QUALITY OF DOCUMENTATION **Individual and Group** **(Psychologists)**	**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®, BHA, or any other auditing agency.***
1. Has the consumer (or their legal guardian) consented to treatment? *COMAR 10.36.05.08 C (2)* *10.21.25.03-1 H (1) (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. 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. 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? *(BHA Guidelines)*	**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
4. Does the consumer record document the consumer's presenting needs? *10.36.05.08 C (2)* *10.21.25.03-1 H (1) (b) (i)*	**Y =** The consumer's presenting needs are documented in the record **N =** The consumer's presenting needs are not documented in the record.	75% of all medical records reviewed document the consumer's presenting needs.
5. Does the consumer record document the consumer's diagnosis? *10.36.05.08 C (2)* *10.21.25.03-1 H (1) (b) (iii)*	**Y =** The consumer's diagnosis is documented in the record. **N =** The consumer's diagnosis is not documented in the record.	75% of all medical records reviewed documented the consumer's diagnosis.
6. Does the consumer record document the consumer's original test data with results and other evaluative material and the results of any formal consultations with other professionals? *COMAR 10.36.05.08 C (2)*	**Y =** The consumer's original test data and results and the results of any formal consultations with other professionals is documented in the record. **N =** The consumer's original test data and results and the results of any formal consultations with other professionals is not documented in the record. **N/A =** Testing or consultations are not indicated.	75% of all medical records reviewed documented the consumer's original test data and results and the results of any formal consultations with other professionals.

7. Does the diagnosis match the Utilization Guidelines for the Target Population and is there supporting documentation for establishing medical necessity? *BHA Guidelines*	**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 professional licensed to do so. **N =** There is no diagnosis in the record **OR** the diagnosis was made by an individual unlicensed to do so. A diagnosis has been assigned, but with no information in the record regarding symptoms, behaviors or history of occurrence.	75% of all medical records reviewed have a score *yes* and have documentation that meets the standard for establishing the diagnosis and medical necessity for services
8. Does the consumer record contain an individualized treatment plan? *10.21.25.03-1 H (1) (c)*	**Y =** 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 record is missing an individualized treatment plan **OR** the individualized treatment plan is missing at least one of the criteria stated 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 include a completed individualized treatment plan.
9. Are the contact notes dated and do they document a detailed description of the billed service? *10.36.05.08 C (2)* *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 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 =** There are no contact notes in the record or Contact notes are missing at least one of the above requirements	75% of all medical records reviewed have a score of *yes* and meet the standard for contact notes being complete.