Appendix A:

The Aetna® Behavioral Health treatment record review criteria and best practices

No	Yes	N/A	No.	Standard	Instructions
A. Treatment record-keeping practices					
N	Y		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 the record? (If the answer is no, mark all questions 'N' and end review.)	The handwriting should be easy to read. The reviewer should not have to make more than two attempts to read documentation within the medical record.
N	Y		2.	Is the patient's personal data documented? For instance, address, gender, date of birth, home phone numbers, emergency contact, marital/legal status, and guardianship (if relevant).	Self-explanatory
N	Y		3.	Is the member's name or unique identifier on every page?	Self-explanatory
N	Y		4.	Are all entries in the record dated? Do they have the author's signature or electronic identifier with title (if applicable) and degree?	Self-explanatory
N	Y		5.	Are there signed release(s) for communication with Primary Care Practitioner (PCP), other medical and behavioral health providers and involved parties signed?	Self-explanatory
N	Y		6.	Are there signed treatment informed consent forms, if required by the state?	Self-explanatory

No	Yes	N/A	No.	Standard	Instructions
B. Assessment and treatment plan					
N	Y		7.	Is there a presenting problem including history and current symptoms and behaviors? Does it include behavior onset and development?	Self-explanatory
N	Y		8.	Is there documentation of a thorough risk assessment? Does it include presence or absence of suicidal or homicidal thoughts?	Self-explanatory
N	Y		9.	Is there a completed thorough mental status examination?	This may be documented on an assessment tool or in a progress note. It should include (at least) most of the elements in the standard.
N	Y		10.	Is a substance abuse assessment completed or ongoing?	For members age 12 and under, mark "N/A"
N	Y		11.	Is there a documented behavioral health treatment history?	Behavioral health history could include treatment dates, practitioners/facilities, current treating clinicians, response to treatment, lab tests and consultation reports (if applicable) and relevant medical treatment history.
N	**Y**		**12.**	**Is there a complete assessment of the family, psychosocial history and cultural variables? Does it also include legal and educational variables? Does it include the source(s) of the information?**	**Self-explanatory**
N	**Y**		**13.**	**Is there a medical history with medical conditions, medications and allergies listed (if available)?**	**Self-explanatory**
N	**Y**		**14.**	**Is there a diagnosis documented?**	**Should include comorbid and relevant psychosocial factors.**
N	**Y**		**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, this question will have a score of N/A.**

No	Yes	N/A	No.	Standard	Instructions
B. Assessment and treatment plan, continued					
N	Y		16.	For suicidal and homicidal patients, or patients who are otherwise at risk, are there assessments at every session?	For suicidal/homicidal patients, there should be risk assessments at every session. If the patient's condition is deteriorating, the record must indicate that more intense levels of care were arranged, i.e., IOP, partial, detox, residential or IP. We score this question N/A for members that don't have these symptoms.
N	Y		17.	Is the treatment plan documentation thorough and complete? Are treatment plan goals consistent with assessment and diagnosis? Does each goal have an estimated timeframe?	(For all psychotherapy) Vague treatment plan goals 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); 28 CCR 1300.80(b)(5)€; 28CCR 1300.80 (b)(6)(B).					
N	Y		18.	If member is 0-6 years of age, was there screening for Autism Spectrum Disorder?	Document findings from an assessment tool or summarized in a progress report. Score N/A if member is not a CA resident.
N	Y		19.	If Autism Spectrum Disorder diagnosis, is there documentation to support this diagnosis?	The diagnosis should be consistent with presenting problems, behaviors, developmental and/or appropriate screening tool data. Score N/A if member is not a CA resident.
N	Y		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 use evidence-based therapies? Score N/A if member is not a CA resident.
C. Documentation and practitioner communication					
N	Y		21.	If you have permission, do you communicate with the PCP at significant points of treatment?	PCP communication may occur after the initial evaluation. This may result from a significant change in member status, after a psychiatric evaluation, the start of medications, if treatment/diagnosis warrants such communication, or after significant changes in medication. (Score N/A if Q5=N or N/A.)

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C. Documentation and practitioner communication, continued					
N	Y		22.	With permission, the treatment record reflects continuity and coordination of care between primary behavioral health clinician and other behavioral health specialist(s) or consultant(s).	There must be a separate release for each practitioner/provider treating the member before the practitioner releases any type of information about the member. (Score N/A if Q5=N or N/A)
N	Y		23.	Is a progress not present for every session?	Self-explanatory
CA-only members (Autism Spectrum Disorders) Reference California Code of Regulations Title 28 CCR 1300.67.1(d); 28 CCR 1300.80(b)(4); 28CCR 1300.80(b)(5)(E); 28CCR 1300.80 (b)(6)(B).					
N	Y		24.	Is there documentation of collaboration, consultation and/or continuity of care?	Evidence includes 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 not a CA resident.
CA-only members Reference California Code of Regulations Title 29 CCR 1300.67.04(c)(4)(A) and 28 CCR1300.70.					
N	Y		25.	Is there documentation including the patient's preferred language?	Records should show documentation of the member's preferred language. Score N/A if member is not a CA resident.
N	Y		26.	Does the treatment plan reflect evidence-based therapies for Autism Spectrum Disorder?	Records should show language help was available to members. This item is N/A if answer to 25 is "No" or if member is not a CA resident.
N	Y		27.	Was there was an offer of qualified interpreter services? If so, does the documentation note refusal or acceptance of services?	Rate this question N/A if response to question 25 or 26 is "No" or the member is not a CA resident.

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D. Prescribing practitioners only: These questions score N/A for all non-prescribing practitioners.					
N	Y		28.	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.
N	Y		29.	Is there documentation of member education on the risks and benefits of the prescribed medications. Is there documentation that the member understands the information?	If prescribing practitioner uses a preprinted medication information sheet, there still needs to be documentation the doctor explained the risks and benefits to the member. The explanation should include the possible side effects and why the provider prescribed the medication. This is in addition to the sheet being given.
N	Y		30.	Is there documentation reflecting the patient's report of efficacy, side effect(s), or concern about taking the medications as prescribed?	Self-explanatory