Quality of Documentation Definitions Tool

Substance Use Disorder – **Opioid Treatment Program (OTP)**

	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 consented for treatment or with the consent of the participant, a parent or guardian has consented for treatment? *42 CFR 8.12 (e)* *Accreditation Standard* **YES / NO**	**Y =** The participant consented for treatment, or a parent or guardian of a minor, with the minor's consent, applied on behalf of the child or adolescent for admission to a certified program. **Additionally**, in instances in which a legal guardian signs consent for the participant, the program has also obtained legal documentation/court order to verify that consent was given by the appropriate person. **N =** Consent for treatment is not present in the record; the participant did not consent for treatment; a parent or guardian of a minor, with the minor's consent, did not apply on behalf of the minor for admission to a certified program; and/or legal documentation is not present in the record in instances where the legal guardian signed consent.	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? *MDH Guidelines* *Accreditation Standard* **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.

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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? *Accreditation Standard* *MDH Guidelines* *42 CFR, Part 2* *Optum Behavioral Health Provider Alert Release of Information (ROI) For MCO's, November 7, 2019* **YES / NO**	**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.	85% of all medical records reviewed contain the required documentation.
4. Was a comprehensive assessment completed by a licensed physician or practitioner, and prior to services being rendered? *COMAR 10.09.80.05 A* *42 CFR 8.12 (f) (4)* *Accreditation Standard* **YES / NO**	**Y =** The record contains a comprehensive assessment, completed by a licensed physician or practitioner, prior to any services being rendered, and includes the following: • Physical health; • Employment or financial support; • Drug and alcohol use; • Drug and alcohol treatment history (if applicable); • Legal; • Family and social; • Educational; • Mental health treatment (history and current); • The use of the Addiction Severity Index (ASI) as the standardized assessment instrument for adults, or an equivalent assessment instrument chosen by the Administration; • Referrals for physical and mental health services; • Recommendation for the appropriate level of substance use disorder treatment; • Reviewed and approved by a licensed physician or licensed practitioner of the healing arts. **N =** There is no assessment present in the record; or the above requirements are not met, as applicable.	85% of all medical records reviewed contain the required documentation.

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5. Does the participant meet American Society of Addiction Medicine (ASAM) criteria for OTP services? *COMAR 10.09.80.04 B (1)* *Accreditation Standard* **YES / NO**	**Y =** The participant meets the current edition of the American Society of Addiction Medicine's criteria for OTP services. **N =** The participant does not meet the above requirement.	85% of all medical records reviewed contain the required documentation.

6. Was the initial ITP completed within 7 working days of the comprehensive assessment, and is it individualized and comprehensive?
COMAR 10.09.80.05 G (1)
42 CFR 8.12 (f) (4)
Accreditation Standard
 	
YES / NO
	Y = The record contains an initial ITP, completed within 7 working days of the comprehensive assessment, and:
	• Developed with the participation of the participant;
	• Based on the comprehensive assessment and ASAM criteria;
	• Sets forth participant needs, including:
	  ○ Socialization;
	  ○ Alcohol and drug abuse or dependence;
	  ○ Psychological;
	  ○ Vocational;
	  ○ Educational;
	  ○ Physical health;
	  ○ Legal;
	  ○ Family; **AND**
	• Contains individualized interventions, including:
	  ○ Participant's individual needs;
	  ○ A schedule of clinical services, including individual, group, and family (if appropriate);
	  ○ Long-range treatment plan goals and objectives;
	  ○ Short-range treatment plan goals and objectives;
	  ○ Strategy for implementation of treatment plan goals;
	  ○ Specific interventions for meeting goals;
	  ○ Target dates for completion of treatment plan goals and objectives;
	  ○ Referrals to ancillary services, if needed;
	  ○ Referrals to self-help groups, if recommended; **AND**
	  ○ Signatures of the participant or parent/guardian, the staff permitted to, who developed the plan.
	
	Additionally, if the alcohol and other drug counselor is unable to develop a treatment plan within the required time, the clinical director or the clinical supervisor has:
	• Determined the reason for a delay in development of a treatment plan;
	• Documented the reason in the participant's record; and
	• Directed an appropriate clinical staff person to develop a treatment plan within
		85% of all medical records reviewed contain the required documentation.

	7 working days of the clinical director's or clinical supervisor's documentation of the delay. **N =** There is no initial ITP in the record, the initial ITP was not completed within the required timeframe; and/or the ITP does not meet the minimum requirements listed above. **In instances where the initial ITP could not be developed within 5 working days of the assessment,** the record does not contain the above-required *additional* documentation. **N/A =** The participant is a new referral and an initial ITP has not yet been developed, and it is still within the required timeframe.	
7. Is the ITP updated every 90 days for the first year of treatment, and every 180 days thereafter? *42 CFR 8.12 (i)* *Accreditation Standard* **YES / NO / NA**	**Y =** The ITP updates are present in the record, and: • Updated every 90 days for the first year of treatment, or every 180 days thereafter; • Developed with the participation of the participant; • Comprehensive, including all required elements of an ITP; • Documents progress towards goals; **AND** • Signed by the alcohol and drug counselor, and participant. **N =** The ITP updates are missing from the record; one or more ITP updates were completed outside of the required timeframe; or an ITP is missing one or more of the required elements above. **N/A =** The ITP has not yet been updated, and it is still within the required timeframe; or the participant has been discharged prior to needing an ITP update.	85% of all applicable medical records reviewed contain the required documentation.
8. Does the record document the participant's dosing schedule, and that medications were administered or dispensed according to the licensed practitioner's medication order? *COMAR 10.09.80.05 H* *COMAR 10.63.03.19 C* *42 CFR 8.12 (h)* *Accreditation Standard* **YES / NO**	**Y =** The record documents the ordered dosing schedule; **AND** that medications were administered and/or dispensed according to the licensed practitioner's medication order. **N =** The record does not contain the above requirements.	85% of all medical records reviewed contain the required documentation.

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9. If guest dosing was utilized, is there documentation to support guest dosing between the home and guest OTP provider? *COMAR 10.09.80.05 G (4)* *COMAR 10.63.03.19 C* *Accreditation Standard* **YES / NO / NA**	**Y =** The record indicates that guest dosing was utilized, and: • Contains the home (original OTP program referral to the program in which the participant will be guest dosing at) order/referral for guest dosing; **AND** • Guest dosing history and notification of any concerns, for example, individual no shows or reason for dosing denial, and confirmation of the last "guest" dose from the program in which the participant guest dosed at **N =** The participant guest dosed at another program, but the record does not contain the above elements. **N/A =** Guest dosing was not utilized by the participant at another program.	85% of all applicable medical records reviewed contain the required documentation.
10. Are progress/contact notes complete, and do they reflect that individual and/or group therapy services were rendered based on the individualized treatment plan? *COMAR 10.09.80.01 B (16)* *COMAR 10.09.80.03 C* *COMAR 10.09.80.05 G (2) (d)* *Accreditation Standard* **YES / NO**	**Y =** Individual and/or group therapy, and all contact with the participant, is documented in the record through written progress/contact notes after each session, including: • The date of service; • The start time and end times; • The participant's primary reason for the substance use disorder visit; • Objective progress towards goals and objectives; • A description of the service provided; • Evidence that individual and/or group services were rendered based on the individualized treatment plan; • Participant responses to the interventions by providers; **AND** • An official e-Signature, or a legible signature, along with the printed or typed name of the individual providing care, with the appropriate degree or title. **N =** There are no progress/contact notes in the record; progress/contact notes are missing; or progress/contact notes are missing one or more of the required elements above.	85% of all medical records reviewed contain the required documentation.

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11. Does the record contain evidence that an initial, and ongoing monthly random toxicology tests were ordered, and the results? *42 CFR 8.12 (f) (6)* *Accreditation Standard* **YES / NO**	**Y =** The record contains evidence that an initial drug abuse test was performed; ongoing monthly random toxicology tests were ordered, **AND** the results. **N =** The record does not contain all of the above requirements.	85% of all medical records reviewed contain the required documentation.
12. Does the record contain documentation that positive toxicology results were addressed by staff with the participant, and appropriate action was taken? *COMAR 10.09.80.05 G (2) (b-c)* *COMAR 10.63.03.19 G & H* *42 CFR 8.12 (f) (6)* *Accreditation Standard* **YES / NO / NA**	**Y =** The record contains documentation that positive toxicology results were addressed by staff with the participant; **AND** appropriate action was taken. **N =** The record does not contain all of the above requirements. **N/A =** Toxicology results were all negative.	85% of all applicable medical records reviewed contain the required documentation.
13. Was a discharge summary completed within 30 days of the participant's discharge, or was a transfer summary completed at the time of discharge from the program? *Accreditation Standard* **YES / NO / NA**	**Y =** If the participant has been discharged from the program, a written discharge summary is completed within 30 days of the participant's discharge, and includes the following: • Reason for admission; • Reason for discharge; • The participant's address; • A summary of services delivered, including frequency and duration of services; • Progress made; • The diagnosis and prognosis at the time of discharge; • Current medications, if any; • Continuing service recommendations; • A summary of the transition process; **AND** • The extent of the individual's involvement in the discharge plan ***OR*** If the participant has been transferred from the program to another program, a written transfer summary is completed at the time of the participant's discharge, and includes the following:	85% of all applicable medical records reviewed contain the required documentation.

	• The reason for admission; • The reason for discharge; • The individual's address; • The diagnosis and prognosis at the time of discharge; **AND** • Current medications, if any. **N =** For a discharged participant, the discharge summary is not in present in the record, was not completed within the required timeframe, and/or is missing one or more of the required elements; and for a transferred participant, the transfer summary is not present in the record, was not completed within the required timeframe, and/or is missing one or more of the required elements. This score also applies to records in which documentation does not support that the participant has been seen recently, but it cannot be determined if they have been discharged or not. **N/A =** The participant remains enrolled.	
14. Does the record document referral(s) to community resources and/or informational services as requested by the participant or recommended by the program? *42 CFR 8.12 (f) (5) (iii)* *Accreditation Standard* **YES / NO / NA**	**Y =** The record documents that the participant requested, and/or the program recommends referral to community resources, vocational rehabilitation, education, employment services, and/or other informational services, **AND** referral to these resources, that includes: • Reason for referral; • Name of the participant; • Referring program; • Receiving program; and • Final disposition of the referral. **N =** The record contains documentation that the participant requested and/or the program determined a referral is necessary, but there is no documentation of referral; or the referral is lacking one or more of the elements as required above. **N/A =** No additional services were requested and/or determined to be necessary; or the participant refused referral.	85% of all applicable medical records reviewed contain the required documentation.
15. If the program utilizes an Electronic Medical Record (EHR) is a companion hard copy file maintained? *Accreditation Standard* **YES / NO / NA**	**Y =** For programs that utilize an EHR, a companion hard copy file is maintained, containing the following original, completed documents, signed by the participant: • *Informed Consent to Treatment;* • Any requests for or complete *Releases of Information* forms shared with other entities; • Any treatment plan or treatment plan update; **AND** • Any program agreements or patient/counselor behavioral contracts.	85% of all applicable medical records reviewed contain the required documentation.

	N = The program does not maintain a companion hard copy file, the hard copy file is missing form(s), or forms in the hard copy file are incomplete. **N/A =** The program does not utilize an EHR to maintain the participant's record.	