EVERNORTH℠

Evernorth Behavioral Health
Behavioral Treatment Record Review Tool

Use of this tool is not required, but can serve as a resource to assist in a treatment record review audit with Evernorth.

Scoring options

	Circle One		Questions	Comments
1	Y	N	Is the record legible?	
2	Y	N	Did the record list reason for the visit?	
3	Y	N	Did the record document customer thoughts of suicide or homicide?	
4	Y	N	Did the record document previous treatment or mental health/substance use diagnosis?	
5	Y	N	Did the record include a Mental Status Exam?	
6	Y	N	Did the record document any medical conditions?	
7	Y	N	Did the record document current and past substance use?	
8	Y	N	Did the record document a treatment plan? *Examples:* S*tart on anti-depressant, or follow-up with Evernorth customer in two weeks*	
9	Y	N	Did the record document a diagnosis?	
Coordination of Care				
10	Y	N	Did the record indicate if the customer has a primary care provider? *If no, mark questions 11 & 12 as "N/A" and skip to question 13.*	

11	Y N N/A	Did the customer consent to releasing information to his/her primary care provider?	
12	Y N N/A	Did the treating behavioral health care provider release information to the customer's primary care provider? *Indicate N/A for marital therapy and adjustment disorders*	
13	Y N	Did the record indicate if the customer has other behavioral health care provider(s) involved in his/her care? *If no, mark questions 14 & 15 as "N/A" and skip to question 16.*	
14	Y N N/A	Did the customer consent to releasing information to other behavioral health care provider(s)?	
15	Y N N/A	Did the treating behavioral health care provider release information to other behavioral health care provider(s)?	
Medications/allergies (only applicable to prescribing providers)			
16	Y N N/A	Did the record indicate if the customer has allergies or adverse reactions to medications? *N/A for providers who do not prescribe medications (For example, master's level and non-prescribing PhDs)*	
17	Y N N/A	Did the record include all medications and their dosages (if known) prescribed by the treating provider?	
Depression and substance use*			
18	Y N N/A	Did the record include results from a PHQ9 or Beck Depression Inventory (or other standard tools) for depression?	
19	Y N N/A	Did the record include results from an AUDIT C or CAGE AID (or other standard tools) for substance use?	
20	Y N	Did the record document whether an advance directive was executed?	
21	Y N N/A	Did the record indicate if a copy of the executed advance directive, or documentation of refusal, was sent to the primary care provider?	

Items 18-21 are not scored. They are for informational purposes only.