

Magellan Health Services Treatment Record Review Tool

Member/record ID: _____

Account: _____

Diagnosis: _____

ASSESSMENT STANDARDS	YES	NO	N/A	EXPLANATIONS OR COMMENTS
SECTION I: GENERAL INFORMATION				Weight: .05
a. The medical record is legible				
b. Member name or ID number noted on each page of medical record				
c. Member's address				
d. Member's employer or school (if applicable)				
e. Home telephone number noted (if applicable)				
f. Work telephone number noted (if applicable)				
g. Guardianship information noted (if applicable)				
h. Marital/legal status				
i. Emergency contacts				
j. All entries are dated and signed by practitioner with professional degree and ID Number (if applicable)				
SECTION I SCORE (For each section, enter total number of "yes" items and total number of "no" items in the columns to the right)				
SECTION II: MEMBER RIGHTS AND MEMBER CONFIDENTIALITY				Weight: .10
a. Signed treatment consent form				
b. Signed Patient Bill of Rights				
c. Psychiatric advance directives are documented (if applicable)				
d. Appropriate authorizations to disclose information are completed <i>(exclusive of that related to PCP communication)</i>				
e. Informed consent for medication documented (if appropriate)				
f. If provider documents "member refused" in medical record, member must sign or initial				
SECTION II SCORE				
SECTION III: INITIAL EVALUATION				Weight: .25
a. Member's presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status, are documented				
b. Psychiatric history includes previous providers and treatment dates (if applicable)				
c. Psychiatric history includes previous treatment interventions				
d. Psychiatric history includes response to previous treatment				
e. Psychiatric history includes sources of clinical data				
f. Psychiatric history includes relevant family information				
g. Psychiatric history includes results of lab tests and consultation reports (if applicable)				
h. Psychosocial information includes: <ul style="list-style-type: none"> • Support systems • Legal history • Educational history 				
i. Relevant medical conditions are listed, prominently identified and revised				
j. Medical history includes current providers caring for member				

ASSESSMENT STANDARDS	YES	NO	N/A	EXPLANATIONS OR COMMENTS
k. Medical history includes current medications and prescribed dosages and dates of initial prescription or refills, and use of over-the-counter medications				
l. For members age 12 and over, a substance abuse evaluation is completed to include nicotine, caffeine, as well as illicit misuse of prescribed and over-the-counter drugs				
m. For children and adolescents, prenatal and perinatal events are documented				
n. For children and adolescents, a complete developmental history (physical, psychological, social, intellectual and academic) is documented				
o. Mental status exam documents member's: <ul style="list-style-type: none"> • Affect • Speech • Mood • Thought content • Judgment • Insight • Attention/concentration • Memory • Impulse control 				
p. Risk factors and special status situations are noted, documented and revised in compliance with written protocols, to include: <ul style="list-style-type: none"> • Non compliance with treatment • AMA/elopement potential • Prior behavioral health inpatient admissions • History of multiple behavioral diagnosis • Suicidal/homicidal ideation • Imminent risk of harm 				
q. DSM-IV diagnosis (all five axes) is documented				
r. DSM-IV diagnosis is consistent with the presenting problems, history, mental status exam and/or other assessment data				
s. Follow-up appointment is scheduled following initial evaluation				
SECTION III SCORE				
SECTION IV: COORDINATION OF CARE (all N/As must have documented explanation by clinical reviewer)				Weight: .15
a. Evidence of provider request of member for authorization for PCP communication				
b. Evidence member refused authorization for PCP communication.				
c. PCP communication after initial evaluation				
d. Evidence of at least one PCP communication at other significant points in treatment, e.g.: <ul style="list-style-type: none"> • At significant changes in clinical status • After medications are initiated, discontinued or significantly altered • After significant changes in diagnosis or treatment plan • At treatment termination Additionally, other point are: <ul style="list-style-type: none"> • At hospitalization • If there are safety issues 				
e. Treatment record reflects continuity and coordination of care between the primary clinician and: (Circle all that apply) <ol style="list-style-type: none"> a) psychiatrist b) ancillary providers c) treatment programs/institutions d) other behavioral health providers e) consultants 				
SECTION IV SCORE				

ASSESSMENT STANDARDS	YES	NO	N/A	EXPLANATIONS OR COMMENTS
SECTION V: TREATMENT PLAN (section not scored for psychiatrists doing medication management only)				Weight: .15
a. Individualized treatment plan is included in member's record and is consistent with the diagnoses				
b. Treatment plan goals are objective and measurable				
c. Treatment plan goals have estimated time frames for goal attainment or problem resolution				
d. Treatment interventions are consistent with treatment plan goals				
e. Member understanding of treatment plan is documented				
f. If the member has a substance use disorder, there is evidence of medication- assisted treatment and/or discussion.				2011: Monitoring indicator only
SECTION V SCORE				
SECTION VI: PROGRESS NOTED IN TREATMENT				Weight: .10
a. Progress notes describe member's strengths and limitations in achieving treatment plan goals				
b. Treatment record documents date of next appointment.				
c. Treatment record includes preliminary discharge plan (if applicable)				
d. Documentation that member is referred for and receiving medication evaluations for psychotropic medication (if applicable).				
e. Discharge note documents achievement of goals or necessary referrals to assist in final attainment of goals				
f. Discharge note is completed within 60 days of last visit				
SECTION VI SCORE				
SECTION VII: MEDICATION (for psychiatrists only)				Weight: .10
a. Medication flow sheet completed or progress note includes documentation of current psychotropic medication, dosages, date(s) of dosage changes				
b. Allergies and adverse reactions, or no known allergies (NKA) or sensitivities, to foods, drugs and other substances are documented				
c. Documentation of member education regarding reason for the medication, benefits, risks and possible medication side effects, including affect of psychotropic medication in women of child-bearing age.				
d. Documentation of member education of women of child-bearing age to avoid becoming pregnant while taking psychotropic medication, and to notify psychiatrist immediately upon becoming pregnant				
e. Documentation of member verbalization of understanding medication education				
f. Record reflects that DEA scheduled drugs are avoided in treatment of members with a history of substance abuse/dependency (if applicable)				
SECTION VII SCORE				
SECTION VIII: REFERRAL/OUTREACH				Weight: .10
a. Treatment record documents preventive services as appropriate: <ul style="list-style-type: none"> • Relapse prevention • Stress management • Wellness programs • Lifestyle changes • Referrals to community resources 				
b. Members who become homicidal, suicidal or unable to conduct activities of daily living are referred to appropriate level of care (if applicable)				
SECTION VIII SCORE				