Provider Guide: Treatment Record Review and Clinical Practice Guideline Review Procedure

This document outlines the procedures for conducting treatment record reviews (TRRs) for providers rendering any of the specialized behavioral health services (SBHS) offered under Medicaid managed care. Please refer to the Louisiana Department of Health (LDH) Behavioral Health Provider Manual for the complete listing of SBHS offered under Medicaid managed care, including §1915(c) and §1915(b) waiver services offered only through Magellan Health of Louisiana – the CSoC Contractor. The manual stipulates service limitations, eligibility and utilization criteria and allowed provider types and specialties for services. All providers participating in Medicaid managed care are responsible for understanding and complying with all requirements specified in the manual.

Purpose

Treatment record reviews serve multiple functions, including to:

- Collect data for the evaluation of quality of care delivered to Magellan members by providers;
- Provide feedback to providers on documentation standards for ongoing education;
- Monitor provider compliance with Magellan clinical practice guidelines (CPGs);
- Monitor provider compliance with Medicaid waiver assurance performance measures;
- Verify record keeping practices adhere to privacy and confidentiality standards;
- Investigate quality of care concerns and grievances related to the clinical or administrative practices of providers, as determined on a case-by-case basis;
- Ensure specific LDH and/or Medicaid requirements are met; and
- Meet requirements of various accreditation standards that are applied to Magellan.

Provider Participation

Participation in the TRR monitoring is a contractual obligation as stated in the Magellan provider agreement in Section 2.5: “Provider agrees to cooperate and participate with all announced or unannounced internal and external quality assessment reviews, utilization review/management, and grievance procedures, or other similar programs established by Magellan and DHH-OBH, or its designee.”

Review Tools

Magellan utilizes a core audit tool to assess the main components of record keeping practices. Additionally, modules can be added when defined criteria are met or when mandated by specific contract requirements. The catalogue of tools includes:

- Treatment Record Review – Magellan Behavioral Health (TRR – MBH)
- Coordinated System of Care (CSoC) Review
- Fraud, Waste and Abuse (FWA) Screening Review
- Attention Deficit Hyperactivity Disorder (ADHD) CPG Review
- Suicide Risk Assessment and Management (SR) CPG Review
- Conduct Disorder (CD) CPG Review
- Trauma-Informed Care (TIC) CPG Review

Procedure Effective Date: 05/23/2019

Review Criteria

Review tools were developed to evaluate fundamental areas of practice, which includes:

- Quality of care consistent with professionally recognized standards of practice;
- Adherence to clinical practice guidelines and/or evidenced–based practices;
- Member rights and confidentiality, including advance directives and informed consent;
- Cultural-competency;
- Patient safety;
- Compliance with Magellan's adverse incident reporting requirements;
- Appropriate use of restraints and seclusion, if applicable;
- Treatment planning, including evidence of implementation as reflected in progress notes and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and
- Ongoing continuity and coordination of care, including adequate discharge planning, with all relevant parties, including but not limited to the member's Wraparound Agency (WAA), Primary Care Physician (PCP) and other behavioral health providers involvement in the member's Plan of Care, as appropriate.

Provider Selection Criteria

Any Magellan contracted provider is subject to review. In general, providers are randomly selected to participate in record reviews; however, there is an emphasis placed on reviewing newly contracted providers, providers serving a high volume of CSoC members and CSoC waiver service providers.

CPGs Selection Criteria

Magellan develops or adopts CPGs to assist providers in screening, assessing and treating common disorders. Magellan utilizes member diagnostic data, including the member's diagnosis and Child and Adolescent Strengths and Needs (CANS) ratings, to identify members that require CPG review. CPG reviews are conducted for members that meet the following criteria:

- **Attention Deficit Hyperactivity Disorder (ADHD) CPG Review Tool:** Diagnosis of ADHD
- **Conduct Disorder (CD) CPG Review Tool:** Diagnosis of Conduct Disorder
- **Suicide Risk (SR) Assessment and Management CPG Review Tool:** Diagnosis of Major Depressive Disorder (MDD) and/or a rating of 1, 2, or 3 on the Suicide Risk Item on the most recent CANS assessment
- **Trauma-Informed Care (TIC) CPG Review Tool:** Rating of 2 or 3 for the Adjustment to Trauma Item in the most recent CANS assessment

Reviewer Qualifications

All TRR and CPG record reviews are conducted by a Licensed Mental Health Practitioner (LMHP) employed by Magellan who has been trained in the administration and scoring of the TRR and CPG review tools. Interrater reliability is conducted at a minimum of annually to ensure consistency and accuracy of scoring. Remediation activities, including education, technical assistance and retesting, are completed as necessary.

Review Protocol

Record Request

- Treatment Record Reviews are generally conducted as a remote, or desktop, review.
- Providers are sent a request letter with the members selected for review and instructions on when and how documents should be submitted.

- Providers are responsible for adhering to Health Insurance Portability and Accountability Act (HIPAA) rules when submitting records. Magellan recommends records are submitted to secure fax or secure email to the designated Magellan CR.
- Documents should be legible and organized. It is recommended that the provider include a guide for locating key documents if record is not reasonably labeled. Missing or Illegible documents will be scored as non-compliant.
- Once records are received, the member records are reviewed by the CR using the TRR – MBH tool and any relevant modules.

Record Assessment

- The CR aggregates ratings and determines item, section and overall scores.
- The CR applies guidance outlined in Table 1 to the aggregate score for the TRR – MBH tool.
- The CR then evaluates performance of item and section scores against standards of clinical practice, patient safety, Medicaid, LDH and other relevant state and federal regulations, Magellan quality improvement initiatives and results of previous Magellan quality or network reviews to determine level of remediation.
- At the discretion of the CR, any areas that do not minimum and/or best practice standards will be subject to remedial actions.

Table 1. Level of Documentation Deficiency

Level	TRR – MBH Overall Score	Description
Minimal Documentation Issues	100% – 80%	No formal follow–up activity required. Provider is requested to incorporate recommendations from the feedback report to improve documentation practices.
Moderate Documentation Issues	79% – 70%	Provider is required to submit an Informal PIP (Performance Improvement Plan), including but not limited to, a plan to remedy documentation deficiencies noted. PIP must be received within thirty (30) days of the date of the results letter. Review and approval of the PIP by Magellan is required. No formal follow–up activity required.
Serious Documentation Issues	69% and below	Provider is required to submit a Formal PIP, including but not limited to, a plan to remedy documentation deficiencies noted. PIP must be received within thirty (30) days of the date of the results letter. Review and approval of the PIP by Magellan is required. Magellan will follow up on the PIP progress, including, but not limited to, an additional treatment record review in six (6) months to determine if the documentations practices have been addressed.

CSoC Review Tool

- Providers will not be subject to remedial actions for the CSoC Review Tool. The questions are designed to monitor compliance with WAA-specific requirements for care coordination.
- It is the provider's responsibility to retain documents in the member's treatment record once received from the WAA.
- If you do not have the documents specified in this module, your regional WAA should be contacted to establish a mutually agreed upon procedure transmit key documents. Please note Magellan requires WAA to electronically transmit all documents.
- Results will be used as part of quality improvement initiatives directed at WAAs.

Review Outcome

- Magellan will transmit your results via a secure email with delivery tracking. This will include the itemized audit tool, a summary table, an overall compliance score and type of PIP with due date (if applicable).
- If NO PIP is required, the provider results will be final, and the review will be considered closed.
- If a PIP is required, Magellan will provide three (3) business days, excluding the day the email is sent, to submit additional documentation to justify a change in a review determination.
    - If provider selects this option, then documentation should be sent securely to LACSoCQI@magellanhealth.com or (888) 656–3857. Documentation should be clearly organized and identify the associated member and specific item. CR will review records and adjust ratings as needed. An email will be sent to provider with final results and any required remedial actions. No additional appeal rights will be given.
    - If no email correspondence and/or documentation is received by the close of the third business day, the ratings will be considered final. No additional communication will be made by the CR. Providers are expected to submit the PIP as outlined in the original results email.
- At the discretion of the CR, a videoconference may be required to provide technical education. Any provider can request a videoconference if desired.
- The provider should contact the CR for any assistance to complete PIP prior to due date. If no communication is received, the CR will assume that technical assistance is not needed.
- PIPs should be submitted by close of business of the date outlined in the email body and the PIP template.
- PIP will be reviewed to ensure it adequately addresses the deficiencies identified. If PIP is not accepted, Magellan will contact provider directly to provide further instructions.
- Once PIP is accepted, the review will be considered closed.
- Please note that active participation in all activities related to the procedures specified in this document are contractually required for providers in the Magellan network.
- Lack of response and/or inadequate response could negatively affect the provider's network status, including but not limited to referral to Magellan's peer review committee, hold from receiving new member referrals, termination of contract, etc.

TRR and CPG Audit Tools

Review Type	#	Section	Element
Treatment Record Review – Magellan Behavioral Health (TRR – MBH) Tool			
TRR – MBH	1	A – General	Record is legible
TRR – MBH	2	A – General	Member name or ID number noted on each page of record
TRR – MBH	3	A – General	Name and credentials of the provider rendering services and the signature or initials of the provider are included on service notes. Initials of providers must be identified with correlating signatures.
TRR – MBH	4	A – General	Record includes member identifying information, including name, identification number, date of birth, gender, and legal guardianship (if applicable)
TRR – MBH	5	A – General	Record includes primary language spoken by the member and any translation needs of the member
TRR – MBH	6	B – Member Rights and Confidentiality	Record shows evidence member rights and responsibilities were reviewed
TRR – MBH	7	B – Member Rights and Confidentiality	Signed and dated informed consent for treatment

Review Type	#	Section	Element
TRR – MBH	8	B – Member Rights and Confidentiality	Release(s) for communication w/ other behavioral health care providers and involved parties are signed or patient refusal documented as applicable
TRR – MBH	9	B – Member Rights and Confidentiality	Release(s) for communication w/ Wraparound Agency are signed
TRR – MBH	10	B – Member Rights and Confidentiality	Evidence of provider request of consumer for authorization for PCP/Pediatrician communication or refusal documented
TRR – MBH	11	C – Initial Evaluation	DSM-5R diagnosis
TRR – MBH	12	C – Initial Evaluation	History & symptomology consistent w/DSM-5R criteria
TRR – MBH	13	C – Initial Evaluation	Reason member is seeking services (presenting problem) and mental health status exam
TRR – MBH	14	C – Initial Evaluation	Behavioral health/psychiatric history
TRR – MBH	15	C – Initial Evaluation	Co–occurring (co–morbid) substance induced disorder assessed
TRR – MBH	16	C – Initial Evaluation	Current and past suicide/danger risk assessed
TRR – MBH	17	C – Initial Evaluation	Assessment of member's strengths, skills, abilities, motivation, etc. included
TRR – MBH	18	C – Initial Evaluation	Level of familial/supports assessed and involved as indicated
TRR – MBH	19	C – Initial Evaluation	Member identified areas for improvement/outcomes documented
TRR – MBH	20	C – Initial Evaluation	Medical history
TRR – MBH	21	C – Initial Evaluation	Exploration of allergies and adverse reactions
TRR – MBH	22	C – Initial Evaluation	All current medications w/dosages
TRR – MBH	23	C – Initial Evaluation	Discussion of d/c planning/linkage to next level
TRR – MBH	24	D – Individualized Treatment Plan	Individualized strengths–based treatment plan is current
TRR – MBH	25	D – Individualized Treatment Plan	Measurable goals/objectives documented
TRR – MBH	26	D – Individualized Treatment Plan	Goals/objectives have timeframes for achievement
TRR – MBH	27	D – Individualized Treatment Plan	Goals/objectives align w/consumer identified areas for improvement/outcomes
TRR – MBH	28	E – Ongoing Treatment	Purpose of visit and/or chief complaint for visit documented
TRR – MBH	29	E – Ongoing Treatment	Progress towards measurable consumer identified goals & outcomes evidenced. If not, barriers are being addressed.
TRR – MBH	30	E – Ongoing Treatment	Clinical assessments & interventions evaluated at each visit
TRR – MBH	31	E – Ongoing Treatment	Substance use assessment is current/ongoing
TRR – MBH	32	E – Ongoing Treatment	Comprehensive suicide/risk assessment is current/ongoing
TRR – MBH	33	E – Ongoing Treatment	Medications are current
TRR – MBH	34	E – Ongoing Treatment	Member compliance or non-compliance with medications is documented; if non-compliant, interventions considered
TRR – MBH	35	E – Ongoing Treatment	Evidence of treatment being provided in a culturally competent manner
TRR – MBH	36	E – Ongoing Treatment	Family/support systems contacted/involved as appropriate/feasible
TRR – MBH	37	E – Ongoing Treatment	Crisis plan documented
TRR – MBH	38	E – Ongoing Treatment	D/C planning/linkage to alternative treatment (level of care) leading to D/C occurring

Review Type	#	Section	Element
TRR – MBH	39	E – Ongoing Treatment	Services were provided in alignment with the Service Definition (in the Behavioral Health Manual) and associated curricula
TRR – MBH	40	E – Ongoing Treatment	Interventions were appropriate and in alignment with the goals and objectives identified in the treatment plan.
TRR – MBH	41	E – Ongoing Treatment	If record documents an adverse incident, record shows provider notifies Magellan and any other required entities as applicable.
TRR – MBH	42	E – Ongoing Treatment	If record includes documentation of emergency and/or afterhours, evidence that follow-up was provided as applicable.
TRR – MBH	43	E – Ongoing Treatment	The service note shows evidence of evidenced–based interventions (e.g., results of workbook activities, workbook handouts, etc.) in accordance with youth's Plan of Care, treatment plan and/or diagnosis.
TRR – MBH	44	E – Ongoing Treatment	Record shows documentation of coordination of care with WAA at critical points in treatment (e.g., crisis, abuse incident, inpatient hospitalization, etc.).
TRR – MBH	45	F – Medication Management	Signed and dated consent forms for medication or refusal documented (as applicable)
TRR – MBH	46	F – Medication Management	Medication flow sheet completed, or progress note includes documentation of current psychotropic medication, dosages, date(s) of dosage changes.
TRR – MBH	47	F – Medication Management	Documentation of member education regarding reason for the medication, benefits, risks, and side effects (includes effect of medication in women of childbearing age and to notify provider if becomes pregnant, if appropriate).
TRR – MBH	48	F – Medication Management	Documentation of member verbalization of understanding of medication education.
TRR – MBH	49	F – Medication Management	AIMS was performed when appropriate (e.g., member is being treated with antipsychotic medication).
TRR – MBH	50	F – Medication Management	IF PRESCRIBED ANTIPSYCHOTIC MEDICATION: Provider documented ongoing screening of weight and re-calculated BMI (e.g., 4 wks., 8 wks., 12 wks., quarterly, annually, q5 yrs.) as well as annual requests for fasting glucose and lipids.
TRR – MBH	51	F – Medication Management	Record includes studies ordered and results of those studies (e.g., laboratory, x-ray, EKG).
TRR – MBH	52	G – Discharge	Discharge plan included an appointment date and time with mental health transitioning provider. If not, the reason was documented.
TRR – MBH	53	G – Discharge	Discharge plan included an appointment date and time with Primary Care Physician if a medical co morbidity was present. If not, the reason was documented.
TRR – MBH	54	G – Discharge	Medication profile was reviewed with outpatient provider at time of transition of care.
TRR – MBH	55	G – Discharge	Medication profile was reviewed with member at time of transition of care.
TRR – MBH	56	G – Discharge	Discharge summary reflected the course of treatment.
TRR – MBH	57	G – Discharge	Discharge summary was in medical record within 30 days of discharge.
TRR – MBH	58	H – Record Management	Records are stored securely
TRR – MBH	59	H – Record Management	Only authorized personnel have access to records

Review Type	#	Section	Element
TRR – MBH	60	H – Record Management	Staff receive periodic training in confidentiality of member information
TRR – MBH	61	H – Record Management	Treatment records are organized and stored to that allow easy retrieval
Coordinated System of Care (CSoC) Review Tool			
TRR – CSoC	1	A – IBHA/POC	Record includes most recent eligibility Independent Behavioral Health Assessment (IBHA). (IBHA completed every 180 days of enrollment.)
TRR – CSoC	2	A – IBHA/POC	Record includes most recent eligibility Plan of Care (POC). (Eligibility POC completed every 180 days of enrollment.)
TRR – CSoC	3	A – IBHA/POC	Record includes most recent updated POC. (POC updated at each Child and Family Team (CFT) meeting.)
TRR – CSoC	4	A – IBHA/POC	Record includes most recent CANS assessment.
TRR – CSoC	5	B – CFT	Record shows documentation of notification of CFT meeting from Wraparound Agencies (WAA). If meeting scheduled at the most recent CFT meeting, the updated POC with next scheduled meeting is sufficient.
TRR – CSoC	6	B – CFT	Record shows documentation of participation in CFT meeting.
TRR – CSoC	7	B – CFT	If question 2B is no, record shows progress update given telephonically or electronically prior to CFT.
Fraud, Waste and Abuse (FWA) Screening Review Tool			
FWA	1	FWA Screening	Service notes include date and begin and end time of service.
FWA	2	FWA Screening	Services notes include relevant CPT code that aligns with service provided.
FWA	3	FWA Screening	Service notes include place of service that is consistent with the Medicaid Provider Manual requirements and service provided.
FWA	4	FWA Screening	There was no evidence that provider billed for missed appointments.
FWA	5	FWA Screening	There was no evidence that provider billed for more hours than were delivered.
FWA	6	FWA Screening	There was no evidence that provider used duplicated notes or notes that were not individualized to the service encounter.
FWA	7	FWA Screening	There was no evidence of insufficient documentation for duration of the service provided.
FWA	8	FWA Screening	There was no evidence that the provider billed for more services than are likely to be performed in one day.
FWA	9	FWA Screening	There were no services performed on holidays. If services were provided on holidays, an explanation was provided.
Attention Deficit Hyperactivity Disorder (ADHD) CPG Review Tool			
ADHD	1	A – Diagnostic Assessment	Screened for presence and duration of symptoms meeting DSM-5R criteria for ADHD and persisting for at least six months, including predominantly inattentive presentation, predominantly hyperactive/impulsive presentation, or combined presentation (Note: children and adolescents must meet six or more of the

Review Type	#	Section	Element
			DSM-5R symptoms and older adolescents and adults age 17 and older must meet at least five of the DSM-5R symptoms)
ADHD	2	A – Diagnostic Assessment	Screened for presence of several inattentive or hyperactive-impulsive symptoms present prior to age 12 years
ADHD	3	A – Diagnostic Assessment	Screened for presence of several inattentive or hyperactive-impulsive symptoms present in two or more settings (home, work, school)
ADHD	4	A – Diagnostic Assessment	Confirmed symptoms across settings received from multiple informants, e.g., parents, guardians, teachers, clinicians involved in care of individual (including results of symptom-focused rating scales from self, parents, teachers, clinicians)
ADHD	5	A – Diagnostic Assessment	Noted clear evidence that the symptoms result in clinically significant impairment in social, academic or occupational functioning
ADHD	6	A – Diagnostic Assessment	Noted clear evidence that symptoms of older adolescents and adults (age 17 and older) reflect inattention causing problems with executive functions
ADHD	7	A – Diagnostic Assessment	Assessed whether fewer than full criteria have been met for the past six months when full criteria were previously met (partial remission)
ADHD	8	A – Diagnostic Assessment	Assessed whether few or many symptoms are in excess of those required to make diagnosis of ADHD (based on DSM-5R) specifying level of severity (mild, moderate or severe) with the use of screening tools
ADHD	9	A – Diagnostic Assessment	Assessed whether symptoms are not better explained by another mental disorder (e.g., substance use disorder, personality disorder, mood disorder, anxiety disorder, dissociative disorder)
ADHD	10	A – Diagnostic Assessment	Assessed whether symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions
ADHD	11	A – Diagnostic Assessment	Coordinated care with medical provider and medical evaluation during diagnostic process ruled out medical causes of symptoms of ADHD and assessed cardiovascular functioning (if treatment with stimulants considered)
ADHD	12	A – Diagnostic Assessment	Assessed for suicidal thoughts or behaviors with potential for injury to self or others, especially if atomoxetine (Strattera®) treatment is considered
ADHD	13	A – Diagnostic Assessment	If suicidal thoughts or behaviors were present, appropriate actions were taken to intervene
ADHD	14	A – Diagnostic Assessment	If provider is not a physician, reviewed findings from consultation with psychiatrist or primary care physician
ADHD	15	B – Therapeutic Interventions	If treatment plan included a referral for a physical health/psychiatric evaluation, provider included the results of the evaluation in the treatment planning
ADHD	16	B – Therapeutic Interventions	Treatment, in accordance with the individualized treatment plan, included education about ADHD and its treatment including behavioral intervention, pharmacological intervention, family therapy delivered to parents, guardian, and if applicable, to the patient

Review Type	#	Section	Element
ADHD	17	B – Therapeutic Interventions	Diagnostic findings, treatment options and goals and treatment plan are discussed with parents, guardians, and if applicable, with patient
ADHD	18	B – Therapeutic Interventions	Evidence substantiates provider actively involved parent, guardian, teacher(s), and patient in treatment planning
ADHD	19	B – Therapeutic Interventions	Comorbid medical and psychiatric conditions discussed with parents, guardians, and if applicable patient
ADHD	20	B – Therapeutic Interventions	Provider assessed if psychotherapy is indicated
ADHD	21	B – Therapeutic Interventions	Provider prescribed a stimulant or other agent deemed appropriate or explained why medication was not prescribed
ADHD	22	B – Therapeutic Interventions	If provider is a prescriber, treatment plan explains the rationale of the selection of pharmacological intervention including risks, benefits, and side effects
ADHD	23	B – Therapeutic Interventions	Education delivered to parents, guardian, and if applicable, patient, about pharmacological treatment, including risks, benefits, side effects of medicine
ADHD	24	B – Therapeutic Interventions	Parents and guardians were educated about follow up within 30 days of initial prescription and two more times within 270 days (HEDIS)
ADHD	25	B – Therapeutic Interventions	Evidence of ongoing/continued assessment of patient response to medication, side effects, adverse effects, and any laboratory monitoring that is necessary
ADHD	26	B – Therapeutic Interventions	Rationale for any changes in medication, if any changes or augmentation
ADHD	27	B – Therapeutic Interventions	If any evidence of a comorbid substance use disorder, provider developed plan to support sobriety
ADHD	28	B – Therapeutic Interventions	If antidepressants prescribed, provider delivered education about a possible increased risk of suicidal behavior, including early warning signs
ADHD	29	B – Therapeutic Interventions	If patient is preschool-aged (4–5 years), provider prescribed parent- and/or teacher-administered behavior therapy as first line of treatment or explained why this was not prescribed
ADHD	30	B – Therapeutic Interventions	If patient is elementary-aged (6–11 years), provider prescribed FDA-approved medication and/or parent–and/or teacher–administered behavior therapy or explained why this was not prescribed
ADHD	31	B – Therapeutic Interventions	If patient is adolescent (12–18 years), provider prescribed FDA-approved medication for ADHD with assent of the adolescent or explained why this was not prescribed
ADHD	32	B – Therapeutic Interventions	If patient is adolescent, provider gave special consideration to provide medication coverage for symptom control while driving
ADHD	33	B – Therapeutic Interventions	If behavior therapy is prescribed, ongoing assessment of treatment progress using clinical observation, interviews, and/or rating scales from parent, guardian, teacher, and if applicable, self
ADHD	34	B – Therapeutic Interventions	If behavior therapy is prescribed, training provided to parents in specific techniques to improve their abilities to modify and shape child's behavior while improving the child's ability to regulate own behavior

Review Type	#	Section	Element
Suicide Risk (SR) Assessment and Management CPG Review Tool			
SR	1	A – Suicide Risk Assessment	CURRENT SUICIDAL IDEATION AND PLANS
SR	2	A – Suicide Risk Assessment	HISTORY OF SUICIDAL IDEATION AND ATTEMPTS
SR	3	A – Suicide Risk Assessment	PRESENCE OF HIGH-RISK FACTORS, such as significant behavior changes in teens, advanced age/debilitating illness/male senior citizens, insomnia, substance use/abuse, anxiety, recent inpatient discharge, history of violence or bullying (victim or perpetrator
SR	4	A – Suicide Risk Assessment	Plan for frequent evaluation for suicidal thinking or behavior in patients prescribed ANTIDEPRESSANT and/or ANTICONVULSANT MEDICATIONS (assess if reviewing for MDD CPG)
SR	5	A – Suicide Risk Assessment	Assessment of LETHAL INTENT. Documentation shows interventions to address this with patient and response to measures.
SR	6	B – Suicide Management	Assessment for access to any weapons or LETHAL MEANS, if suicidal.
SR	7	B – Suicide Management	Developed plan to DIMINISH ACCESS TO WEAPONS/LETHAL MEANS, if suicidal.
SR	8	B – Suicide Management	Developed PLAN FOR MAINTAINING SOBRIETY and discussed the role of substance use in increasing suicide risk.
SR	9	B – Suicide Management	Attempted to INVOLVE FAMILY AND OTHER SUPPORT SYSTEM MEMBERS in suicide management plans or documented why not appropriate.
SR	10	B – Suicide Management	Documented ACTUAL FAMILY/SUPPORT SYSTEM INVOLVEMENT in suicide management plan.
SR	11	B – Suicide Management	HALLUCINATION INTERVENTION (Intervention to alleviate command hallucinations, if present)
Conduct Disorder (CD) CPG Review Tool			
CD	1	A – Diagnostic Assessment	Evaluation included member's prenatal and birth history, focusing on substance abuse by mother, maternal infections, and medications.
CD	2	A – Diagnostic Assessment	Evaluation included developmental history of member, with a focus on disorders of attachment (e.g., parental depression and substance abuse}, temperament, aggression, oppositionality, attention and impulse control.
CD	3	A – Diagnostic Assessment	Evaluation included physical and sexual abuse history (as victim and perpetrator).
CD	4	A – Diagnostic Assessment	Evaluation includes history of symptom development, including impact on family and peer relationships and academic problems (with attention to IQ, language, attention, and learning disabilities).
CD	5	A – Diagnostic Assessment	Assessed for presence and duration of symptoms meeting criteria for CD and the subtype of the disorder (childhood onset versus adolescent onset; overt versus covert versus authority; under-restrained versus over-restrained; socialized versus under-socialized).
CD	6	A – Diagnostic Assessment	Assessed whether symptoms are not better explained by a medical condition, including a referral a physical evaluation as needed.

Review Type	#	Section	Element
CD	7	A – Diagnostic Assessment	Assessed whether symptoms are not better explained by another mental disorder (e.g., substance use disorder, personality disorder, mood disorder, anxiety disorder, dissociative disorder)
CD	8	B – Treatment	Treatment team is cohesive, and plan includes treatment modalities that include interventions in the family, school, and peer group systems.
CD	9	B – Treatment	Treatment includes comorbid disorders where applicable (e.g., ADHD, specific developmental disabilities, intermittent explosive disorder, affective or bipolar disorder, anxiety disorder, and substance use disorder).
CD	10	B – Treatment	Treatment includes family interventions such as parent guidance, training, and family therapy.
CD	11	B – Treatment	Individual and group psychotherapy with adolescent are considered.
CD	12	B – Treatment	Peer intervention is considered to discourage deviant peer association and promote a socially appropriate peer network.
CD	13	B – Treatment	Treatment involves juvenile justice system involvement where appropriate (i.e., court supervision, Families in Need of Services, etc.)
CD	14	B – Treatment	Psychopharmacological treatment is used as an adjunct therapeutic intervention and not in isolation.
Trauma-Informed Care (TIC) CPG Review Tool			
TIC	1	A – Diagnostic Assessment	Assessment includes screening questions about traumatic experiences and PTSD symptoms.
TIC	2	A – Diagnostic Assessment	If youth is younger than 7 years old, screening questions are directed to caregivers.
TIC	3	A – Diagnostic Assessment	If screening indicates significant PTSD symptoms, a referral to a qualified clinician to conduct a formal evaluation is made.
TIC	4	A – Diagnostic Assessment	Formal evaluation valuation considers differential diagnoses of other psychiatric disorders or physical/medical conditions that mimic PTSD.
TIC	5	B – Treatment	Treatment planning incorporates appropriate interventions for comorbid psychiatric disorders.
TIC	6	B – Treatment	Trauma-focused psychotherapy, including cognitive-behavioral therapy, psychodynamic psychotherapy, and/or family therapy, are considered as the first line of treatment. If services are not available, treatment team consults with Magellan to identify resources in the member's community to address trauma and PTSD symptoms.
TIC	7	B – Treatment	If therapeutically appropriate and service is accessible, trauma–focused psychotherapy directly addresses youth's traumatic experiences.
TIC	8	B – Treatment	If therapeutically appropriate, guardians are available, and service is accessible, trauma-focused therapy involves the caregivers in the treatment interventions.
TIC	9	B – Treatment	If therapeutically appropriate and service is accessible, trauma–focused psychotherapy focuses not only on symptom improvement but also on enhancing functioning, resiliency, and/or developmental trajectory.

Review Type	#	Section	Element
TIC	10	B – Treatment	If pharmacological intervention is utilized for treatment of PTSD symptoms, it is not used in isolation but rather in multimodal approach.
TIC	11	B – Treatment	School accommodations are made if youth is experiencing significant functional impairment related to trauma reminders.