The Aetna Behavioral Health treatment record review criteria and best practices

	STANDARD	BEST PRACTICE INSTRUCTIONS
A. TREATMENT RECORD-KEEPING PRACTICES		
1.	Is the record legible to someone other than the writer, that is, doesn't cause a problem to read some or a majority of record? (If the answer is "No," mark all questions "N" and end review.)	The handwriting should be easy to read, and the reviewer shouldn't have to make more than two attempts to read documentation within the medical record.
2.	Is the patient's personal data documented: address, gender, date of birth, home phone number, emergency contact, marital/legal status and guardianship (if relevant)?	Self-explanatory
3.	Is the member's name or unique identifier on every page?	Self-explanatory
4.	Do all entries in the record contain the author's signature or electronic identifier with title (if applicable) and degree?	Self-explanatory
5.	Are all entries dated?	Self-explanatory
B. ASSESSMENT AND TREATMENT PLAN		
6.	Is there a presenting problem, including history and current symptoms and behaviors, including behavior onset and development?	Self-explanatory
7.	Is there documentation of a thorough risk assessment, including presence or absence of suicidal or homicidal thoughts?	Self-explanatory
8.	Is there a complete mental status examination, including affect, mood, thought content, insight, judgment, speech, attention, concentration and impulse control?	This may be documented on an assessment tool or in a progress note and will include most of the nine elements in the standard.
9.	Is there a substance abuse assessment for all those over 12 years of age and a history, including substances used, amount, frequency and prior treatment history?	For members under age 12, mark N/A.
10.	Is there behavioral health treatment history documented?	Behavioral health history could include treatment dates, providers/facilities, current treating clinicians, response to treatment, lab tests and consultation reports (if applicable), and relevant behavioral health treatment history.
11.	Is there a comprehensive assessment of the family, psychosocial history and cultural variables that could also include legal and educational variables? Does it include the source(s) of the information?	Self-explanatory
12.	Is there a medical history that could include medical conditions, and a medication history that includes medications taken (prescriptions, as well as over the counter), dosages, dates, responses to medications, or allergies?	Self-explanatory

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13.	Is there a diagnosis documented?	Diagnosis should include comorbid and relevant psychosocial factors.
14.	Is the diagnosis consistent with the assessment?	The diagnosis should be consistent with presenting problems, history, mental status exam and/or other assessment data.
15.	For children and adolescents, is there a developmental history that could include prenatal and perinatal events, physical, psychological, social, intellectual, academic, and educational history?	Self-explanatory (If the member is an adult, then this question will be scored N/A.)
16.	For suicidal and homicidal patients, or patients who are otherwise at risk, are there risk assessments at every session?	For suicidal (or homicidal) members, there should be risk assessments at every session. If the member's condition is deteriorating, the record must indicate that more intense levels of care have been arranged, for example, intensive outpatient, partial, detox, residential or inpatient. This question will be scored N/A for members who don't have these symptoms.
17.	Is the treatment plan documentation thorough and complete? Are treatment plan and goals consistent with assessment and diagnosis? Does each goal have an estimated time frame?	(For all psychotherapy) Treatment plan goals that are vague won't be credited.
CA-only members (autism spectrum disorders): Reference California Code of Regulations Title 28 CCR 1300.67.1(d), 28 CCR 1300.80(b)(4), 28 CCR 1300.80(b)(5)(E), 28 CCR 1300.80(b)(6)(B). Non-CA residents will be scored as N/A.		
18.	If member is age 0–6 years, was there screening for autism spectrum disorder?	This may be documented on an assessment tool or the findings summarized in a progress note. Score N/A if member is a non-CA resident.
19.	If autism spectrum disorder is the diagnosis, is there documentation to support this diagnosis?	The diagnosis should be consistent with presenting problems, behaviors, developmental and/or appropriate screening tool assessment data. Score N/A if member is non-CA resident.
20.	Does the treatment plan show evidence-based therapies for autism spectrum disorder?	Does the treatment plan reflect the outcome of the assessment and indicate plans to use evidence-based therapies? Score N/A if member is a non-CA resident.
C. DOCUMENTATION AND PRACTITIONER COMMUNICATION		
21.	Is there documentation to show that the provider requested the member's permission to communicate with the primary medical practitioner?	A signed consent from the member must be obtained before the practitioner corresponds with the member's primary medical practitioner.
22.	Did the member grant permission to communicate with the primary medical practitioner?	This is a non-scored item. (Score N/A if Q21 = N.)

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23.	If the member did grant permission, is there documentation that the provider communicated with the primary medical practitioner?	Primary medical practitioner communication may occur after the initial evaluation, as a result of a significant change in member status, after a psychiatric evaluation if medications are initiated or treatment/diagnosis warrants such communication, or after significant changes in medication. Evidence of communication could be documentation of a phone conversation, email correspondence or a letter. (Score N/A if Q21 and Q22 = N.)
24.	If there is documentation about other behavioral health specialists or consultants treating the patient, is there documentation to show the provider requested the patient's permission to communicate with the other behavioral health specialist or consultant?	Other behavioral health specialists may include psychiatrists, ancillary providers, treatment programs/institutions/facilities, or other behavioral health providers or consultants.
25.	Did the patient grant permission to communicate with the other behavioral health specialists?	Self-explanatory (This is a non-scored item. Mark N/A if Q24 = N.)
26.	If the patient did grant permission, is there documentation that the provider communicated with the other behavioral health specialist or consultant?	There must be a separate release for each provider/ practitioner treating the member before the practitioner releases any type of information about the member. (Score N/A if Q25 = N or N/A.)
27.	Is a progress note present for every session?	Self-explanatory
28.	Does the documentation include a discharge plan?	A discharge plan could include follow-up as necessary, outreach documentation, crisis numbers and/or an opportunity to return to the provider in the future. Score N/A if member is still in treatment at the time the record is submitted for audit.
29.	Is there documentation about advance directives?	Advance directives must be present for Medicare patients only. All others are scored N/A.
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30.	Is there documentation of collaboration, consultation and/or continuity of care?	Evidence would include appropriate release of information and documentation of a phone conversation, email correspondence or a letter (examples may include the referring party, the educational system, or any other medical or behavioral specialist). Score N/A if member is a non-CA resident.
CA-only members: Reference California Code of Regulations Title 28 CCR 1300.67.04(c)(4)(A) and 28 CCR 1300.70.		
31.	Is there documentation indicating the patient's preferred language?	We'll review records to ensure there is documentation of the member's preferred language. Score N/A if member is a non-CA resident.
32.	Is there documentation of offer of a qualified interpreter?	We'll review records to ensure that providers offer our members language assistance. This item is N/A if response to Q31 is "No" or the member is a non-CA resident.

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33.	If there was an offer of qualified interpreter services, does documentation indicate refusal or acceptance of services?	This question is rated N/A if response to Q31 or Q32 is "No" or the member is a non-CA resident.
D. PRESCRIBING PRACTITIONERS ONLY: These questions are scored as N/A for all non-prescribing practitioners.		
34.	Is there clear documentation of psychotropic medications, dosages and dates of changes?	Prescribing practitioner may use medication flow sheet, order sheet or progress note to document psychotropic medications, dosages and dates of changes.
35.	Is there documentation of member education about the risks and benefits of the prescribed medications and member's understanding of information?	If prescribing practitioner uses a preprinted medication information sheet, there still needs to be documentation that the risks and benefits information is explained to the member (about the possible side effects and why the medication is being prescribed). This is in addition to the sheet being given.
36.	Is the recommended treatment consistent with the assessment and diagnosis?	Self-explanatory
37.	If a member is prescribed behavioral health medication(s), is there documentation to indicate the member was asked if medication is taken as prescribed?	Self-explanatory
38.	If a member is prescribed behavioral health medication(s), is there documentation that any barriers and challenges with adherence were discussed?	Is there a progress note documenting that medication adherence issues/challenges were discussed?
E. NON-SCORED ITEMS		
39.	Was there timely medical practitioner communication following patient assessment?	Evidence of communication could be documentation of a telephone conversation, email correspondence, or a letter written within 30 days of assessment and/or at key stages of the member's treatment. Communication with a psychiatrist or a primary medical provider would satisfy this coordination requirement.
40.	Did the communication with the medical practitioner contain sufficient and accurate clinical information about the member?	This requires a diagnosis consistent with documented symptoms and specific medications prescribed (if applicable) in the initial communication with the medical practitioner.