HIGHMARK Delaware
HEALTH OPTIONS

MEDICAL RECORD REVIEW STANDARDS – Behavioral Health Providers

1. MEMBER ID	Each page in the record contains member name or member ID number.
2. SIGNED ENTRY	All entries are signed or initialed (electronically) by the provider.
3. DATED ENTRY	All entries are dated.
4. LEGIBILITY	The record is legible to someone other than the provider or provider's staff.
5. 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 documented.
6. MEDICATION LIST	Prescribed medications and dosages are documented on a medication list.
7. ALLERGIES OR ADVERSE REACTIONS	Presence/absence of allergies or adverse reactions to medications are prominently noted. An absence of allergies should be clearly documented in the record.
8. TOBACCO USE	Use/nonuse of tobacco products is documented on members age 12 and older.
9. ALCOHOL USE	Use/nonuse of alcohol an illicit drugs is documented on members age 12 and older.
10. DRUG USE	Use/nonuse of illicit drugs is documented on members age 12 and older.
11. LAB, DIAGNOSTIC TESTS & OTHER STUDIES	Labs and other studies must be appropriate to the presenting complaint, or diagnosis.
12. WORKING DIAGNOSIS	There is a clearly documented diagnostic impression by the provider that is consistent with findings for each member visit.
13. PLAN OF ACTION /THERAPIES /TREATMENT	The provider initiating a treatment plan must describe the active target interventions with specific, measureable goals, and stated in behavioral terms, at the level of care proposed. Includes follow-up care.
14. 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.
15. CONSULTATION / REFERRALS / CONTINUITY/ COORDINATION OF CARE	The medical record reflects continuity and coordination of care between the PCP, specialists, consultants, ancillary providers and healthcare institutions, as applicable. Discharge summaries are included, if applicable.
16. DISCHARGE PLAN	If the member terminates treatment, documentation of a discharge plan is present.
17. CARE MEDICALLY APPROPRIATE	Medical record describes appropriate and necessary care, and there is no evidence of the member being placed at inappropriate risk. Record reflects that members who become homicidal or suicidal receive immediate and relevant interventions.
18. CONFIDENTIALITY	Medical records contain confidentiality statements or a copy of signed consents to release information.