

**Magellan Health Services/Public Sector Solutions
Treatment Record Review Tool/Recovery Focused Version**

Provider: _____

Level of Care: _____

Date: _____

Name of Auditor: _____

Contract: _____ **Quarter:** _____

Member's Name: _____

Identification No.: _____

Admission Date: _____

Discharge Date: _____

Date of Birth: _____

ASSESSMENT STANDARDS	YES	NO	N/A	COMMENTS
Scoring: For each section, enter total number of "yes" & "no" items in the columns to the right				
SECTION I: GENERAL INFORMATION				
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 & signed by practitioner w/prof degree and ID Number (if applicable)				
k. Services were rendered by appropriately credentialed staff				
SECTION I SCORE				
SECTION II: MEMBER RIGHTS AND MEMBER CONFIDENTIALITY				
a. Signed treatment consent form				
b. Patient Bill of Rights was signed <u>and</u> documentation indicates language was explained in terms that the member understands				
c. Psychiatric advance directives are documented (if applicable)				
d. Authorizations to disclose appropriate information were signed				
e. Informed consent for medication signed (if appropriate)				
f. If provider documents "member refused services" in record, explanation for refusal and member signature/initials are present				
SECTION II SCORE				
SECTION III: INITIAL EVALUATION				
a. Member-identified inner strengths and social conditions documented				
b. Member's talents/skills/abilities/preferences/achievements are explored and documented				
c. Member's presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status, are documented				
d. Psychiatric history includes previous providers and treatment dates (if applicable)				
e. Psychiatric history includes previous treatment interventions				
f. Psychiatric history includes member assessment of effectiveness of previous treatment interventions				
g. Psychiatric history includes sources of clinical data				
h. Psychiatric history includes relevant family information relating to behavioral health, substance use, social growth and emotional well-being				
i. Psychiatric history includes results of lab tests and consultation reports (if applicable)				
j. Psychosocial information includes description of natural support systems (including key relationships)				
k. Psychosocial information includes description of member's enjoyable activities				
l. Psychosocial information includes description of member's living circumstances				
m. Psychosocial information includes description of member's legal history				
n. Psychosocial information includes description of member's educational history				

ASSESSMENT STANDARDS Scoring: For each section, enter total number of "yes" & "no" items in the columns to the right	YES	NO	N/A	COMMENTS
o. Psychosocial information includes description of member's religious preferences				
p. Psychosocial information contains information regarding work/volunteer activities				
q. Relevant medical conditions and special health care needs are listed, prominently identified and revised				
r. Medical history includes current providers caring for member				
s. Medical history includes current medications and prescribed dosages and dates of initial prescription or refills, and use of over-the-counter medications				
t. For members age 12 and over, a substance abuse evaluation is completed to include nicotine, caffeine, and alcohol, as well as illicit misuse of prescribed and over-the-counter drugs				
u. For children and adolescents, prenatal and perinatal events are documented				
v. Allergies and adverse reactions, or no known allergies (NKA) or sensitivities, to foods, drugs and other substances are documented				
w. Mental status exam documents member's: <ul style="list-style-type: none"> • Affect • Speech • Mood • Thought content • Judgment • Insight • Attention/concentration • Memory • Impulse control 				
x. Risk factors and special status situations are noted, documented and revised in compliance with written protocols, to include: <ul style="list-style-type: none"> • Reasons for inability to effectively participate in treatment • AMA/elopement potential • Prior behavioral health inpatient admissions • History of multiple behavioral diagnosis • Suicidal/homicidal ideation • Imminent risk of harm 				
y. DSM-IV diagnosis (all five axes) is documented				
z. DSM-IV diagnosis is consistent with the presenting problems, history, mental status exam and/or other assessment data				
a1. Follow-up appointment is scheduled following initial evaluation				
a2. Explored potential challenges to follow up with member (time of day, transportation, etc.)				
a3. Documentation indicates peer & community supports were considered (if applicable)				
a4. Evidence that a "crisis plan" has been developed with member's input, e.g., a WRAP Plan, other type of proactive plan				
SECTION III SCORE				
SECTION IV: COORDINATION OF CARE				
Note: All N/A's must have documented explanation by Clinical Reviewer				
a. Evidence that provider requested member authorization for PCP communication				
b. Signed documentation if 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., safety issues, medication changes, treatment plan changes, hospitalization, termination				
e. Treatment record reflects continuity and coordination of care between the primary clinician and: (Circle all that apply) a) psychiatrist b) ancillary providers c) treatment programs/institutions d) other behavioral health providers e) consultants				
SECTION IV SCORE				
SECTION V: TREATMENT PLAN				
a. Strengths-based individualized treatment plan included in member's record is consistent with their diagnosis, and advances their individualized recovery plan, and reflects their language and culture (real-life goals in all life domains)				

ASSESSMENT STANDARDS	YES	NO	N/A	COMMENTS
Scoring: For each section, enter total number of "yes" & "no" items in the columns to the right				
b. Timeline is established for plan review and supports timely review/revision when clinically significant events occur				
c. Treatment plan goals are objective and measurable				
d. Treatment plan goals have estimated time frames for goal attainment or problem resolution				
e. Review and changes to treatment plan provide evidence of member progress in achieving goals				
f. Treatment interventions consistent with treatment plan goals				
g. Member's participation in development and endorsement of treatment plan is documented (for children this includes families)				
h. Member's expectation for future quality of life (hope, new activities, etc.) was explored				
i. Treatment plan is signed by a MD (if required)				
SECTION V SCORE				
SECTION VI: PROGRESS NOTED IN TREATMENT				
a. Services listed on the treatment plan were provided in a language spoken by the member				
b. Array and quality of services provided met the needs of the member, as evidenced by positive outcomes (FARS/CFARS, progress in meeting goals)				
c. Progress notes describe member's strengths and challenges in achieving treatment plan goals				
d. Treatment record documents date of next appointment				
e. Treatment record includes preliminary discharge plan (if applicable)				
f. Evidence that type & frequency of treatment intervention is effective and age-appropriate (for children, family-based)				
g. For outpatient therapy, evidence that member helped define the duration of treatment				
h. Documentation that member is referred for and receiving medication evaluations for psychotropic medication (if applicable)				
i. Discharge note documents achievement of goals or necessary referrals to assist in final attainment of goals				
j. Discharge note is completed within 60 days of last visit				
SECTION VI SCORE				
SECTION VII: MEDICATION				
a. Medication flow sheet completed or progress note includes documentation of current psychotropic medication, dosages, and date(s) of dosage changes				
b. Documentation of member education regarding reason for the medication, benefits, and possible medication side effects in an understandable manner				
c. 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				
d. Documentation of member verbalization of understanding medication education				
e. 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				
a. Treatment record documents preventive services as appropriate: <ul style="list-style-type: none"> -Relapse prevention -Relationship building -Skill building -Wellness programs -Lifestyle changes -Community connections -Decision making -Stress management -Tobacco cessation -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)				
c. If appropriate, drug and alcohol referral with evidence of collaboration				
TOTAL SCORE FOR SECTION VIII				

IX Florida Addendum	YES	NO	N/A	COMMENTS
SECTION IX: Florida PMHP Specific				
a. At least one face-to-face meeting with licensed clinician during development of the treatment plan				
b. Evidence that appropriate interventions and progress monitoring were provided for members who meet special conditions such as discharge from state hospital or incarceration				
c. Active community living support plan has been developed with residents of assisted living facilities				
TOTAL SCORE FOR SECTION IX				

Ambulatory Follow Up:

Who referred member to current mental health provider(s)?

Within the 14 days prior to initial visit, was member discharged from (circle all that apply):

- Partial Hospitalization Program
- Intensive Outpatient
- Inpatient Hospitalization
- Residential Treatment Center
- Other (please list): _____

Additional Notes: