QUALITY OF DOCUMENTATION Mobile Treatment Services (MTS)	**GUIDELINES FOR SCORING INDIVIDUAL RECORDS** **1 = Poor, 2 = Below Standard, 3 = Standard, 4 = Above Standard, 5 = Excellent** **Y = Meets Standard N = Does Not Meet Standard** **N/A = Not Applicable**	**GUIDELINES FOR DETERMINING PROGRAM COMPLIANCE WITH STANDARDS** ***Programs are expected to strive to achieve all quality of documentation standards in 100% of the instances. Programs that are compliant in less than 75% of the charts reviewed will be required to develop a Performance Improvement Plan (PIP) in conjunction with the Maryland Department of Health and/or its authorized agencies and representatives.***
1. Has the consumer (or their legal guardian) consented to treatment? *10.21.17.04 A*	**Y =** Consent for services is documented by signature of the consumer or, when applicable, legal guardian. In instances when this is not possible, the program shall document the reasons why the individual cannot give written consent; verify the individual's verbal consent; and document periodic attempts to obtain written consent. **N =** Consent for treatment is not present in the chart **OR** there is a consent form signed by an individual as the consumer's guardian, but there is no documentation to support this individual's ability to sign as legal guardian.	75% of all medical records reviewed have documented consent for services.
2. If the consumer is a child for whom courts have adjudicated their legal status or an adult with a legal guardian, are there copies of court orders or custody agreements? *10.21.17.04 A (1)(c)* *10.21.17.08 B (10)*	**Y =** Court orders and custody agreements regarding healthcare decision-making are present in the chart **OR** there is a letter from the agency naming a specific person to make healthcare decisions. **N =** There are no court orders or custody agreements establishing healthcare decision-making responsibility present in the medical record. **N/A =** The consumer is an adult without a guardian.	75% of all applicable medical records reviewed have the required documentation necessary to confirm guardianship and health-care decision-making authority by the individual consenting to treatment.

3. Does the medical record contain a completed BHA Documentation for Uninsured Eligibility Benefit form or Uninsured Eligibility Registration form and verification of uninsured eligibility status? *BHA Guidelines*	**Y =** The medical record contains verification of uninsured eligibility status (such as confirming Maryland residence via photo ID). **N =** The medical record does not contain verification of uninsured eligibility status (such as confirming Maryland residence via photo ID). **N/A =** The consumer has active Medicaid; therefore uninsured documentation is not required.	75% of all applicable medical records reviewed have the required Uninsured Eligibility documentation.
4. Is there documentation present indicating that the consumer (over the age of 18) has been given information on making an advance directive for mental health services? *10.21.17.04 C*	**Y=** The individual received information, verbally and in writing, regarding making an advance directive for mental health services; staff documented whether an individual has a current advance directive for mental health services; if an individual has a mental health advance directive, a copy of the document is included in the medical record; and if an individual requests assistance with making an advance directive for mental health services, staff is assigned to assist the individual. **N=** At least one of the requirements above is not documented in the medical record. **N/A =** The consumer is a child/adolescent under the age of 18.	75% of all medical records reviewed have documented information that the consumer has received information on advanced directives.

5. Does the consumer have a PMHS specialty mental health diagnosis included in the Priority Population that is formulated or affirmed by a psychiatrist and is there supporting documentation for establishing medical necessity? *MD PMHS Medical Necessity Criteria-Mobile Treatment-Adults* *10.21.19.05 B*	**Y =** Present in the record is a diagnosis that meets target population for the PMHS as outlined in the Utilization Guidelines **AND** there is clear documentation of the rationale for the rendered diagnosis and medical necessity **AND** the diagnosis was rendered by or affirmed by a MTS psychiatrist (An individual qualified to diagnose under the provisions of Health Occupations Code of MD may provide *continuing* psychiatric diagnosis). **N =** There is no diagnosis in the record **OR** the diagnosis was made by an individual unlicensed to do so; a diagnosis has been assigned, but with no information in record regarding symptoms, behaviors or history of occurrence **OR** the MTS psychiatrist did not affirm a psychiatrist diagnosis entered in the consumer's medical record.	75% of all medical records reviewed have documentation that meets the standard for establishing the diagnosis and medical necessity for services.
6. Is there a screening assessment? *10.21.19.04 B*	**Y=** Within 10 working days of receipt of a referral for MTS, a face-to-face screening assessment, conducted by the assigned mental health professional, is conducted to assess the individual's needs, strengths, available resources, and willingness to participate in MTS. MTS staff shall determine priority for enrollment based on the individual's need. **N=** There is no documentation of a referral source and/or referral date so there is no way to determine if the screening assessment was scheduled appropriately; there is no documentation stating why the screening did not occur in the required timeframe; the screening was not conducted face to face, **OR** the screening did not assess needs, strengths, resources, and/or willingness to participate in MTS.	75% of all medical records reviewed have screening assessment documentation completed within the required timeframe.

7. Is the face to face initial MTS psychiatric evaluation completed within 30 days of receipt of referral? *10.21.19.05 A* *CMS State Medicaid Manual Part 4 4221 B*	**Y=** The assessment is dated and completed by the MTS psychiatrist, in collaboration with the assigned treatment coordinator within 30 days of receipt of referral for MTS **OR** there is documentation stating why the evaluation did not occur in the required timeframe; The MTS psychiatrist completed an evaluation that includes: relevant history, evaluation of current mental status including- (a) The need for medication (b) A review of current meds and source of prescriptions; The psychiatrist has assessed general physical health and either performed a physical examination or waive the requirement that the individual has a physical examination and document the rationale for the waiver; Formulate and document the psychiatric diagnosis and rationale for diagnosis or affirm a diagnosis **N=** There is no evaluation present; there is no date on the assessment; the evaluation was not face to face; the evaluation was not completed within 30 days of referral; **OR** there is no documentation stating why the evaluation did not occur within the required timeframe; The assessment is present, but is missing at least one of the required components listed above.	75% of all medical records reviewed document that the psychiatric evaluation addresses all of the criteria and was completed within 30 days of referral.

8. Was the Initial ITP completed before the 45th day after an individual is admitted to MTS and includes the following: description of current behavior and level of functioning that includes needs and strengths; and (when relevant) a description of the family's or significant others needs or strengths? *10.21.19.05 C (2)(a-c)*	**Y=** The initial ITP was completed before the 45th day after an individual is admitted to MTS; The ITP includes all of the following required elements: description of current behavior and level of functioning that includes needs and strengths; and (when relevant) a description of the family's or significant others needs or strengths. **N=** There is no initial ITP in the record **OR** the ITP was not completed before the 45th day after an individual is admitted to MTS; There is no initial ITP in the record **OR** the ITP present does not contain all of the required elements. **N/A=** The consumer is a new referral and an initial ITP has not yet been developed.	75% of all medical records reviewed have documented that an initial ITP contains all of the required elements and was completed before the 45th day after admission to MTS.

9. Does the ITP contain short- and long-term goals, related to the assessment and congruent intervention/treatment strategies, including the plan for transitioning to traditional outpatient mental health services that are outcome-oriented and stated in behavioral, measurable terms? *10.21.19.05 C (2) (d-e)* *CMS State Medicaid Manual Part 4 4221 C*	**Y=** The goals/objectives have been developed directly from the evaluation, which identified the individual's needs and strengths and family's needs and strengths (if relevant); the short- and long-term goals/objectives are stated in behavioral, measurable terms, are outcome oriented; **AND** the plan includes a plan for transitioning to traditional outpatient mental health services. The goals/objectives listed are individualized and not the same for all other consumers reviewed in this service. N= There is no ITP and/or there is no screening assessment and/or psychiatric evaluation in the record **OR** the ITP goals/objectives have no relationship to the current assessment; Goals/objectives are written as general statements with vague language and no measures of accomplishment; the goals are not outcome oriented; the ITP does not address a transition plan to traditional outpatient mental health services; **AND/OR** consumers reviewed in this service have the same goals/objectives. **N/A =** The consumer is a new referral and an ITP has not yet been developed.	75% of all medical records reviewed have documented ITPs with measurable goals, congruent interventions, including a plan for transitioning to traditional OMHC services.
10. Is an ITP Review completed at a minimum of every 3 months? *10.21.19.05 C (3)*	**Y** = ITP reviews were completed at a minimum of every 3 months. **N** = No ITP review(s) are present **OR** ITP reviews have not been completed at a minimum of every 3 months. **N/A** = The consumer is a new referral and an ITP review has not yet been developed.	75% of all medical records reviewed meet the standard for an ITP review completed at a minimum of every 3 months.

11. Does the medical record document active participation in establishing the goals and interventions of the ITP and include all required signatures with dates? 10.21.19.05 C(4)(a)	**Y=** All required signatures to include: the consumer (unless the individual tape records agreement/disagreement with the plan); the MTS psychiatrist, and the individual's treatment coordinator, with dates are present **OR** there is documentation that the consumer verbally agreed to the ITP and the rationale for refusal to sign is also documented. (At least the following shall participate as members of an individual's treatment team: MTS Psychiatrist or 3rd-4th year psychiatric resident supervised by the MTS psychiatrist Licensed social worker Registered Nurse Treatment Coordinator Any other staff involved in providing services to the individual (when available) **N =** A signature and/or date is missing and/or there is no documentation of a verbal agreement or rationale for refusal to sign **OR** there is no ITP in the record. **N/A =** The consumer is a new referral and an ITP has not yet been developed.	75% of all medical records document active participation in the development of the ITP via applicable signatures.
12. Does the record reflect the development of a transition plan, if the individual is discharged? MDH Guidelines	**Y =** A transition/discharge plan is present that is developed with the individual's program coordinator and the individual and includes a brief description of the recommendations for continued treatment, if any; referrals for continuing services; and information about how the individual can re-access services when needed. **N =** There is no transition/discharge plan **OR** all of the required elements of a discharge plan are not present. **N/A =** The individual is in treatment with the provider.	75% of all medical records reviewed meet the standard for the record documenting a discharge date and plan consistent with the services provided.

13. Within 10 working days after an individual is discharged from a program, has the consumer's service coordinator completed and signed a discharge summary that include, at a minimum: reason for admission, reason for discharge, services provided, progress made, diagnosis at the time of discharge, current medications, continuing service recommendations and summary of the transition process, and extent of individual's involvement in the discharge plan? *10.21.17.10 D(1-8)*	**Y=** The discharge summary is completed 10 working days after the consumer has discharged from the agency and includes **all** of the following required elements: reason for admission, reason for discharge, services provided (including frequency/duration of services), progress made, diagnosis at the time of discharge (if appropriate), current medications (if any), continuing service recommendations and summary of the transition process, and extent of individual's involvement in the discharge plan. **N=** There is no discharge summary in the record **OR** the discharge summary present does not contain all of the required elements. **N/A=** The consumer remains enrolled in treatment.	75% of all medical records reviewed contain a discharge summary with all of the required elements.

14. Did the mobile treatment provider follow discharge and transitioning procedures? *10.21.19.07*	**Y=** When the MTS discharges an individual who is unwilling to continue to accept MTS or is admitted to an IP facility for longer than 3 months, the MTS program does as follows: Permits the individual to re-enroll in MTS and; Makes assertive efforts to re-enroll the individual **-OR-** When the MTS discharges an individual who moves from the area served by MTS, the MTS does as follows: Refer the individual for appropriate mental health and support service in the individual's community. **-OR-** When the ASO determines that transition/discharge from MTS is medically appropriate, the MTS does as follows: Document the individual's achievement of treatment goals; anticipated needs for treatment and rehabilitation services, and readiness for participation in OMHC or other appropriate outpatient mental health services, as demonstrated by keeping appointments, using transportation independently, obtaining and taking prescribed medications, and actively participating in treatment. **N=** There is no documentation reflecting the circumstances surrounding the individual's discharge **OR** the MTS program did not meet the above requirements upon review of the discharge documentation. **N/A=** The consumer remains enrolled in treatment.	75% of all medical records reviewed contain documentation to support the MTS program following discharge and transitioning procedures.

15. Does the record reflect appropriate coordination with community and family resources that are considered essential to meeting the individual's needs? *10.21.19.06.F* *10.21.19.03.F*	**Y =** There is documentation showing referrals for or collaboration with other support services that the consumer may need or in which the consumer is involved. There is documentation of face-to-face or telephonic meetings between the MTS staff and the outside agencies; there may **be** documentation of collaboration regarding jointly planning and implementing changes in the goals and interventions of each service. **N=** The record contains no evidence of care coordination, support, linkage, and advocacy practices; Clinical information indicates that multiple services are needed or currently being provided and there is no information documented to refer and collaborate with other outside support services. **N/A**= collaboration with other services is not indicated; or the consumer declined referrals to or collaboration with additional services	75% of all medical records reviewed meet the standard for the ITP and contact notes coordination with community and family resources.

16. Does the medical record contain contact notes that reflect all face-to-face and other clinically relevant contacts with or about the individual; reflect goals and interventions on the ITP are being addressed and implemented; and progress summary notes? *10.21.19.05 D(1-2)* *10.09.59.03 J(1-4)* *CMS State Medicaid Manual Part 4 4221 D6*	**Y =** Contact notes for the audit period contain all of the listed items below and no contact notes are missing. The record contains evidence that the following treatment and support services are provided: Medication Services Independent Living Shills Assessment & Training Health Promotion & Training Interactive Therapies Supported Housing Services for Adults The reviewed progress summary notes for the audit period contain all of the listed items below and no progress summary notes are missing. The contact notes document that the goals and interventions from the ITP are being addressed and implemented. **N =** There are no contact or progress summary notes in the record; **OR** contact notes do not contain all of the following items: date of service; chief medical complaint or reason for the visit; a brief description of the service provided; actual time the services were rendered; the amount of time it took to deliver the services; the relationship of the services to the treatment regimen described in the treatment plan; updates describing the patient's progress; and legible signature and printed or typed name of the professional providing care, with the appropriate title; Progress summary notes do not include at least one of the following: a description of progress toward the goals, and changes in goals and interventions based on the review of progress; the contact notes fail to document that the goals and interventions are being addressed and implemented.	75% of all medical records reviewed meet the standard for contact and progress summary notes reflecting face-to-face and other clinically relevant contacts with or about the individual and reflecting goals and interventions are being addressed.

17. Is the psychiatric evaluation, ITP, diagnosis, and additional clinical supporting information submitted to Beacon ProviderConnect® consistent with the clinical documentation in the consumer's medical record? *Beacon Provider Manual*	**Y =** The evaluation and goals/objectives on the ITP are directly related to the current Beacon ProviderConnect® and contact notes contain information and interventions matching the Beacon ProviderConnect® form. **N =** The record is missing an evaluation, ITP, and/or contact notes from which to determine compliance **OR** Neither the evaluation nor any of the ITP goals/objectives relate to the current Beacon ProviderConnect®. Contact notes document interventions unrelated to those indicated on the Beacon ProviderConnect® or give a different picture than the Beacon ProviderConnect® authorization request submission. **N/A =** The Beacon ProviderConnect® form is an initial authorization, which does not include clinical information.	75% of all medical records reviewed meet the standard for the assessment, ITP and contact notes being consistent with the current Beacon ProviderConnect®.