QUALITY OF DOCUMENTATION **SUD Level I-Outpatient Services**	**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 CSA, Beacon Health Options®, BHA, or any other auditing agency.***
1. Has the patient consented for treatment or with the consent of the patient, a parent or guardian has consented for treatment? 10.47.01.04 H (1) **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). **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 patient meet American Society of Addiction Medicine (ASAM) patient placement criteria for Level I? 10.09.80.04 B (1) 10.47.02.04 B (1) **Yes / No**	**Y**= The patient meets the current edition of the American Society of Addiction Medicine Patient Placement Criteria for Level I, 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 Level I, or its equivalent as approved by the Administration.	75% of all applicable medical records reviewed contain evidence that the patient meets ASAM patient placement criteria for Level I.
5. Has the program established an interview date that falls within 10 working days of the individual's initial contact? 10.47.01.04 A (1) (a) **Yes / No**	**Y**= The program, upon request for admission, established an interview date that falls within 10 working days of the individual's initial contact. **N**= The program, upon request for admission, did not establish an interview date that falls within 10 working days of the individual's initial contact.	75% of all applicable medical records reviewed have documentation indicating when interview dates are scheduled.

6. Is a comprehensive assessment completed within 2 weeks of admission or has the provider obtained a comprehensive assessment, completed by a licensed, or certified clinician or certified program within the last year, and has updated the assessment prior to the development of the treatment plan? 10.09.80.05 A 10.47.01.04 B (1-2) 10.47.02.04 D (1) Waiver to COMAR Assessment Requirement (07/01/2011) Memorandum: ASI/POSIT Waiver (9/17/2009) **Yes / No**	**Y=** The program provides an assessment within 2 weeks of admission that addresses the following areas: physical health; employment or financial support; drug and alcohol; treatment history; legal; family and social; educational; and mental health. **OR** a program does not need to complete a comprehensive assessment for each patient if the patient has received an assessment by a licensed or certified clinician or certified program within the past year, and the admitting program is able to obtain the results. The admitting program must be able to obtain and update the comprehensive assessment prior to the development of the treatment plan. **N=** A comprehensive assessment completed by the program or a licensed or certified clinician is missing; an updated assessment 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.

7. Was the initial ITP completed within 7 working days of the comprehensive assessment, signed and dated by the participant and alcohol and drug counselor, and does the ITP set forth individualized needs, including: socialization, alcohol and drug abuse or dependence, psychological, vocational, educational, physical health, legal, and family? 10.09.80.01 B (9) 10.47.02.04 D (2) 10.09.80.05 B (3) 10.47.01.04 C (1) (a) **Yes / No / NA**	**Y=** An individualized treatment plan (that address the individual's bio-psychosocial needs through goals and objectives) is completed within 7 working days of the comprehensive assessment with the participation of the patient that addresses: the patient's individualized needs, including: socialization; alcohol and drug abuse or dependence; psychological; vocational; educational; physical health; legal; and family. Additionally, if the alcohol and other drug counselor is unable to develop a treatment plan within the required time, the clinical director or the clinical supervisor has: determined the reason for a delay in development of a treatment plan; documented the reason in the patient's record; and directed an appropriate clinical staff person to develop a treatment plan within 7 working days of the clinical director's or clinical supervisor's documentation of the delay. **N=** There is no initial ITP in the record OR the initial ITP present is not completed within 7 working days of the comprehensive assessment, the ITP was not developed with participation of the patient, and/or the ITP does not contain all of the above required elements. Additionally, if the alcohol and other drug counselor is unable to develop a treatment plan within the required time, the clinical director or the clinical supervisor has not done the following: determined the reason for a delay in development of a treatment plan; documented the reason in the patient's record; and directed an appropriate clinical staff person to develop a treatment plan within 7 working days of the clinical director's or clinical supervisor's documentation of the delay. **N/A =** The consumer is a new referral and an ITP has not yet been	75% of all medical records reviewed have documented that an ITP was completed timely, developed with the participation of the patient, and includes individualized needs to include socialization, alcohol and drug abuse or dependence, psychological, vocational, educational, physical health, legal, and family.

8. Does the ITP contain individualized interventions, including: recipient's individual needs, long-range and short-range goals, specific interventions for meeting goals, completion target dates, criteria for successful completion of treatment, referrals to ancillary services, if needed, and referrals to recovery support services, if needed? 10.09.80.05 B (3) (b) (i-iii) 10.47.01.04 C (1) (b) **Yes / No / NA**	**Y**= The ITP contains Individualized interventions, including: recipient's individual needs, long-range and short-range treatment plan goals and objectives; strategy for implementation of treatment plan goals and objectives; target dates for completion of treatment plan goals and objectives; a schedule of clinical services including individual, group, and, if appropriate, family counseling; criteria for successful completion of treatment; referrals to ancillary services, if needed; and referrals to self-help groups, if recommended. **N=** The ITP is missing from the record **OR** is missing 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 individualized interventions.
9. Is the ITP updated every 90 days; completed and signed and dated by the alcohol and drug counselor and participant; and reviewed and approved by a licensed physician or licensed practitioner of the healing arts? 10.47.02.04 D (2) 10.47.01.04 C (2**)** **Yes / No / NA**	**Y=** The ITP is developed with the participation of the patient, based on the comprehensive assessment and participant placement criteria, is updated every 90 days, signed by the alcohol and drug counselor and participant, and reviewed by a licensed physician or licensed practitioner of the healing arts. **N=** The ITP is missing from the record; the ITP is not developed with the participation of the participant, based on the comprehensive assessment and participant placement criteria; OR the ITP is not updated every 90 days and signed by the alcohol/drug counselor and/or participant; OR the ITP is not reviewed and approved by a licensed physician or licensed practitioner of the healing arts. **N/A =** The participant is a new referral and an ITP has not yet been developed.	75% of all medical records reviewed meet the standard for the ITPs updated every 90 days and signed by responsible parties

10. Does the record reflect the development of a transition plan, if the patient is discharged? MDH Guidelines **Yes / No / NA**	**Y**= The record contains a discharge plan that is written description of specific goals and objectives to assist the patient upon leaving treatment, recommendations to assist the participant with continued recovery efforts and appropriate referral services. **N =** There is no 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 discharge date and plan consistent with the services provided.
11. Within 30 days of the patient's discharge from the program, has the program completed a discharge summary or does the record reflect a written transfer summary, completed at the time of discharge? 10.47.01.04 G (1-3) 10.47.01.08 A (1) (f) 10.47.01.04 G (4-6) **Yes / No / NA**	**Y**= Within 30 days of the patient's discharge from the program a written discharge summary is completed and includes a discussion of: reason for admission; reason for discharge; the individual's address; a summary of services delivered, including frequency and duration of services, and progress made; if appropriate, the diagnosis and prognosis at the time of discharge; current medications, if applicable; continuing service recommendations and summary of transition process; and the extent of the individual's involvement in the discharge plan; OR the record reflects a written transfer summary that includes: the reason for admission; the reason for discharge; the individual's address; the diagnosis and prognosis at the time of discharge; and current medications, if applicable. The transfer summary is completed at the time of the patient's discharge from the program. **N =** A discharge or transfer summary is missing **OR** not completed 30 days following the consumer's discharge from the agency **OR** the discharge or transition 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 or transfer summary that is completed timely and addresses all of the required elements.

12. Are the progress/contact notes complete? 10.09.80.01 B (16) 10.09.80.03 C 10.47.02.04 E 10.47.01.08 A (1) (d) **Yes / No / NA**	**Y**= Each individual and group counseling session or each contact with the patient is documented in the recipient's record through written progress notes after each counseling session. 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 patient is not documented in the recipient's record through written progress notes after each counseling session 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.