PROVIDER ALERT

Outpatient Mental Health Clinic (OMHC) Documentation

May 27, 2015

This alert is a general reminder for all Outpatient Mental Health Clinics (OMHCs). Following is a list of documentation items auditors routinely look for in all medical records.

Consent Form (COMAR 10.21.17.04 A)

- Consent forms needs to be signed with every admission. If unable to obtain the signature of an individual served or the guardian, attempts to do so must be documented in the medical record.
- If the individual is a minor, in the care of anyone other than biological parents, you MUST have court orders or custody agreements in the record. A signed and dated letter from the guardian detailing the guardianship arrangement would be accepted, if court orders or custody agreements are not available.

Advance Directive for Mental Health (COMAR 10.21.17.04 C)

- If over the age of 18, the individual needs to be given information on making a mental health advance directive; **OTHERWISE,** the record must document that the individual declined to make or accept assistance with making a mental health advanced directive.

Consumer Diagnosis/Continuing Stay/ Evaluation and Assessments (COMAR 10.21.20.06 A)

- A mental health diagnosis must be clearly documented with a rationale for the diagnosis and the need for ongoing therapy.
- The individual's presenting needs are to be documented in the record.
- By the 2nd visit, an assessment by a licensed mental health professional must be completed, documented in the individual's medical record and include
    - presenting problem
    - relevant history (including family, emotional, and somatic problems),
    - mental status exam
    - A diagnosis and rationale or the reason for not formulating a diagnosis and a plan, including time frame for when the diagnosis will be formulated.
- Including the information above, for **minors**, the assessment needs to be completed by the 5th visit with a face to face evaluation and include
    - Developmental history
    - Educational History
    - Current placement and home environment
    - Cognitive development
    - Social history
    - Self-care development
    - History (if any) of substance abuse, physical or sexual abuse, out of home placements, and involvement with juvenile services.

Substance Abuse/Use Screening (COMAR 10.21.20.06 B)

- All adults and adolescents should be administered a scientifically, validated, age- appropriate substance use screening tool.
- For younger individuals, clinical judgment should be used to determine appropriateness. If substance use services are indicated, documentation should address services required and collaboration.

Individual Treatment Plan (COMAR 10.21.20.07 A)

The record contains an individualized treatment plan (ITP) completed by the 5th visit. The ITP shall include, at a minimum

- Diagnosis
- Presenting needs, strengths, recovery, and treatment expectations and responsibilities
- Individualized, measurable long term goals, short term goals, and congruent interventions with target dates of completion
- Transition/discharge plan to include
    - a recommendation for transition/discharge to a lower level of care
    - what the individual needs to accomplish
    - the individual's functioning level
    - a projected timeframe for achievement, and
    - needed services to achieve the transition/discharge
- Dated signatures of two (2) collaborating clinicians including the prescribing psychiatrist or CRNP (if applicable); and the dated signature of the individual and/or parent/guardian
- Documentation that the individual was offered a copy of the ITP and whether the copy was accepted or declined

ITPs should be reviewed as frequently as necessary; however, ITPs must be reviewed, at minimum, every 6 months.

Contact/Progress Notes (COMAR 10.09.59.03 C)

The following must be present on all contact notes

- date of service
- start time and either duration or end time
- chief medical complaint or reason for visit
- individual's current mental status
- description of service specified by the ITP and provided, and any plans in treatment
- progress toward treatment goals
- dated, legible signature with credentials or title of staff providing service
- Notes shall be individualized and may not be duplicative

Collaboration (COMAR 10.21.20.07 A)

- Assist the individual in using informational and community resources that are related to medical, personal, social, emotional, educational and vocational development and adjustment on an as needed basis.
- Referral for substance abuse treatment or an integrated SA/MH rehabilitation/treatment plan if needed.

Discharge Summary (COMAR 10.21.17.10 C)

Within 10 working days after an individual is discharged from a program, a staff person responsible for coordinating services to the individual shall complete and sign a discharge summary.

At a minimum, a discharge summary must include

- Reason for admission and discharge
- Services provided including the frequency and duration of services
- Progress made
- Diagnosis at time of discharge
- Current medications, if any
- Continuing service recommendations and summary of the transition process
- Extent of the individual's involvement in the discharge plan