QUALITY OF DOCUMENTATION **Individual & Group—** **Licensed Professional Counselors (LPC)**	**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, ValueOptions®, MHA, or any other auditing agency.***
1. Has the consumer given informed consent to receive counseling services? *COMAR 10.58.03.04 A (5-6)* *10.21.25.03-1 H (1) (a)*	**Y =** There is documentation that the consumer has given informed consent to receive counseling services. The counselor has received appropriate written authorization to provide counseling services for minors or other clients unable to give informed consent; or the counselor has protected the interests of minors or other clients unable to give informed consent. **N =** There is no documentation that the consumer has given informed consent to receive counseling services. The counselor has not received appropriate written authorization to provide counseling services for minors or other clients unable to give informed consent; or the counselor has not protected the interests of minors or other clients unable to give informed consent.	75% of all medical records reviewed have documented informed 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 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.

3. Has the counselor provided sufficient information to a client to allow a client to make an informed decision regarding treatment? *10.58.03.08 A (5)* *10.21.25.03-1 H (1) (a)*	**Y =** There is documentation that the counselor has provided all of the following: (a) The purpose and nature of an evaluation or treatment process; (b) Additional options to the proposed treatment; (c) Potential reactions to the proposed treatment; (d) The estimated cost of treatment; (e) The right of a client to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal; and (f) The right of a client to decline treatment, if part or all of the treatment is to be recorded for research or review by another person **N**= There is not sufficient information to allow the client to make an informed decision regarding treatment or the record does not contain all of the above required elements.	75% of all applicable medical records reviewed have the required documentation.
4. Does the consumer have a PMHS mental health DSM-V/ICD-10 diagnosis to support outpatient mental health services? *Maryland Medical Necessity Criteria: Level of Care VI: Outpatient Services* *ICD-9 Crosswalk*	Y= The consumer has a PMHS mental health diagnosis. N= The consumer does not have a PMHS mental health diagnosis.	75% of all medical records reviewed have documentation that meets standard for establishing a PMHS diagnosis.

5. Does the individual meet admissions and continuing stay medical necessity criteria for outpatient mental health services? *Maryland Medical Necessity Criteria*	**Y =** All of the following *admissions* criteria are met for admission: (1) The consumer has a PMHS specialty mental health DSM-IV diagnosis with at least mild symptomatic distress and/or impairment in functioning due to the psychiatric symptoms and an appropriate description of the symptoms consistent with the diagnosis. (2) The individual's behaviors or symptoms can be safely and effectively treated while living independently in the community. **-AND-** The following *continuing* stay criteria are met: (1) The consumer continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria. (2) The target outcomes have not yet been reached. (3) Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address lack of progress are evident and/or a second opinion on the treatment plan has been considered. **N =** The individual fails to meet admissions and continuing stay criteria for outpatient mental health services upon review of medical record documentation and applying standards cited above.	75% of all medical records reviewed contain documentation of the patient meeting MD medical necessity criteria for outpatient services.
6. Does the medical record contain an evaluation/assessment? *10.58.03.04 A (10)* *10.21.25.03-1 H (1) (b)*	**Y =** The medical record contains an evaluation or treatment reports which can be lawfully released to a client, insurance carriers, court systems, institutions, or authorized persons. The comprehensive assessment includes: individual or family's presenting problem; individual or family's history; individual's diagnosis; and rationale for the diagnosis. **N =** The medical record does not contain an evaluation.	75% of all applicable medical records reviewed have the required evaluation.

7. Does the medical record contain a treatment plan? *10.58.01.02 B (8) (a-e)* *10.58.03.05 A (1) (a)* *10.21.25.03-1 H (1) (c)*	**Y =** The client has been informed of the goals and procedures of services to be performed. The counselor has assisted the individual through the counseling relationship to define goals, make decisions, and plan a course of action reflecting the needs, interests, and abilities of the individual, family, or group. The record contains an individualized treatment plan that includes the: problems, needs, strengths, and goals that are measurable; interventions that are medically necessary; and signatures of the individual, or if the individual is a minor, the guardian, and the treating mental health professional. **N =** The medical record does not contain a treatment plan containing the elements as described above. **N/A**= The consumer is a new referral and a treatment plan has not yet been developed or the consumer discharged from treatment prior to the development of the plan.	75% of all medical records reviewed contain a treatment plan with all of the required elements.
8. Does the medical record contain evidence of face-to-face client contact hours in the form of progress/contact notes? *10.58.01.02 B (9)* *10.21.25.03-1 H (2)* *10.09.59.03 C* *10/28/08 MHA Memorandum-Compliance with MA Requirements & Billing the PMHS*	**Y=** The medical record contains documentation of face-to-face client contact hours, meaning at least 45 minutes of direct session time with clients present. The contact note includes: date of service; start time and end time; location; summary of interventions provided; and the date of service and treating mental health professional's official e-Signature, or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate title. **N =** The medical record does not contain documentation of face-to-face client contact hours, meaning at least 45 minutes of direct session time with clients present. The record does not include progress notes or fails to address at least one of the above requirements.	75% of all medical records reviewed have a score of *yes* and contain evidence meeting the standard for the inclusion of face-to-face client contact hours.
9. Does the medical record contain documentation of the counselor referring the consumer to and collaborating with informational and community resources? *10.58.01.02 B (8) (e)*	**Y =** The counselor has assisted an individual through the counseling relationship to use informational and community resources as these procedures are related to personal, social, emotional, educational, and vocational development and adjustment. **N =** Clinical information indicates that multiple mental health services are needed or currently being provided yet the counselor has not assisted an individual through the counseling relationship to use informational and community resources as these procedures are related to personal, social, emotional, educational, and vocational development and adjustment. **N/A =** There are either no additional mental health services needed; **OR** there is documentation that the consumer has refused referrals/collaboration with other service providers.	75% of all medical records reviewed have a score *yes* and meet the standard for the medical record reflecting recommendations for and collaboration with community resources.