Treatment Record Review Overview

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Overview of Changes

• Wording updates
• Elimination of duplication/redundant items
• PCP communication
• Addition of behavioral health care communication section
Effective Date of Changes:

July 1, 2015
General Information

• No changes to this section
• A note about legibility...
• Consumer first and last name on each page of record
• The consumer’s Medicaid number, full name, and birth date must appear on one page of the record
Consumer Rights and Confidentiality

- No changes
- Informed consent for meds signed or refusal documented (prescribers only)
Coordination of Care

• Evidence of ROI request for PCP communication (or refusal documented)

• Evidence of PCP communication at significant points in treatment
  – medication initiated, discontinued, or significantly altered
  – significant changes in diagnosis/clinical status
Initial Evaluation
Purpose of the Initial Evaluation

• Document the presenting problem and biopsychosocial factors impacting the client’s mental health
• Formulate a diagnostic impression
  – Accepting both DSM IV-TR and 5
  – Document symptoms and how they align with the criteria outlined in the DSM
The Initial Evaluation Drives the Treatment Plan and the Service

- **Step 1**: Initial Evaluation
- **Step 2**: Treatment Plan
- **Step 3**: Service
Co-Occurring Assessment

For members 12 years of age and older, document past and present use of:

- Tobacco products
- Caffeine
- Alcohol
- Illicit, prescribed, and over-the-counter drugs.

For all members (adult and child), document family history of substance abuse.

If appropriate, document drug and alcohol referral with evidence of collaboration.
Risk Assessment

• The risk assessment addresses risk of harm to others and suicidality.
  ✓ Ideations
  ✓ Plans
  ✓ Means
  ✓ Intent

• Ensure referral, as appropriate.

All members must have an individualized crisis plan.
Family Involvement & Natural Supports

• Assess availability of natural supports and document member’s wishes for involvement

• Obtain Release of Information (ROI) as necessary
Assessment of Consumer Strengths and Identified Areas for Improvement

• Assess these factors in order to create a strengths-based treatment plan.
Discharge Planning

• Should begin at intake and answer the following:
  – *How will the client know that they are ready to transition to a lower level of care?*
  – *How will the client know that they need to transition to a higher level of care?*
  – *What supports will be used in this process?*
Individualized Treatment Plan

• Driven by the initial assessment
• Collaboration between clinician and client
• Specific and individualized goals
• Measurable Interventions
• Specific timeframes for achievement
• Evidence of member understanding
• Treatment plans should be updated as goals are achieved or changed
Ongoing Treatment/Service Documentation
Service Documentation

The purpose of the service note is to document progress towards identified goals.

Be sure to document:

• Intervention
• Client response to intervention
• Progress or barriers to goal achievement

Other important things to document in the service note:

• Risk Assessment
• Substance Use Assessment
• Referrals
Discharge Plan

The discharge plan must be documented on the day of discharge and include:

- Discharge instructions
- Follow-up appointments
- Post-discharge plan
BHIS Specific

No changes to this section

• Quarterly consultation/supervision
• Discharge plan documented on the day of discharge (group care only)
• Ambulatory follow up
PMIC Specific

No changes to this section

• PMIC discharge plan has been documented on day of discharge.
• PMIC discharge plan has been implemented.
CPG (Clinical Practice Guidelines)

• Major Depressive Disorder
• Schizophrenia
• Attention Deficit Hyperactivity Disorder
• Substance abuse disorder
• Suicidal
Fraud and Abuse

• Time in and time out
• Signed progress notes, treatment plans, discharge planning with providers name and credentials
• Personnel records/background checks, and updated provider certifications and/or licensure when needed
Questions?
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Thanks