MEDICAL RECORD REVIEW STANDARDS BEHAVIORAL HEALTH PRACTITIONERS

1. INDIVIDUAL RECORD*	Each member's individual medical record is maintained separately.
2. MEMBER ID*	Each page in the record contains member name or member ID number.
3. BIOGRAPHICAL DATA*	Personal data includes address, employer, telephone numbers, emergency contact, marital status, etc.
4. ENTRY ID*	All entries include the responsible clinician's name, professional degree and relevant identification number, as appropriate.
5. ENTRY DATA*	All entries are dated.
6. LEGIBILITY*	The record is legible to someone other than the physician or physician's staff.
7. PSYCHOLOGICAL ASSESSMENT/PRESENTING PROBLEM LIST*	A mental status examination is documented in the medical record. Presenting problems and relevant psychological and social conditions affecting the member's medical and psychiatric status are documented. Imminent risk of harm or suicidal ideation are prominently noted, documented and revised in compliance with protocol. A complete developmental history is documented for children and adolescents.
8. MEDICATION LIST*	Prescribed medications, dosages of each and prescription fill/refill dates are documented on a separate medication list.
9. ALLERGIES OR ADVERSE REACTIONS*	In addition, presence/absence of allergies or adverse reactions to medications are prominently noted on each member chart. An absence of allergies should also be clearly documented in the record.
10. TOBACCO USE	Use/nonuse of tobacco products is documented on members age 11 and older.
11. ALCOHOL/DRUG USE	Use/nonuse of alcohol and illicit drugs is documented on members age 11 and older.
12. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
13. WORKING DIAGNOSIS*	There is a clearly documented diagnostic impression by the practitioner that is consistent with findings for each member visit. The appropriate DSM diagnosis code is documented.
14. PLAN OF ACTION /THERAPIES /TREATMENT/ PRESCRIBED REGIMENS	The provider initiating a treatment plan must describe the active target interventions with specific, measurable goals, and stated in behavioral terms, at the level of care proposed. Progress notes which include follow-up, and describe the member's strengths and limitations in achieving the treatment plan are documented. Informed consent for medication and the member's understanding of the treatment plan are documented.
15. PREVENTIVE SERVICES	There is documentation of preventive services, as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources.

16. CONSULTATION/REFERRALS/ CONTINUITY/COORDINATION OF CARE*	The medical record reflects continuity and coordination of care between the primary clinician, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Notes from consultations with ordering physician's initials or other documentation signifying review and detailing plans moving forward are to be included. Discharge summaries are included, if applicable. Documentation should include member's consent or declination to release information to the member's Primary Care Physician (PCP).
17. DISCHARGE PLAN	If the member terminates treatment, documentation of a discharge plan is present.
18. CARE MEDICALLY APPROPRIATE	Documentation in the medical record describes the services provided to the member, and demonstrates that medically appropriate care is being provided. Record reflects that members who become homicidal, suicidal or unable to conduct activities of daily living, receive immediate and relevant interventions (behavioral and pharmacotherapeutic), and are promptly referred to the appropriate level of care.
19. CONFIDENTIALITY	Each record contains copies of confidentiality statements/HIPAA forms and copies of all signed consents to release information.

***Indicates Critical Factors**