Quality of Documentation Definitions Tool

Individual & Group – **Licensed Clinical Professional Counselor (LCPC)**

	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 given informed consent to receive counseling services? *COMAR 10.58.03.04 A (5-6)* *COMAR 10.21.25.03-1 H (1) (a)* **YES / NO**	**Y =** There is documentation that the participant has given informed consent to receive counseling services; **AND** the counselor has received appropriate written authorization to provide counseling services for minors or other participants unable to give informed consent. **Additionally**, 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 counseling services; the counselor has not received appropriate written authorization to provide counseling services for minors or other participants unable to give informed consent; and/or the counselor 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.
2. Has the counselor provided sufficient information to a participant to allow them to make an informed decision regarding treatment*?* *COMAR 10.58.03.08* *COMAR 10.58.03.05* *COMAR 10.58.03.04 C* *COMAR 10.21.25.03-1 H (1) (a)* **YES / NO**	**Y =** There is documentation that the counselor has provided all of the following: • The purpose and nature of an evaluation or treatment process; • Additional options to the proposed treatment; • Potential reactions to the proposed treatment; • The estimated cost of treatment; **AND** • The right of a participant to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal; ***Additionally***, if the counselor is involved in research, there is also	85% of all medical records reviewed contain the required documentation.

	documentation that the counselor has: • Obtained full informed consent of a participant participating in a human research program; • Clearly indicated to prospective recipients treatment given as part of a research study; • Obtained written permission in advance of treatment; • Included in documentation, the right of a participant to decline treatment, if part or all of the treatment is to be recorded for research or review by another person; **AND** • Did not imply that a penalty may result if the participant refuses to participate in the human research program. **N =** The record does not contain documentation that the participant has been provided sufficient information to make an informed decision regarding treatment, or does not contain all of the above required elements, as applicable.	
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*	**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,	85% of all applicable medical records reviewed contain the required documentation.

YES / NO / NA	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.	
5. Does the medical record contain a comprehensive assessment? *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.
6. Does the medical record contain a treatment plan? *COMAR 10.58.01.02 B (8)* *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. 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, or the participant discharged from treatment prior to the development of the plan.	85% of all applicable medical records reviewed contain the required documentation.

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7. Does the medical record contain progress notes for each face-to-face service billed? *COMAR 10.09.59.03 D* *COMAR 10.58.01.02 B (9)* *COMAR 10.21.25.03-1 H (2)* **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 documentation of progress/contact notes; or contains progress/contact notes that do not include 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.
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.	85% of all medical records reviewed contain the required documentation.

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	N = The record does not contain documentation that supports that the participant meets both admissions and continuing stay criteria for outpatient mental health services.	
9. Does the medical record contain documentation of the counselor referring the participant to and collaborating with informational and community resources? *COMAR 10.58.01.02 B (8) (e)* *COMAR 10.58.03.05 A (1) (c and e)* **YES / NO / NA**	**Y =** The record contains documentation that the counselor has referred the participant, as needed, to informational and community resources as these procedures are related to personal, social, emotional, educational, vocational development and adjustment; **AND** documentation of attempts to collaborate with other professional persons concurrently providing mental health services. **N =** Clinical information in the record indicates that other services are needed and/or are currently being provided, but the record does not contain documentation that the counselor has assisted in referring the participant and/or attempted to collaborate with those professional persons concurrently providing services. **N/A =** There are either no additional mental health services needed; or there is documentation that the participant has refused referrals and/or collaboration with other service providers.	85% of all applicable medical records reviewed contain the required documentation.