Magellan Documentation Standards for Behavioral Health Treatment Records*

Introduction

We require our providers to maintain organized, well-documented member treatment records that reflect continuity of care. Magellan's treatment record documentation standards are consistent with the standards of various regulatory and accrediting organizations. One of the ways we systematically measure compliance with these standards is via the Treatment Record Review (TRR) process, to evaluate and improve member care.

When reviewing treatment records, we examine areas of the treatment record that serve as critical indicators of the quality of care provided. Please use this checklist as your guide to ensure your documentation meets Magellan's standards and expectations.

General Information

The treatment record must contain the following **member** information:

- ☐ Name or unique identification number on **each page**
- ☐ Address
- ☐ Employer or school
- ☐ Home and alternative phone numbers
- ☐ At least one emergency contact, including address and phone number
- ☐ Guardianship information, if applicable
- ☐ Marital/legal status

Each clinical entry must clearly indicate:

- ☐ Date of entry
- ☐ Type of contact
- ☐ Practitioner's signature
- ☐ Practitioner's degree/credential

Member Rights and Confidentiality

The following information requires **member or legal guardian** signature and must be in the treatment record:

- ☐ Informed consent for evaluation, treatment and communication
- ☐ Patient Bill of Rights
- ☐ Authorization to use and disclose information to other behavioral health care practitioners and the member's Primary Care Physician (PCP)
- ☐ Informed consent for medication, if applicable
- ☐ Advance psychiatric directive, if applicable
- ☐ Documentation of refusal to sign any particular consent or authorization, if applicable

Initial Evaluation

The initial evaluation must cover the following information and include documentation of findings in the treatment record:

- ☐ Member's presenting problem(s), along with relevant psychological and social conditions affecting the member's medical and psychiatric status
- ☐ Psychiatric history including the following:
  - Previous providers and treatment dates, if applicable
  - Previous treatment interventions and response to treatment, if applicable
  - Sources of clinical data
  - Relevant family information
  - Results of lab tests and consultation reports, if applicable

- ☐ Psychosocial information that includes:
  - Support systems
  - Legal history
  - Educational history
- ☐ Relevant medical conditions
- ☐ Current providers caring for the member
- ☐ Current medications, prescribed dosages, dates of initial prescription or refills and use of over-the-counter medications
- ☐ For members age 12 and over, a substance abuse evaluation covering nicotine, caffeine, as well as illicit misuse of prescribed and over-the-counter drugs

Initial Evaluation, continued

- ☐ For children and adolescents, documentation of prenatal and perinatal events and a complete developmental history (physical, psychological, social, intellectual, and academic)
- ☐ Allergies and adverse reactions, or no known allergies (NKA) or sensitivities, to foods, drugs and other substances
- ☐ Mental status that documents member's:
  - Affect
  - Mood
  - Judgment
  - Attention/Concentration
  - Impulse Control
  - Speech
  - Thought content
  - Insight
  - Memory
- ☐ Risk factors and special status situations noted, documented and revised in compliance with written protocols, including:
  - Non-compliance with treatment
  - Against Medical Advice (AMA)/elopement potential
  - Prior behavioral health inpatient admissions
  - History of multiple behavioral diagnosis
  - Suicidal/homicidal ideation
  - Imminent risk of harm
- ☐ DSM diagnosis consistent with the presenting problem(s), history, mental status exam and/ or other assessment data
- ☐ Follow-up appointment scheduled following initial evaluation
- ☐ Ambulatory follow-up, including referral source for member to current behavioral health provider
- ☐ Indication whether member is referred to practitioner as a result of discharge from a partial, intensive outpatient, or inpatient hospitalization; residential treatment center, or other facility within the previous 14 days

Coordination of Care

The treatment record must include documentation of communication, or attempted communication, with the member's Primary Care Physician (PCP) and/or other behavioral health providers:

- ☐ Provider request of member authorization for PCP communication and documentation of PCP communication after initial evaluation
- ☐ Member's refusal to authorize PCP communication, if applicable
- ☐ Evidence of at least one PCP communication at significant points in treatment (e.g., safety issues, medication changes, treatment plan changes, hospitalization, discharge)

Treatment Plan

The treatment record must include an individualized treatment plan consistent with the member's diagnosis and must include:

- ☐ Objective, measurable goals
- ☐ Estimated time frames for goal attainment or problem resolution
- ☐ Treatment interventions consistent with treatment plan goals
- ☐ Evidence of member's understanding of the treatment plan

Progress Noted in Treatment

Progress notes describe the member's strengths and limitations in achieving treatment plan goals, including environmental factors that support change or may serve as obstacles to progress. The treatment record must include:

- ☐ Date of next appointment
- ☐ Preliminary discharge plan, if applicable
- ☐ Documentation that the member is referred for and receiving medication evaluation for psychotropic medication, if applicable

- ☐ Discharge note completed within 60 days of last visit, and documentation of goal achievement or needed referrals

Medication (prescribing practitioners only)

Completion of a medication flow sheet and progress notes must include:

- ☐ Current psychotropic medication, dosages and date(s) of dosage changes
- ☐ Member education regarding reason for medication and possible side effects
- ☐ Member education to women of child-bearing age on importance of avoiding pregnancy while taking psychotropic medication, and to notify psychiatrist immediately upon becoming pregnant
- ☐ Acknowledgment by member of their understanding of medication education
- ☐ Avoidance of Drug Enforcement Agency (DEA) scheduled drugs in treatment of members with a history of substance abuse/dependency

Referral/Outreach

The treatment record must document the utilization of preventive services, as appropriate, including:

- ☐ Relapse prevention strategies
- ☐ Lifestyle changes
- ☐ Stress management
- ☐ Wellness programs
- ☐ Referrals to community resources

Members who become homicidal, suicidal or unable to conduct activities of daily living must be promptly referred to the appropriate level of care.

*Magellan documentation standards for behavioral health treatment records do not replace the documentation requirements as outlined in state and federal law, including, but not limited to, the Virginia Administrative Code, Department of Medical Assistance Services (DMAS) Emergency Regulations or the DMAS Provider Manuals.