and/or progress notes which include employment/vocational needs	
Documentation showing monthly or more frequently, as indicated by needs of client, contact notes and/or progress notes which include legal status	
Documentation showing monthly or more frequently, as indicated by needs of client, contact notes and/or progress notes which include social status	
Documentation showing monthly or more frequently, as indicated by needs of client, contact notes and/or progress notes which include overall individual stability;	
Documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;	
Documentation of approval of any exception to the standard schedule of takehome doses and the physician's justification for such exception	
Initial treatment phase lasts from three to seven days. During this phase, the provider conducts orientation	
Initial treatment phase lasts from three to seven days. During this phase, the provider provides individual counseling	
Initial treatment phase lasts from three to seven days. During this phase, the provider develops the initial treatment plan for treatment of critical health or social issues.	
Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider conducts weekly monitoring of the member's response to medication	
Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider provides at least four individual counseling sessions	
Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider revises the treatment plan within 30 days to include input by all disciplines	
Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider revises the treatment plan within 30 days to include input by the member	

Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider revises the treatment plan within 30 days to include input by significant others	
Early stabilization begins on the third to seventh day following initial treatment through 90 days in duration, whereas the provider conducts random monthly drug screen tests.	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall perform random monthly drug screen tests until the member has negative drug screen tests for 90 consecutive days as well as random testing for alcohol when indicated	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall thereafter, monthly testing to members who are allowed six days of take-home doses, as well as random testing for alcohol when indicated	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall continuous evaluation by the nurse of the member's use of medication	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall continuous evaluation by the nurse of the member's use of treatment from the program	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall continuous evaluation by the nurse of the member's use of treatment from other sources	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall documented reviews of the treatment plan every 90 days in the first two years of treatment by the treatment team	
Maintenance treatment follows the end of early stabilization and lasts for an indefinite period of time. The provider shall documentation of response to treatment in a progress note at least every 30 days	

Medically supervised withdrawal from synthetic narcotic with continuing care (only when withdrawal is requested by the member). The provider shall decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by member	
Medically supervised withdrawal from synthetic narcotic with continuing care (only when withdrawal is requested by the member). The provider shall provide counseling of the type based on medical necessity	
Medically supervised withdrawal from synthetic narcotic with continuing care (only when withdrawal is requested by the member). The provider shall provide counseling of the quantity based on medical necessity	
Medically supervised withdrawal from synthetic narcotic with continuing care (only when withdrawal is requested by the member). The provider shall conduct discharge planning as appropriate	
Evidence that those with take home medication priviledge the member must have negative drug/alcohol screen for at least 30 days	
Evidence that those with take home medication priviledge the member must have regular clinic attendance	
Evidence that those with take home medication priviledge the member must have absence of serious behavioral problems during treatment	
Evidence that those with take home medication priviledge the member must have absence of criminal activity during treatment	
Evidence that those with take home medication priviledge the member must have stability of home environment	
Evidence that those with take home medication priviledge the member must have stability of social relationships	
Evidence that those with take home medication priviledge the member must have assurance that take home medication can be safely stored (lock boxes which patient provides)	
Evidence that after the first 30 days and during the remainder of the first 90 days in treatment, one therapeutic dose per week was given to the member to self-administer at home (days 30-90);	

Evidence that in the second 90 days, two therapeutic doses per week was given to the member to self-administer at home (days 91-180);	
Evidence that in the third 90 days of treatment, three therapeutic doses per week was given to the member to self-administer at home	
Evidence that in the final 90 days of treatment of the first year, four therapeutic doses per week was given to the member to self-administer at home	
Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after one year in treatment, a six-day dose supply, consisting of take home doses and therapeutic doses may be allowed once a week	
Evidence the treatment team and medical director determined that the therapeutic privilege doses are appropriate that after two years in treatment, a 13-day dose supply, consisting of take home doses and therapeutic doses may be allowed once every two weeks	
Evidenced that a take home dose was dispensed to members who have attended the clinic at least two times and who have been determined by the nurse to be physically stable and by the counselor to create a minimal risk for diversion when the OTP is closed for a legal holiday or Sunday.	
In the event of a Governor's Declaration of Emergency, emergency provisions for take home dosing may be enacted, as approved by the State Opioid Treatment Authority (SOTA).	
Evidence of a new determination made by the treatment team regarding take home privileges due to positive drug screens at any time for any drug other than prescribed	
Evidence of take home privledges being revoked due to the patient has a urine drug screen with any substances other than Methadone, Methadone Metabolites, or a medication that the patient does not have a valid prescription.	