QUALITY OF DOCUMENTATION OMHC	**GUIDELINES FOR SCORING INDIVIDUAL RECORDS** **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, If an agency such as DSS has custody. **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 or a minor child in the care/custody of his/her biological parent(s).	75% of all applicable medical records reviewed have the required documentation necessary to confirm custody and health-care decision-making authority by the guardian 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 a completed BHA issued Documentation for Uninsured Eligibility Benefit form **OR** printed screenshots of the on-line ValueOptions Uninsured Eligibility/Member Registration form and verification of uninsured eligibility status (such as confirming Maryland residence via photo ID). **N =** The medical record does not contain a completed BHA issued Documentation for Uninsured Eligibility Benefit form **OR** printed screenshots of the on-line ValueOptions Uninsured Eligibility/Member Registration form and 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. Does the medical record contain a completed Maryland Medicaid/Behavioral Health Administration Authorization To Disclose Substance Use Treatment Information For Coordination Of Care form; or documentation that the individual was offered the form and refused to sign; or the form was not presented to the individual? ValueOptions Provider Alert Release of Information Form (ROI), March 27, 2015 ValueOptions Provider Alert Release of Information (ROI) Requests, August 13, 2015	**Y =** The medical record contains a completed Maryland Medicaid/Behavioral Health Administration Authorization To Disclose Substance Use Treatment Information For Coordination Of Care form; **OR** documentation that the individual was offered the form and refused to sign. **N =** The medical record does not contain a completed Maryland Medicaid/Behavioral Health Administration Authorization To Disclose Substance Use Treatment Information For Coordination Of Care form; **OR** documentation that the individual was offered the form and refused to sign; **OR** the form was not presented to the individual. **N/A =** The consumer is only receiving mental health services.	75% of all applicable medical records reviewed have the required Maryland Medicaid/Behavioral Health Administration Authorization To Disclose Substance Use Treatment Information For Coordination Of Care form; or documentation that the individual was offered the form and refused to sign.

5. 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 =** There is documentation that the consumer was given information on making an advance directive **OR** documentation that the consumer declined assistance with or making an advanced directive. **N =** There is no documentation in the medical record indicating that the provider has given the consumer information about advanced directives. **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.
6. Does the diagnosis match the Utilization Guidelines for the Target Population and is there supporting documentation for establishing medical necessity? *10.21.25.03 (19) & (20)*	**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 a licensed professional. **N =** There is no diagnosis in the record **OR** the diagnosis was rendered by an unlicensed individual or a diagnosis has been assigned, but with no information regarding symptoms, behaviors or history of occurrence.	75% of all medical records reviewed have documentation that meets the standard for establishing the diagnosis and medical necessity criteria for services.

7. Is the assessment completed by the 2nd visit and is the assessment comprehensive? *10.21.20.06 A(1-2) & C(2)* *CMS State Medicaid Manual Part 4 4221 B*	**Y** = There is an assessment that is dated and completed by the consumer's 2nd visit OR the assessment was completed outside of the required timeframe and there is a documented rationale for service delay and there is documentation that a licensed mental health professional formulated and documented in the individual's medical record information that includes: (a) A description of the presenting problem; (b) Relevant history, including family history and somatic problems; (c) Mental status examination; and (d) A diagnosis and the rationale for the diagnosis; or the reason for not formulating a diagnosis; and a plan, including time frame, for formulating a diagnosis. **Additional Assessment for a Minor**. In addition to the requirements outlined above, before a minor's fifth visit, the minor's assigned treatment coordinator has: (1) Conducted a face-to-face evaluation to assess the minor's level of functioning and availability of family and other social supports; and (2) If a comprehensive assessment, that includes the elements listed below, has not been completed within the 6 months before enrollment, assured the completion of an assessment, that includes, at a minimum, the minor's: (a) Developmental history; (b) Educational history and current placement; (c) Home environment; (d) Family history and evaluation of the current family status, including legal custody status; (e) Social, emotional, and cognitive development; (f) Motor, language, and self-care skills development; (g) History, if any, of substance abuse; (h) History, if any, of physical or sexual abuse; (i) History, if any, of out-of-home placements; and (j) Involvement, if any, with the local department of social services or Department of Juvenile Services. **N** = There is no assessment in the medical record or the assessment is present but is missing at least one of the above required components OR the assessment was not completed by the 2nd visit and there is no documented rationale for delay in service delivery.	75% of all medical records reviewed document that the comprehensive assessment was completed by the 2nd visit.

8. Was a Substance Abuse Screening Assessment completed? *10.21.20.06 B*	**Y =** There is documentation in the medical record of a face-to-face diagnostic assessment that includes a scientifically validated/age-appropriate screening tool to determine whether or not the individual has a co-occurring substance abuse disorder. **N =** There is no documentation that a substance abuse screening was performed. **N/A =** A substance abuse screening was not needed due to age of consumer.	75% of all medical records reviewed have documented that a diagnostic substance abuse screening was performed.
9. Is there evidence of integration of, or collaboration with, Substance Abuse services? *10.21.20.08 D (1)(2)*	**Y =** There is either a referral for substance abuse treatment or an integrated SA/MH rehabilitation/treatment plan. **N =** There is no documented SA/MH integrated treatment plan **OR** a referral to a substance abuse treatment provider. **N/A =** There is information that indicates the consumer does not use substances and has not in the past **OR** the consumer refuses SA treatment.	75% of all medical records reviewed have documentation of a substance abuse assessment and integration of or collaboration with Substance Abuse services.
10. Was the ITP completed on or before the consumer's 5th visit and does the ITP include: diagnosis, presenting needs, strengths, recovery, and treatment expectations and responsibilities? *10.21.20.07 A (1) (a-b) (i-vi)*	**Y =** The initial ITP was completed by the individual's 5th visit and the ITP includes diagnosis, presenting needs, strengths, recovery, and treatment expectations and responsibilities. **N =** There is no initial ITP present in the record, **OR** the ITP was not completed before the individual's 5th visit, **OR** the ITP is missing at least one of the above criteria. **N/A =** The consumer is a new referral and an ITP has not yet been developed.	75% of all medical records reviewed have documented that an ITP was completed before the 5th visit and the ITP includes diagnosis, presenting needs, strengths, recovery, and treatment expectations and responsibilities.

11. Does the ITP contain goals, objectives, or outcomes, related to the assessment, that are individualized, specific, and measurable with an achievable timeframe and congruent interventions? *10.21.17.08 B (8)* *10.21.20.07 A (1) (b)(iii- vi)* *CMS State Medicaid Manual Part 4 4221 C*	**Y =**The ITP goals/objectives have been developed directly from the assessment; goals/objectives are written as individualized, specific, and measurable with an achievable timeframe; the goals/objectives listed are individualized and not the same for all other consumers reviewed in this service; and the interventions listed on the ITP are congruent with the stated goals/objectives. **N =** There is no ITP in the record **OR** the ITP is missing at least one of the above criteria. **N/A =** The consumer is a new referral and an ITP has not yet been developed.	75% of all medical records reviewed meet the standard for the ITP containing goals, objectives or outcomes that are individualized, specific and measurable with an achievement timeframe and meet the standard for the interventions on the ITP being congruent with goals/objectives.
12. Is the ITP reviewed at a minimum of every 6 months; does the ITP include all required signatures, and is it documented that the consumer accepted or declined a copy of the ITP? *10.21.20.07 A (2-4)*	**Y =** ITP reviews are completed at a minimum of every 6 months; the ITP includes all required signatures to include the consumer and/or parent/guardian; at least two licensed mental health professionals who collaborate about the individual's treatment; and the psychiatrist or Certified Registered Nurse Practitioner in psychiatry (if meds are prescribed) with dates; or there is documentation that the consumer verbally agreed to the ITP and the rationale for refusal to sign is also documented; and it is documented that the consumer accepted or declined a copy of the ITP. **N =** There is no ITP in the record **OR** the ITP is missing at least one of the above criteria. **N/A =** The consumer is a new referral and an ITP has not yet been developed.	75% of all medical records reviewed meet the standard for the ITPs reviewed at a minimum of every 6 months; the ITP include all required signatures, and it is documented that the consumer accepted or declined a copy of the ITP.
13. 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 has a recommendation for transition/discharge to a lower level of care that includes the client's functioning at the time of transition/discharge, the supports that will be required at time of transition/discharge, and a timeframe to accomplish the transition/discharge. **N =** There is no transition/discharge plan **OR** all of the required elements of a discharge plan are not present. **N/A =** The individual remains in active treatment with the provider.	75% of all medical records reviewed meet the standard for the record documenting a transition/discharge date and plan consistent with the services provided.

14. Within 10 working days after an individual is discharged from a program, has the service coordinator completed and signed a discharge summary that includes, 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=** A discharge summary is completed 10 working days after the consumer has discharged from the agency **AND** the summary is signed and dated by the staff person responsible for coordinating services to the individual. The discharge summary 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 =** A discharge summary is missing **OR** not completed 10 working days following the consumer's discharge from the agency **OR** the discharge summary present does not contain all of the required elements. **N/A=** The consumer remains enrolled in treatment.	75% of all applicable medical records reviewed have the required discharge summary that addresses all of the required elements.
15. Do the ITP and contact notes reflect recommendations for and/or collaboration with other mental health services to support the individual's recovery? *10.21.20.07 A (1)(vi)* *10.21.20.09 B*	**Y =** There is documentation showing referrals for or collaboration with other mental health services that the consumer may need or in which the consumer is involved. **N =** The record is missing an ITP **OR** contact notes **OR** clinical information indicates that multiple mental health services are needed or currently being provided and there is no information documented to refer and collaborate with other mental health services. **N/A =** The consumer is a new referral and an ITP review has not yet been developed; 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 reflecting recommendations for and collaboration with other mental health services to support the individuals recovery.

16. Does the record contain complete contact notes which reflect goals and interventions on the ITP are being implemented and reflect progress towards the goals of the ITP? *10.09.59.03 J (1-4)* *10.21.20.07 B (1) (a-h)* *CMS State Medicaid Manual Part 4 4221 D6 & D7*	**Y =** The contact notes contain the following: date; start time and either the duration or the end time; the individual's chief medical complaint or reason for the visit; the individual's mental status; the delivery of services specified by the ITP; and a brief description of the service provided. The notes document that the goals and interventions from the ITP are being addressed and implemented and the contact notes mention consumer responses to the interventions and their progress towards ITP goals. **N =** The record is missing an ITP **OR** contact notes; the contact notes are missing one of the required components; **OR** few contact notes document that goals and interventions from the ITP are being addressed and implemented **OR** the contact notes fail to reflect progress towards the goals of the ITP. **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 complete contact notes reflecting that interventions on the ITP/IRP are being implemented and contact notes reflect consumer's progress towards the goals of the ITP.

17. Is there documentation of the consumer's past and current somatic/medical history and documentation of ongoing communication and collaboration with the Primary Care Physician? *10.21.20.06 D*	**Y =** A licensed mental health professional has documented pertinent past and current somatic medical history, including: a. The individual's somatic health problems, if any; b. Relevant medical treatment, including medication; and c. A recommendation, if needed, for somatic care follow-up; **and** An exchange of medical information with the primary care provider has been documented **OR** the plan, if indicated, including the time frame, for the individual's referral to a primary care provider for evaluation and treatment. **N =** There is no documentation regarding the consumer's somatic status, nor is there communication/collaboration with the consumer's PCP (or no referral to for a PCP) **OR** there is documentation present regarding the consumer's somatic status, but no documentation of communication/collaboration with the PCP (or no referral for a PCP). **N/A =** Ongoing communication and collaboration is not indicated.	75% of all medical records reviewed meet the standard for documenting current somatic medical history and documenting the evidence of collaboration with a Primary Care Physician.