Quality of Documentation Definitions Tool

Individual & Group – **Licensed Social Worker (LCSW-C)**

	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 social worker apprised the participant of the nature and extent of treatment services? *COMAR 10.42.03.03 A (1-2)* **YES / NO**	**Y =** There is documentation that the social worker has: • Apprised the participant of the risks, opportunities, and obligations associated with services available to the participant; **AND** • Made the fee for service clear, maintained adequate financial records, stipulated payment schedules, and confirmed arrangements for financial reimbursement with the participant **N =** There is no medical record documentation of the social worker explaining the scope of treatment services as described above.	85% of all medical records reviewed contain the required documentation.
2. Has the participant given informed consent to receive services? *COMAR 10.42.02.02 B (9)* *COMAR 10.21.25.03-1 H (1) (a)* **YES / NO**	**Y =** There is documentation that the participant has given informed consent to receive services, after receiving reasonably full and accurate information pertaining to the risks, benefits, and possible consequences of the services. ***Additionally,*** the social worker has received appropriate written authorization to provide services for minors or other participants unable to give informed consent. In instances in which a legal guardian signs consent for the participant, the counselor has also obtained legal documentation/court order to verify that consent was given by the appropriate person. **N =** There is no documentation that the participant has given informed consent to receive services; the social worker has not received appropriate written authorization to provide services for minors or other participants unable to give informed consent; **or** the social worker has not obtained legal documentation/court order in instances where a legal guardian signed consent for the participant.	85% of all medical records reviewed contain the required documentation.

Quality of Documentation Definitions Tool
Individual & Group – **Licensed Social Worker (LCSW-C)**

3. 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.
4. 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.
5. Does the medical record contain an assessment? *COMAR 10.42.03.03 A (5) (a)* *COMAR 10.21.25.03-1 H (1) (b)* **YES / NO**	**Y =** The medical record contains a legible, comprehensive assessment that includes all of the following: • Individual or family's presenting problem; • Individual or family's history; • Individual's diagnosis (based on DSM V); **AND** • Rationale for the diagnosis. **N =** The medical record does not contain an assessment; or does not contain all of the above required elements.	85% of all medical records reviewed contain the required documentation.

Quality of Documentation Definitions Tool
Individual & Group – **Licensed Social Worker (LCSW-C)**

6. Does the medical record contain a treatment plan? *COMAR 10.42.03.03 A (5) (a)* *COMAR 10.42.03.06 A (3-4)* *COMAR 10.21.25.03-1 H (1) (c)* **YES / NO / NA**	**Y =** The participant record accurately reflects the services provided, including treatment plans and treatment goals. The record contains legible, individualized treatment plans that include: • 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 does not accurately reflect services provided, as treatment plans are missing from the record, or treatment plans do not contain all of the above required elements. **N/A =** The participant is a new referral and a treatment plan has not yet been developed, or the participant discharged from treatment prior to the development of the plan.	85% of all applicable medical records reviewed contain the required documentation.
7. Does the medical record contain progress notes for each face-to-face service billed? *COMAR 10.42.03.03 A (5) (a-e)* *COMAR 10.09.59.03 D* *COMAR 10.21.25.03-1 H (2)* **YES / NO / NA**	**Y =** The participant record contains evidence that the social worker is treating the participant's mental disorder and providing psychotherapy, as the record includes legible progress/contact notes that include: • Date of service; • Start time and end time; • Location; • Summary of interventions provided; **AND** • The treating mental health professional's official e-signature, or legible signature, along with the printed or typed name and title. **N =** The participant record does not contain evidence that the social worker is treating the participant's mental disorder and providing psychotherapy; the record does not include progress/contact notes, or is missing progress/contact notes; or progress/contact notes do not contain all of the above required elements. **N/A =** The participant is a new referral, and sessions after the assessment have not occurred.	85% of all applicable medical records reviewed contain the required documentation.

Quality of Documentation Definitions Tool
Individual & Group – **Licensed Social Worker (LCSW-C)**

8. 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 record contains documentation (*i.e.* comprehensive assessment) that meets standard for establishing a PBHS mental health DSM V/ICD-10 diagnosis; **AND** • 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 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.	85% of all medical records reviewed contain the required documentation.