

Treatment Record Documentation

In support of quality care, Magellan requires participating providers to maintain organized, well-documented member treatment records that reflect continuity of care. This includes documenting, in a timely manner, all aspects of treatment including face-to face encounters, telephone contacts, clinical findings and interventions. Magellan reviews treatment records with providers receiving a high volume of referrals from Magellan, as required by our customers or as part of a quality review.

The following checklist will help assist providers with treatment record documentation:

- Has the patient completed all necessary forms?
- Was contact made with the patient's primary medical professional following the Initial Evaluation/Assessment, at pertinent times during treatment (initiation of medication), and at treatment termination?
- Were consents to communicate with other agencies/providers signed by the patient before communications occurred?
- Is the patient's name and identification number noted on each page of the treatment record?
- Is the patient's legal guardian noted in the medical record for adolescents, children and adults (when applicable)?
- Are all documentations in the treatment record legible?
- Has the patient signed the Patient Bill of Rights? Magellan offers a "Member Rights and Responsibilities" document in the "Providing Care" section of their Web site, www.MagellanProvider.com. This document may be accessed under "Initiating Care".
- Are all entries in the treatment record dated and signed (including the provider's degree and ID# if required by the state)?
- Did the patient (or legal guardian to the patient) sign the Consent to Treatment Form, and is there a copy in the treatment record?
- If medication was prescribed, is there a signed consent in the treatment record?
- Have all practitioners/consultants/ancillary providers or services involved in treating the patient been contacted to promote continuity and coordination of care?
- Does the treatment record contain specific dates for follow-up appointments (after the initial evaluation and in each progress note)?
- Do the progress notes describe the patient's strengths and limitations in achieving treatment plan goals?
- Is there documentation that the patient has been referred to and is receiving medication evaluations for psychotropic medication, if applicable?

- For psychiatrists prescribing medications: Is there documentation of current medication(s), dosage(s), date(s) of dosage changes in progress notes?
 - Is there documentation that the patient has been educated regarding possible medication side effects?
 - Is there documentation that the reason for medication was explained to the patient?
 - Is there documentation of member education of women of childbearing age to avoid getting pregnant while taking psychotropic, and to notify the psychiatrist immediately upon becoming pregnant?
 - Is there documentation of member verbalization of understanding of medication education?
 - Were DEA scheduled drugs avoided in members with Chemical Dependency history?

For a full listing of elements reviewed during the treatment record review process, refer to the Treatment Record Documentation Worksheet in Appendix A of the Magellan Provider Handbook which can be accessed at <https://www.magellanprovider.com/forms/>. If you have any questions regarding the criteria, please contact us toll free at 1-877-742-1531.