Attachment B: 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, i.e., does not 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 should not 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 numbers, emergency contact, marital/legal status and guardianship (if relevant)?	*All personal demographic data should be included.*
3.	Is the member's name or unique identifier on every page?	*Either the member's name or ID should be on each page.*
4.	Do all entries in the record contain the author's signature or electronic identifier with title (if applicable) and degree?	*Each entry should contain a signature, even if there are multiple entries within the same page.*
5.	Are all entries dated?	*All entries should be dated, even if there are multiple entries within the same page.*
B. ASSESSMENT & TREATMENT PLAN		
6.	Is there a presenting problem including history and current symptoms & behaviors, including behavior onset and development?	*Presenting problem documentation should include the history, current symptoms & behaviors as well as behavior onset and development.*
7.	Is there documentation of a thorough risk assessment including presence or absence of suicidal or homicidal thoughts?	*Risk assessment should cover past and present thinking including presence and absence of suicidal or homicidal thoughts.*
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 at least 5 of the 9 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?	*The evaluation should be thorough and include evidence of inquiry about use of alcohol, illicit drugs, illicit misuse of prescription drugs and OTC drugs. If there is documentation of abuse or dependence, there should also be documentation of the history of usage. "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 family and psychosocial history and cultural variables which could include family, social, legal, educational and history, and does it include the informant? Does the cultural history take into account cultural variables that may affect therapy?	*This section should comprehensively describe family and psychosocial history and areas that could be noted include cultural variables with relevant family, social, legal and educational history.*
12.	Is there a medical history which could include medical conditions and a medication history that includes medications taken (prescriptions as well as over the counter), dosages, dates, responses to medications, allergies?	*Medication history could include medication names, how long the member was on the medications (for both prescription and over-the-counter [OTC] medications), responses to medication and ongoing illnesses.*
13.	Is there a DSM IV diagnosis with all five (5) axes completed?	*Axis I: Clinical Disorder, Axis II: Personality Disorder/Mental Retardation, Axis III: General Medical Conditions, Axis IV: Psychosocial and environmental factors contributing to the disorder, Axis V: Global Assessment of Functioning or Children's Global Assessment Scale for children under 18.*

ASSESSMENT & TREATMENT PLAN, Continued		
14.	Is the diagnosis consistent with the assessment?	*The DSM IV TR 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?	*Developmental history could include areas such as normal or problem pregnancy, mother's drug use, abnormal birth weights, if child was routinely followed by pediatrician for first five years, developmental milestones within normal time frames, began school on time or delayed learning disabilities, diagnosis of hyperactivity and/or any medications prescribed.*
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, IOP, partial, detox, residential or IP.*
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 will not 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); 28CCR 1300.80 (b)(6)(B)		
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.*
19.	If autism spectrum disorder diagnosis, is there documentation to support this diagnosis?	*The DSM IV TR diagnosis should be consistent with presenting problems, behaviors, developmental and/or appropriate screening tool assessment data.*
20.	Does the treatment plan reflect evidence-based therapies for autism spectrum disorder?	*Does the treatment plan reflect the outcome of the assessment and indicate plans to utilize evidence-based therapies?*
C. DOCUMENTATION & PRACTITIONER COMMUNICATION		
21.	Is there documentation to reflect that the provider requested 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.*
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, e-mail correspondence or a letter.*
24.	If there is documentation about other behavioral health specialists or consultants treating the patient, is there documentation to reflect 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. Marked N/A if Q21=N)*

DOCUMENTATION & PRACTITIONER COMMUNICATION, Continued		
26.	If the patient did grant permission, is there documentation the provider communicated with the other behavioral health specialist or consultant?	*There must be a separate release for each provider/practitioner treating the member prior to the practitioner releasing any type of information about the member.(Scored N/A if Q22=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.*
29.	Is there documentation about Advance Directives?	*Advance Directives must be present for Medicare patients only.*
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); 28CCR 1300.80 (b)(6)(B)		
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, e-mail correspondence or a letter (examples may include the referring party, the educational system or any other medical or behavioral specialist).*
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?	*Records will be reviewed to ensure that there is documentation of Aetna member's preferred language.*
32.	Is there documentation of offer of a qualified interpreter?	*Records will be reviewed to ensure that Aetna members are offered language assistance. This item is N/A if member is a non-CA resident.*
33.	If there was offer of qualified interpreter services does documentation indicate refusal or acceptance of services?	This question is rated N/A if response to question #31 or #32 is "No" or the member is a non-CA resident.
	D. PSYCHIATRISTS ONLY	
34.	Is there clear documentation of psychotropic medications, dosages and dates of changes?	*Psychiatrist 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 regarding the risks and benefits of the prescribed medications and member's understanding of information?	*If psychiatrist uses a preprinted medication information sheet, there still needs to be documentation that the risks and benefits information is explained to the member (regarding 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?	Recommended treatment should be consistent with the assessment and diagnosis.
37.	If a member is prescribed BH medication(s), is there documentation to indicate the member was asked if medication is taken as prescribed?	*If medication has been prescribed, there should be documentation that the prescriber attempted to determine if the medication is being taken as prescribed. Appropriate follow–up should occur as indicated. This item will be scored for psychiatrists only.*
38.	If a member is prescribed BH medication(s), is there documentation that any barriers and challenges with adherence were discussed?	*Is there a progress note that documents that medication adherence issues/challenges were discussed? This item will be scored for psychiatrists only.*