Quality of Documentation Definitions Tool

Individual & Group – **Licensed Psychologist (PhD/PsyD)**

	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 instances. Programs that are compliant in less than 85% of the charts reviewed will be required to develop a Performance Improvement Plan (PIP) in conjunction with the CSA, Optum Maryland, BHA, or any other auditing agency.***
1. Has the participant, or their legal guardian, consented to treatment? *COMAR 10.36.05.05 B* *COMAR 10.36.05.07 E* *COMAR 10.36.05.08* *COMAR 10.21.25.03-1 H (1) (a)* **YES / NO**	**Y =** There is documentation that the participant has given informed consent to receive psychological services (assessment, psychotherapy, counseling, or consulting); **AND** the psychologist has received appropriate written authorization to provide counseling services for minors or other participants unable to give informed consent **AND** In instances in which a legal guardian signs consent for the participant, the psychologist has also obtained legal documentation/court order to verify that consent was given by the appropriate person. ***Additionally***, <u>in research</u>, there is also documentation that the psychologist has made clear to the client, and obtained written consent of: • The nature of the participation as well as the costs and other obligations to be accepted by research participants; • The purpose and nature of any evaluations, treatment, or educational or training procedure; • All aspects of research including any risks an consequences of the research that will reasonably be expected to influence willingness to participate; • The right to withdraw from treatment or research at any time; **AND** • The notification that permission shall be given by the client, student, or research participant before the use of observation or electronic taping, recording, or filming procedures. **N =** The record does not contain the above required elements, as applicable.	85% of all medical records reviewed contain the required documentation.

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2. Does the medical record contain a completed *MDH Documentation for Uninsured Eligibility Registration* and verification of uninsured eligibility status, or documentation of approval by MDH? *MDH Guidelines* **YES / NO / NA**	**Y =** The medical record contains a completed *MDH Documentation for Uninsured Eligibility Registration* **AND** verification of uninsured eligibility status; **OR** documentation of approval by MDH to bill uninsured. **N =** The medical record does not contain documentation that meets standard for billing uninsured (*i.e.* the registration and verification are missing, or approval by MDH is missing). **N/A =** The participant has active Maryland Medicaid; therefore, the documentation is not required.	85% of all applicable medical records reviewed contain the required documentation.
3. Does the medical record contain a completed Maryland Medicaid/Maryland Department of Health/Optum Maryland *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? *MDH Guidelines* *42 CFR, Part 2* *Optum Behavioral Health Provider Alert Release of Information (ROI) For MCO's, November 7, 2019* **YES / NO / NA**	**Y =** For participants receiving substance use treatment from this provider, the medical record contains a completed Maryland Medicaid/Maryland Department of Health/Optum Maryland *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 =** Clinical documentation in the record indicates that the participant is receiving substance use treatment from this provider; however, the record does not contain a completed Maryland Medicaid/Maryland Department of Health/Optum Maryland *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/A =** The participant did not receive substance use treatment services by this provider; therefore, the documentation is not required.	85% of all applicable medical records reviewed contain the required documentation.
4. Does the medical record contain a comprehensive assessment? *COMAR 10.36.05.08 C (1-2)* *COMAR 10.21.25.03-1 H (1) (b)* **YES / NO**	**Y =** The medical record contains a comprehensive assessment that 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 assessment, or the assessment is incomplete.	85% of all medical records reviewed contain the required documentation.
5. Does the medical record contain a treatment plan? *COMAR 10.21.25.03-1 H (1) (c)* **YES / NO / NA**	**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 participant, or if the participant is a minor, the guardian, and the treating mental health professional.	85% of all applicable medical records reviewed contain the required documentation.

	For participants engaged in long-term counseling, the record contains treatment plan reviews that include progress towards previously-identified goals, in addition to the above required elements. **N =** The medical record does not contain treatment plans; or contains treatment plans that do not include all of the above required elements. **N/A =** The participant is a new referral and a treatment plan has not yet been developed, the participant is only seeing the psychologist for testing, or the participant discharged from treatment prior to the development of the plan.	
6. Does the medical record contain contact notes that include a detailed description of the service? *COMAR 10.36.05.08 C (2)* *COMAR 10.21.25.03-1 H (2)* *COMAR 10.09.59.03 D* **YES / NO / NA**	**Y =** The medical record contains documentation of progress/contact notes that contain the following: • Date of service; • Start time and end time; • Location; • Summary of interventions provided; • Objective progress towards goals; **AND** • The date of service and treating mental health professional's official e-Signature, or a legible signature, along with their printed or typed name and title. **N =** The medical record is missing contact notes; or contains contact notes that do not include all of the above required elements. **N/A =** The participant has only been seen for testing.	85% of all applicable medical records reviewed contain the required documentation.
7. Does the participant meet admissions and continuing stay medical necessity criteria for outpatient mental health services? *Maryland Medical Necessity Criteria* *ICD-10 Crosswalk* **YES / NO**	**Y =** All of the following *admissions* criteria are met: • The participant has a PBHS specialty mental health DSM-V 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; **AND** • The participant's behaviors or symptoms can be safely and effectively treated while living independently in the community; **AND** ***Additionally***, all of the following *continuing stay* criteria are met: • The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria; • The target outcomes have not yet been reached; **AND** • Progress in relation to specific symptoms/impairments/dysfunction is clearly	85% of all medical records reviewed contain the required documentation.

	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 record does not contain documentation that supports that the participant meets both admissions and continuing stay criteria for outpatient mental health services.	
8. Does the participant record document the participant'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 (1-2)* **YES / NO / NA**	**Y =** The participant's original test data and results and other evaluative material, and the results of any formal consultations with other professionals is contained in the record. **N =** The above required elements are not contained in the record. **N/A =** The participant was not seen for testing by this psychologist, and/or there were no formal consultations done with other professionals.	85% of all applicable medical records reviewed contain the required documentation.