Magellan HEALTHCARE

Treatment Record Review Tool

This is the standard review tool used for all behavioral health records.
Additional indicators may be included based on regulatory and/or customer requirements.

A - General
1A) Record is legible
2A) Consumer name or ID number noted on each page of record
3A) Entries are dated and signed by appropriately credentialed provider
4A) Record contains relevant demographic information including address, employer/school, phone, emergency contact, marital status
B - Consumer Rights and Confidentiality
1B) Signed treatment informed consent form, or refusal documented
2B) Patient Bill of Rights signed, or refusal documented
3B) Psych advance directives, or refusal documented
4B) Informed consent for medications signed, or refusal documented
5B) Release(s) for communication with PCP, other providers and involved parties signed, or refusal documented
C - Initial Evaluation
1C) Reason member is seeking services (presenting problem) and mental health status exam
2C) DSM-5 diagnosis
3C) History and symptomatology consistent with DSM-5 criteria
4C) Psychiatric history
5C) Co-occurring (co-morbid) substance induced disorder assessed
6C) Current and past suicide/danger risk assessed
7C) Assessment of consumer strengths, skills, abilities, motivation, etc.
8C) Level of familial/supports assessed and involved as indicated
9C) Consumer identified areas for improvement/outcomes documented
10C) Medical history
11C) Exploration of allergies and adverse reactions
12C) All current medications with dosages
13C) Discussion of discharge planning/linkage to next level
D - Individualized Treatment Plan
1D) Individualized strengths based treatment plan is current
2D) Measurable goals/objectives documented
3D) Goals/objectives have timeframes for achievement
4D) Goals/objectives align with consumer identified areas for improvement/outcomes
5D) Use of preventive/ancillary services including community and peer supports considered
E - Ongoing Treatment
1E) Documentation substantiates treatment at the current intensity of support (level of care)
2E) Progress towards measurable consumer identified goals and outcomes evidenced; if not, barriers are being addressed
3E) Clinical assessments and interventions evaluated at each visit
4E) Substance use assessment is current/ongoing
5E) Comprehensive suicide/risk assessment is current/ongoing
6E) Medications are current

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7E) Member compliance or non-compliance with medications is documented; if non-compliant, interventions considered
8E) Evidence of treatment being provided in a culturally competent manner
9E) Family/support systems contacted/involved as appropriate/feasible
10E) Ancillary/preventive services considered, used, and coordinated as indicated
11E) Crisis plan documented
12E) Discharge planning/linkage to alternative treatment (level of care) leading to discharge occurring
F - Addendum for Special Populations
1F) Guardianship information noted
2F) Developmental history for children and adolescents
3F) If member has substance use disorder, there is evidence of Medication Assisted Treatment or discussion
G - Addendum for NCQA Site Only
1G) Records are stored securely
2G) Only authorized personnel have access to records
3G) Staff receive periodic training in confidentiality of member information
4G) Treatment records are organized and stored to allow easy retrieval
H - Coordination of Care
1H) Evidence of provider request of consumer for authorization of PCP communication
2H) Evidence consumer refused authorization for PCP communication
3H) PCP communication after initial assessment/evaluation
4H) Evidence of PCP communication at other significant points in treatment, e.g., medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status; at termination of treatment
5H) Treatment Record reflects continuity and coordination of care between primary behavioral health clinician and (note all that apply under comments): psychiatrist, treatment programs/institutions, other behavioral health providers, ancillary providers
Evaluation of Treating Provider Communication
6H) Accuracy: Communication matched information in chart
7H) Timeliness: Communication with in 30 days of initial assessment
8H) Sufficiency: Communication appropriate to condition/treatment
9H) Frequency: Occurred after initial assessment
10H) Frequency: Occurred after change in treatment/medications/risk status
11H) Frequency: Occurred after termination of treatment
12H) Clarity: Reviewer understands communication
I - Medication Management
1I) Medication flow sheet completed or progress note includes documentation of current psychotropic medication, dosages, date(s) of dosage changes
2I) Documentation of member education regarding reason for the medication, benefits, risks, and side effects (includes affect of medication in women of childbearing age, and to notify provider if becomes pregnant, if appropriate)
3I) Documentation of member verbalizing understanding of medication education