| **QUALITY OF DOCUMENTATION**<br><br>**Individual & Group—Licensed Social Workers** | **<u>GUIDELINES FOR SCORING INDIVIDUAL RECORDS</u>**<br><br>**Y = Meets Standard N = Does Not Meet Standard**<br><br>**N/A = Not Applicable** | **GUIDELINES FOR DETERMINING PROGRAM COMPLIANCE WITH STANDARDS**<br><br>***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.*** |
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| **1. Has the social worker apprised the client of the nature and extent of treatment services?**<br>*COMAR 10.42.03.03 A (1-3)*<br>*10.21.25.03-1 H (1) (a)* | **Y** = There is documentation that the social worker has done the following:<br><br>(1) Apprise the client of the risks, opportunities, and obligations associated with services available to the client;<br><br>(2) Make the fee for service clear, maintain adequate financial records, and confirm arrangements for financial reimbursement with the client; and<br><br>(3) Notify the client promptly and seek the transfer, referral, or continuation of service in relation to the client's need or preference if the licensee anticipates the termination or interruption of service to the client<br><br>**N** = There is no medical record documentation of the social worker explaining the scope of treatment services as described above. | 75% of all medical records reviewed have documented treatment explanations. |
| **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?**<br>ValueOptions Provider Alert Release of Information Form (ROI), March 27, 2015<br>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.<br><br>**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.<br><br>**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. |

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| **3. Does the consumer have a PBHS mental health DSM V/ICD-10 diagnosis to support outpatient mental health services?**<br>*Maryland Medical Necessity Criteria: Level of Care VI: Outpatient Services ICD-9 Crosswalk* | Y= The consumer has a PMHS mental health diagnosis.<br><br>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. |
| **4. Does the individual meet admissions and continuing stay medical necessity criteria for outpatient mental health services?**<br>*Maryland Medical Necessity Criteria* | **Y** = All of the following *admissions* criteria are met for admission:<br><br>(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.<br><br>(2) The individual's behaviors or symptoms can be safely and effectively treated while living independently in the community.<br><br>**-AND-**<br><br>The following *continuing* stay criteria are met:<br><br>(1) The consumer continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria.<br><br>(2) The target outcomes have not yet been reached.<br><br>(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.<br><br>**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. |
| **5. Does the medical record contain an assessment and a diagnosis?**<br>*10.42.01.02 B (4) (5) (a)*<br>*10.21.25.03-1 H (1) (b)* | **Y** = The medical record contains an assessment and includes a diagnosis based on the Diagnostic and Statistical Manual in current use.<br>The comprehensive assessment includes: individual or family's presenting problem; individual or family's history; individual's diagnosis; and rationale for the diagnosis.<br><br>**N** = The medical record does not contain an assessment and a diagnosis. | 75% of all applicable medical records reviewed have the required assessment and clinical diagnosis. |

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| **6. Does the client record contain treatment plans and treatment goals?**<br>*10.42.03.03 A (5) (a-b)*<br>*10.21.25.03-1 H (1) (c)* | **Y =** The client record is legible and accurately reflects the services provided, including treatment plans and treatment goals.<br>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.<br><br>**N =** The client record is not legible and does not accurately reflect services provided, including treatment plans and treatment goals.<br><br>**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 treatment plans and treatment goals. |
| **7. Does the client record contain progress notes?**<br>*10.42.03.03 A (5) (b-c)*<br>*10.42.01.02 B (5) (c-d)*<br>*10.21.25.03-1 H (2)*<br>*10.09.59.03 C*<br>*10/28/08 MHA Memorandum-Compliance with MA Requirements & Billing the PMHS* | **Y**= The client record contains evidence that the social worker is treating the client's mental disorder and providing psychotherapy; the record includes progress notes and indicates the time and date the services were provided.<br><br>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.<br><br>**N =** The client record does not contain evidence that the social worker is treating the client's mental disorder and providing psychotherapy; 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 *yes* and contain evidence meeting the standard for the inclusion of face-to-face client contact hours. |