QUALITY OF DOCUMENTATION **SUD OTP Services**	**GUIDELINES FOR SCORING INDIVIDUAL RECORDS** **Y = Meets Standard N = Does Not Meet** **Standard NA = 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 patient consented for treatment or with the consent of the patient, a parent or guardian has consented for treatment? Code of Federal Regulations 42 CFR 8.12 (e) **Yes / No**	**Y** = The patient consented for treatment or a parent or guardian of a child or adolescent, with the child or adolescent's consent, applied on behalf of the child or adolescent for admission to a certified program. **N** = Consent for treatment is not present in the chart; or the patient did not consent for treatment; or a parent or guardian of a child or adolescent, with the child or adolescent's consent, did not apply on behalf of the child or adolescent for admission to a certified program.	75% of all medical records reviewed have documented consent for services.
2. 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 participant was offered the form and refused to sign; or documentation the form was not presented to the participant? Beacon Health Options Provider Alert Release of Information Form (ROI), March 27, 2015 Beacon Health Options Provider Alert Release of Information (ROI) Requests, August 13, 2015 **Yes / No**	**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 participant 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 participant was offered the form and refused to sign; **OR** the form was not presented to the participant.	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 participant was offered the form and refused to sign.

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? MHA Guidelines **Yes / No / NA**	**Y =** The medical record contains a completed BHA issued Documentation for Uninsured Eligibility Benefit form **OR** printed screenshots of the on-line Beacon Health Options 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 Beacon Health Options Uninsured Eligibility/Member Registration form and verification of uninsured eligibility status (such as confirming Maryland residence via photo ID). **NA =** 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 patient meet American Society of Addiction Medicine (ASAM) patient placement criteria for OTP services? 10.09.80.04 B (1) **Yes / No**	**Y**= The patient meets the current edition of the American Society of Addiction Medicine Patient Placement Criteria for OTP, or its equivalent as approved by the Administration. **N**= The patient does not meet the current edition of the American Society of Addiction Medicine Patient Placement Criteria for OTP, or its equivalent as approved by the Administration.	75% of all medical records reviewed contain evidence that the patient meets ASAM patient placement criteria for OTP.
5. Is a comprehensive assessment completed prior to services being rendered, completed by a licensed or certified clinician, and include an assessment of drug and alcohol use; substance use disorder treatment history; referrals for physical and mental health services; and recommendations for the appropriate level of substance use disorder treatment? 10.09.80.05 A Code of Federal Regulations 42 CFR 8.12 (f) (4) **Yes / No**	**Y=** A comprehensive assessment has been completed by a licensed or certified clinician prior to services being rendered. The assessment includes an assessment of drug and alcohol use, substance use disorder treatment history; referrals for physical and mental health services; and recommendations for the appropriate level of substance use disorder treatment. **N=** A comprehensive assessment has not been completed by a licensed or certified clinician prior to services being rendered; is missing **OR** the assessment fails to address at least one of the above criteria.	75% of all medical records reviewed document that the comprehensive assessment was completed timely or obtained a comprehensive assessment within the last year, and updated the assessment prior to treatment planning.

6. Does the record contain/document an individual treatment plan, which has been reviewed and approved by a licensed or certified clinician and deemed acceptable to the consumer, which contains short-term goals and specifies the services to be provided and the frequency and the schedule for their provisions and which has been updated as needed? 10.09.80.01 B (9) 10.09.80.05 B (3) 10.09.80.05.G (1) Code of Federal Regulations 42 CFR 8.2 Code of Federal Regulations 42 CFR 8.12 (f) (4) **Yes / No /NA**	**Y=** An individualized treatment plan, which has been reviewed and approved by a licensed or certified clinician and accepted by the individual; which contains short-term goals and specifies the services to be provided and the frequency and schedule for their provisions; and is updated as needed. **N=** There is no individualized treatment plan; **OR** the plan is not acceptable to the individual; **OR** the individualized treatment plan does not include all the required elements. **NA =** The individual is a new referral and an ITP has not yet been developed.	75% of all applicable medical records reviewed have documented that an individualized treatment plan was reviewed and approved by a licensed or certified clinician; accepted by the individual; and contains the required elements
7. Does the record document the individual's dosing schedule? Code of Federal Regulations 42 CFR 8.12 (g) (1) **Yes / No**	**Y=** Documentation supports the individual was dosed according to the ordering provider's order. **N=** Documentation does not support the individual was dosed according to the ordering provider's order; **OR** documentation was missing.	75% of all medical records reviewed have documented the individual has received the ordered dose according to the ordering provider's order
8. Are individual and/or group therapy services rendered based on the individualized treatment plan? 10.09.80.05 G (2) (d) 10.63.03.19 L Code of Federal Regulations 42 CFR 8.12 (f) (5) **Yes / No / NA**	**Y=** Individual and/or group therapy services are rendered based on the individualized treatment plan. **N=** Individual and/or group therapy services are not rendered although the individualized treatment plan recommends therapy services; **OR** an individualized treatment plan is missing. **NA=** Individual and/or group therapy is not recommended.	75% of all applicable medical records reviewed have documented individual and/or group therapy services were rendered based on the individualized treatment plan OR the records document individual and/or group therapy are not recommended

9. Are the progress/contact notes complete? 10.09.80.01 B (16) 10.09.80.03 C **Yes / No**	**Y**= Each individual and group counseling session or each contact with the individual is documented in the individual's record through written progress notes. The notes include as follows: • The date of service with start and end times; • The participant's primary reason for the substance use disorder visit; • A description of the service provided; • An official e-Signature, or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate degree or title. **N =** Each individual and group counseling session or each contact with the individual is not documented in the individual's record through written progress notes **OR** the notes are missing at least one of the elements above.	75% of all medical records reviewed meet the standard for complete contact notes.
10. Is there evidence of an initial drug test and ongoing monthly random drug testing? 10.09.80.05 G (2) (b-c) 10.63.03.19 G Code of Federal Regulations 42 CFR 8.12 (f) (6) **Yes / No**	**Y=** The record contains an initial drug test order and results, and ongoing monthly lab orders and results for presumptive/definitive drug testing for the individual. **N=** The record does not contain an initial drug test order and results, and ongoing monthly lab orders and results for presumptive/definitive drug testing for the individual.	75% of all medical records reviewed contain documentation supporting an initial drug test and ongoing monthly random drug testing

11. If the toxicology results were positive, does the record document that the results were addressed by staff with the individual and that appropriate intervention was implemented? **Yes / No / NA**	**Y=** The record documents positive toxicology results were addressed by staff with the individual and appropriate action was taken. **N=** The record does not document positive toxicology results were addressed by staff with the individual and appropriate action was taken; **OR** the record documents positive toxicology results were addressed by staff with the individual and appropriate action was not taken; **OR** the record documents positive toxicology results were not addressed by staff with the individual. **NA=** The record documents negative toxicology results.	75% of all applicable medical records document positive toxicology results were addressed by staff with the individual and appropriate action was taken
12. If guest dosing was utilized, is there documentation to support guest dosing between the home and guest OTP providers? 10.09.80.05 G (4) **Yes / No / NA**	**Y=** The record contains the "home" order/referral for "guest dosing", "guest dosing" history and notification of any concerns, for example, individual no shows or reason for dosing denial, and confirmation of the last "guest" dose. **N=** The record does not contain the above elements. **NA=** "Guest dosing" was not utilized.	75% of all applicable medical records reviewed contain documentation to support "guest dosing"
13. Does the record reflect the development of a transition plan, if the consumer is discharged? MDH Guidelines **Yes / No / NA**	**Y=** The record contains a discharge plan which includes written recommendations to assist the individual with continued recovery efforts and appropriate referral services. **N=** The record does not contain a discharge plan which includes written recommendations to assist the individual with continued recovery efforts and appropriate referral services. **NA=** The individual remains in active treatment with the provider.	75% of all applicable medical records reviewed contained a discharge plan with the required elements

14. Does the record document referral(s) and/or collaboration with informational and/or community services requested by the consumer or determined by the program? Code of Federal Regulations 42 CFR 8.12 (f) (5) (iii) **Yes / No / NA**	**Y=** The record documents referral(s) and/or collaboration with informational and/or community services requested by the consumer or determined by the program. **N=** The record does not document referral(s) and/or collaboration with informational and/or community services requested by the consumer or determined by the program. **NA=** There are either no additional services needed; **OR** the consumer did not request additional services; **OR** there is documentation that the consumer has refused informational and/or community services.	75% of all applicable medical records reviewed have a score of yes and meet the standard for the record documenting referral(s) and/or collaboration