# Quality of Documentation Definitions Tool

## Outpatient Mental Health Center (OMHC)

| | **GUIDELINES FOR SCORING INDIVIDUAL RECORDS**<br><br>**Y = Meets Standard**<br>**N = Does Not Meet Standard**<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 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.*** |
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| **1. Has the participant or parent/guardian consented to treatment?**<br>*Accreditation Standard*<br><br>**YES / NO** | **Y =** There is documentation that the participant or parent/legal guardian has given consent to treatment.<br><br>In instances when obtaining consent is not possible, the program shall document the reasons why the participant cannot give written consent; verify the participant's verbal consent; and document periodic attempts to obtain written consent.<br><br>**Additionally**, in the instance where a legal guardian has been appointed, the OMHC has received appropriate documentation (court orders and custody agreements regarding healthcare decision-making, or a letter from the agency naming a specific person to make healthcare decisions, if an agency such as DSS has custody).<br><br>**N =** There is no documentation that consent was obtained; or the above required elements are not present in the record. | 85% of all medical records reviewed contain the required documentation. |
| **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?**<br>*MDH Guidelines*<br>*Accreditation Standard*<br><br>**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.<br><br>**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).<br><br>**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. |

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| **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?**<br>*Accreditation Standard*<br>*MDH Guidelines*<br>*42 CFR, Part 2*<br>*Optum Behavioral Health Provider Alert Release of Information (ROI) For MCO's, November 7, 2019*<br><br>**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.<br><br>**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.<br><br>**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. Is there documentation present indicating that the participant, over the age of 18, has been given information on making an advance directive for mental health services?**<br>*Annotated Code of MD 10-701(c) (9)*<br>*Annotated Code of MD 5-602.1*<br>*MDH Guidelines*<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y =** There is documentation that the participant was given information on making an advance directive **OR** documentation that the participant declined assistance with or making an advanced directive.<br><br>**N =** There is no documentation in the medical record indicating that the provider has given the participant information about advanced directives.<br><br>**N/A =** The participant is a child/adolescent under the age of 18. | 85% of all applicable medical records reviewed contain the required documentation. |
| **5. Was a comprehensive assessment completed by the 2nd visit?**<br>*CMS State Medicaid Manual Part 4 4221 B*<br>*Accreditation Standard*<br><br>**YES / NO** | **Y** = The record contains a comprehensive assessment, completed by the participant's 2nd visit; **OR** if completed outside of the required timeframe:<br>• There is a documented rationale for service delay;<br>• There is documentation that a licensed mental health professional formulated and documented in the participant's medical record information that includes:<br>  ○ A description of the presenting problem;<br>  ○ Relevant history, including family history and somatic problems;<br>  ○ Mental status examination;<br>  ○ Substance Abuse Screening assessment (scientifically | 85% of all medical records reviewed contain the required documentation. |

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| | validated, age-appropriate tool), *as applicable by age*; **AND**<br>• A diagnosis and the rationale for the diagnosis; **OR**<br>• The reason for not formulating a diagnosis, and a plan, including time frame, for formulating a diagnosis.<br><br>**N** = There is no assessment in the medical record; or the assessment is present but late and required documentation as listed above is missing; or the assessment is not comprehensive. | |
| **6. If the participant is a minor and the comprehensive assessment does not contain the required elements for a minor, does the record contain an additional face-to-face assessment completed by the minor's fifth visit?**<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y =** There is an additional assessment, dated and completed before the minor's fifth visit, that includes all of the following:<br>• Developmental history;<br>• Educational history and current placement;<br>• Home environment;<br>• Family history and evaluation of the current family status, including legal custody status;<br>• Social, emotional, and cognitive development;<br>• Motor, language, and self-care skills development;<br>• History, if any, of substance abuse;<br>• History, if any, of physical or sexual abuse;<br>• History, if any, of out-of-home placements; **AND**<br>• Involvement, if any, with the local department of social services or Department of Juvenile Services.<br><br>**N** = There is no assessment in the medical record; the assessment is present but not comprehensive, and an additional face-to-face assessment was not completed to gather the required information as listed above; and/or the additional assessment was not completed within the required timeframe.<br><br>**N/A** = The participant is an adult and no additional face-to-face evaluation is required; or if the minor's comprehensive assessment included the required information. | 85% of all applicable medical records reviewed contain the required documentation. |
| **7. Does the diagnosis match the Utilization Guidelines for the Target Population and is there supporting documentation for establishing medical necessity?**<br>*COMAR 10.09.59.05 A*<br>*Maryland Medical Necessity Criteria: Level of Care VI: Outpatient Services* | **Y =** The record contains documentation of a diagnosis, which meets the target population; **AND** clear documentation of rationale for the diagnosis and medical necessity.<br><br>**N =** The record lacks one or more of the requirements listed above. | 85% of all medical records reviewed contain the required documentation. |

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| *ICD-10 Crosswalk*<br>*Accreditation Standard*<br><br>**YES / NO** | | |
| **8. If the assessment indicates a secondary co-occurring Substance Use Disorder, is there evidence of integration or collaboration with Substance Abuse services?**<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y =** The assessment indicates a co-occurring substance use disorder, and the record contains:<br>• Documentation in the treatment plan and progress/contact notes that the OMHC has integrated substance abuse services; **OR**<br>• Consent for, and coordination of care and collaboration with a substance abuse treatment services provider.<br><br>**N =** The assessment is missing from the record, the assessment does not contain an appropriate substance use disorder screening, or the screening is incomplete; therefore, it cannot be determined if integration or coordination of care and collaboration with substance abuse services is warranted. Or the required elements above are not present in the record.<br><br>**N/A =** The assessment does not indicate a co-occurring substance use disorder; **OR** the participant does not consent to coordination of care and collaboration with substance abuse treatment services. | 85% of all applicable medical records reviewed contain the required documentation. |
| **9. Was the initial ITP completed by the participant's 5th visit, and is it comprehensive?**<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y =** The record contains an initial ITP, completed by the participant's 5th visit, and includes all of the following:<br>• The participant's diagnosis;<br>• The participant's presenting needs, strengths, recovery, and treatment expectations and responsibilities;<br>• A description of needed and desired treatment and interventions to be provided, specifying the modality, frequency, and responsible staff;<br>• A description of how the needed and desired treatment will help the participant to manage the participant's psychiatric disorder and to support recovery;<br>• Short-term and long-term treatment goals in measurable terms, and target dates for each goal; and<br>• If appropriate, referral for and collaboration with other services or child service agencies and providers to support the participant's treatment and recovery, including but not limited to: mental health residential services, psychiatric rehabilitation services, self-help organizations, vocational programs, substance abuse services, the | 85% of all applicable medical records reviewed contain the required documentation. |

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| | local department of social services, the local department of juvenile services, schools, and somatic care;<br>• Documentation that the participant was offered a copy of the plan and if they accepted or declined;<br>• All required signatures, to include those by:<br>  ○ the participant and/or parent/guardian;<br>    ▪ or there is documentation that the participant verbally agreed to the ITP but refused to sign, and the rationale for either<br>  ○ at least two licensed mental health professionals who collaborate about the participant's treatment; **AND**<br>  ○ *if meds are prescribed through the OMHC,* the OMHC psychiatrist or Certified Registered Nurse Practitioner in psychiatry (whomever prescribes);<br><br>**N =** There is no initial ITP present in the record; the ITP was not completed before the participant's 5th visit; or the ITP is missing one or more of the required elements above.<br><br>**N/A =** The participant is a new referral, an ITP has not yet been developed, and it is still within the required timeframe. | |
| **10. Is the ITP reviewed at a minimum of every 6 months?**<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y =** The record contains ITP reviews, completed at a minimum of every 6 months, and includes all of the following:<br>• An assessment of the participant's progress toward the accomplishment of previously identified treatment goals that incorporates the perspective of the participant served;<br>• Goal changes based on a review of progress;<br>• Changes in treatment strategies; and<br>• Changes in diagnosis, if any;<br>• Documentation that the participant was offered a copy of the plan and if they accepted or declined;<br>• All required signatures, to include those by:<br>  ○ the participant and/or parent/guardian;<br>    • or there is documentation that the participant verbally agreed to the ITP but refused to sign, and the rationale for either<br>  ○ at least two licensed mental health professionals who collaborate about the participant's treatment; **AND**<br>  ○ *if meds are prescribed through the OMHC,* the OMHC psychiatrist or Certified Registered Nurse Practitioner in psychiatry (whomever prescribes); | 85% of all applicable medical records reviewed contain the required documentation. |

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<tr><td></td><td>N = There are no ITP reviews in the record; one or more ITP reviews are completed outside of the required timeframe; or one or more ITP reviews are missing one or more required elements listed above.<br><br>N/A = The participant is a new referral, an ITP has not yet been developed, and it is still within the required timeframe; ITP reviews have not been completed, and it is still within the required timeframe; or the participant discharged prior to the first ITP review.</td><td></td></tr>
<tr><td>11. Are the progress/contact notes complete, and do they reflect implementation of goals and interventions from the ITP, and progress towards goals on the ITP?<br>COMAR 10.09.59.03 D<br>CMS State Medicaid Manual Part 4 4221 D6 & D7<br>Accreditation Standard<br><br>YES / NO / NA</td><td>Y = Each session and contact is documented in the record through written progress/contact notes, and includes all of the following:<br>• The date of service;<br>• The start time and end time;<br>• The participant's chief medical complaint, or reason for the visit;<br>• The participant's mental status;<br>• The delivery of services specified by the ITP;<br>    ○ Goals and interventions from the ITP should be addressed;<br>• A brief description of the service provided;<br>• The plan for changes in treatment, if any;<br>• The participant's progress towards treatment goals; AND<br>• A legible signature, which may include an electronic signature, and printed or typed name of the licensed mental health professional providing care, with the appropriate title.<br><br>N = The record does not contain contact/progress notes; at least one progress/contact note is missing from the record; the record does not contain an ITP to refer to; or one or more progress/contact notes is missing one or more of the required elements above.<br><br>N/A = The participant is a new referral, an ITP has not yet been developed, and it is still within the required timeframe.</td><td>85% of all applicable medical records reviewed contain the required documentation.</td></tr>
<tr><td>12. Does record documentation reflect recommendations for and/or collaboration with other mental health services to support the participant's recovery?<br>Accreditation Standard<br><br>YES / NO / NA</td><td>Y = The record contains documentation of referrals for and/or collaboration by the OMHC with the following, as appropriate, for:<br>• Psychiatric rehabilitation and support services;<br>• Somatic care;<br>• Speech and language services;<br>• Vision and hearing services;<br>• Special instruction, special education, or other educational</td><td>85% of all applicable medical records reviewed contain the required documentation.</td></tr>
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<td>interventions;<br>• Occupational therapy;<br>• Self-help organizations; and/or<br>• Substance abuse services<br><br>N = The record contains clinical documentation in the assessment and/or ITP that referral/collaboration with one or more service is appropriate, but does not show that it has been done; the assessment and/or ITP documentation is missing from the record, and it cannot be determined if referral and/or collaboration is warranted.<br><br>N/A = Assessment and/or ITP documentation reflects that further referral and/or collaboration is indicated; the participant refused the referral; or the participant refused to sign consent for the OMHC to collaborate.</td>
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<td>13. Is there documentation of the participant’s past and current somatic/ medical history and documentation of ongoing communication and collaboration with the Primary Care Physician?<br>Accreditation Standard<br><br>YES / NO / NA</td>
<td>Y = A licensed mental health professional has documented:<br>• Pertinent past and current somatic medical history, including:<br>  ○ The participant's somatic health problems, including but not limited to allergies, neurological disorders, communicable diseases;<br>  ○ Relevant medical treatment, including medication;<br>  ○ A recommendation, if any, for somatic care follow-up;<br>• If the participant does not have a primary care provider, the plan, including the timeframe, for the participant’s referral to a primary care provider for evaluation and treatment;<br>• An exchange of medical information with the primary care provider; AND<br>• With consent, and if indicated, documentation of ongoing collaboration with the primary care provider<br><br>N = The record does not contain past and current somatic medical history; the documented history is not complete as required above; there is no collaboration with a PCP; or there is no plan to refer to a PCP, for a participant without one.<br><br>N/A = Somatic medical history was documented appropriately, and referral and/or collaboration is indicated but the participant refused referral and/or consent to collaborate; or referral and/or collaboration is not clinically indicated.</td>
<td>85% of all applicable medical records reviewed contain the required documentation.</td>
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# Quality of Documentation Definitions Tool

## Outpatient Mental Health Center (OMHC)

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| **14. Was a discharge summary completed within 10 working days of the participant's discharge from the program?**<br>*Accreditation Standard*<br><br>**YES / NO / NA** | **Y=** If the participant has been discharged from the program, a written discharge summary is completed within 10 working days of the participant's discharge, and includes the following:<br>• Reason for admission;<br>• Reason for discharge,<br>• Services provided, including the frequency and duration of services;<br>• Progress that was made;<br>• Diagnosis at the time of discharge, if appropriate:<br>• Current medications, if any;<br>• Continuing service recommendations;<br>• Summary of the transition process;<br>• Extent of participant's involvement in the discharge plan; **AND**<br>• Signature of the staff person responsible for coordinating services to the individual, who also completed the discharge summary.<br><br>**N =** The discharge summary is not in present in the record, but the participant has been discharged; the participant has not been seen recently, a discharge summary is not present, and it cannot be determined if the participant has been discharged or not; the discharge summary is missing one of the required elements above.<br><br>**N/A =** The participant remains enrolled in treatment. | 85% of all applicable medical records reviewed contain the required documentation. |