

SAMPLE CORRECTIVE ACTION PLAN (CAP)

TRR QUESTION	PLANS FOR ADDRESSING DEFICIENCIES	TARGET DATES	COMMENTS
The following sample questions are taken from Aetna's TRR Audit Standards.	CAP responses should specifically address the audit question and provide concrete information regarding how the provider plans to correct the identified deficiency. The following are sample responses that illustrate how a provider may respond.	Target dates for implementing CAP should be within 30 days of receipt of the TRR scoring letter.	This area is optional and may be used for further clarification of the provider's plans to address the deficiency.
Is there a DSM IV diagnosis with all five axes completed?	This clinician will document the assessment of each active Aetna patient on all five of the DSM IV Axes.	One month from date of response to Aetna.	The DSM IV diagnosis will be documented within the first two sessions.
For children and adolescents, is there a developmental history that could include prenatal events and prenatal, physical, psychological, social, intellectual, academic and educational history?	This clinician will document a comprehensive developmental history for each active Aetna child and adolescent patient.	One month from date of response to Aetna.	The assessment will be noted in the progress notes or as part of the intake process within the first two sessions.
Is there documentation to reflect that the provider requested patient's permission to communicate with the primary medical practitioner?	This clinician will obtain permission to communicate with each active Aetna patient's primary medical practitioner. If the patient does not give permission for this communication, it will be documented in the chart.	One month from date of response to Aetna.	The patient will be provided with a release form within the first two sessions.
If the patient did grant permission, is there documentation that the provider communicated with the primary medical practitioner?	If the patient grants permission for this clinician to communicate with the primary medical provider, this clinician will make follow-up attempts as required to collaborate with the primary medical practitioner during treatment.	One month from date of response to Aetna.	Attempts at contact with the primary medical practitioner will be documented within one week from when the patient grants permission.
Does the documentation include a discharge plan?	This clinician will ensure that each active Aetna patient has a documented discharge plan in the progress notes or on a discharge summary form.	One month from date of response to Aetna.	Discharge documentation will be noted within one month of the patient's most recently attended session if there will be no further sessions.

Please note: Aetna created this document as a sample tool to assist providers in documentation. Aetna does not require the use of this document, nor are we collecting the information contained herein.