

BEHAVIORAL HEALTH COUNSELING: PROFESSIONAL (COORDINATED) H0004 HO
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Provider:		Member ID:	
Review Date:		Reviewer Name:	

1.	Is there a behavioral health condition that establishes medical necessity for this service? (Note: If Question #1 scores zero, the remaining questions score zero.)	1	0		
2.	Is there a current Service Plan for Individual Therapy that demonstrates participation by Physician/Psychologist/Approved Licensed Professional* and member including all required signatures, credentials, each with dates, start and stop times? (Note: If Question #2 scores zero, all remaining questions will score zero.)	3	1.5	0	
3.	Does the plan demonstrate participation by all required team members, including members from other agencies involved in the behavioral health care of the member (dates, start and stop times), including all required signatures and credentials?	3	1.5	0	
*4.	Do the goals and objectives for individual therapy address the process for change in thoughts, feelings, and/or behaviors that are contributing to the identified problems based on assessed need, therefore demonstrating service definition? (If this question scores zero, question 2 and all remaining questions score zero).	3	2	1	0
*5.	Does the Service Plan contain measurable component objectives the member would take toward achieving service plan goals? (Must meet service definition).	3	2	1	0
6.	Are goals and objectives commensurate with time spent in services?	3	0		
7.	Is the frequency and intensity at which the service is prescribed consistent with the member's assessed need?	3	0		
*8.	Are there projected achievement dates for the objectives on the Service Plan that are realistic and stepped?	3	2	1	0
9.	Is there a Service Plan review that includes: <ul style="list-style-type: none"> • A review of the amount of individual therapy provided and the objectives that were addressed • Progress towards achievement of objectives • Problems which impede treatment/progress (whether member or center based) • Whether timelines designed for its completion were met • A decision either to continue or modify the individual therapy objectives 	3	2	1	0
10.	Is the Service Plan reviewed when a critical juncture occurs in the member's clinical status?	3	0		

11.	Does the Service Plan include individualized and measureable discharge criteria for therapy?	3	1.5	0	
*12.	Do the service notes include: <ul style="list-style-type: none"> • Signature with appropriate Practitioner Credentials • Service start and stop times • Location of service • Date • Service code and/or descriptor? (Note: If there is no signature by an approved clinician, questions #12 through #18 score zero for those notes.)	3	2	1	0
*13.	Are interventions grounded in a specific and identifiable theoretical base within the service note and related to the member's identified behavioral health condition? (Note: If Question #13 scores 0, then Questions 14, 15, 16, 17, and 18 score 0.)	3	2	1	0
*14.	Does the content of the Individual Therapy service notes relate back to the individual therapy objectives and assessed need?	3	2	1	0
*15.	Does the documentation demonstrate the member's individualized response to the specific psychotherapeutic interventions utilized within the session?	3	2	1	0
*16.	Is pertinent interval history documented including changes in symptoms and functioning and addressing appropriate high-risk factors?	3	2	1	0
*17.	Does the documentation include a plan for continued therapy?	3	1.5	0	
*18.	Are the services consistent with best practice and provided at a frequency commensurate with assessed need?	3	2	1	0
19.	Does a comprehensive review of the current clinical status substantiate that medical necessity is met for continued stay?	3	0		

Total Score = _____ [Possible 55]

* Refer to Provider Manual for licensing requirements

* The scoring for these questions is as follows:

- 3 – 100% of the documentation meets this standard
- 2 – 99% to 75% of the documentation meets this standard
- 1 – 74% to 50% of the documentation meets this standard
- 0 – Under 50% of the documentation meets this standard