Quality of Documentation Definitions Tool
Therapeutic Behavioral Services (TBS)

	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 or parent/guardian consented to rehabilitation services? *COMAR 10.09.34.03 B (1) (a) (viii)* *Accreditation Standard* **YES / NO**	**Y =** There is documentation that the participant, age 16 or older, or parent/legal guardian, has given consent to treatment. 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. **Additionally**, in the instance where a legal guardian has been appointed, 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) has been received. **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? *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. Was an initial therapeutic behavioral assessment completed, and is it comprehensive? *COMAR 10.09.34.01 B (11)* *COMAR 10.09.34.03 B* *Accreditation Standard* *Maryland Medical Necessity Criteria: Level of Care VI: Outpatient Services* *ICD-10 Crosswalk* *CMS State Medicaid Manual Part 4 4221 B* **YES / NO**	**Y =** The record contains an initial behavioral assessment, completed by a licensed healthcare professional, and includes the development of a behavioral plan, which: • Was developed with the participant and parent/guardian; • Identifies the target behaviors or symptoms that are placing the current living arrangement at risk or presenting a barrier to transition to a less restrictive living arrangement; • Defines specific interventions to be used to resolve the behaviors or symptoms, including how a therapeutic aide will implement therapeutic behavioral services; • Defines outcome measures that can be used to demonstrate the decreasing frequency of targeted behaviors; • Defines alternative behaviors; • Defines the clinically accepted techniques for behavior change, including where, when, and the frequency of the techniques to be used and the risks and benefits of each; • Details the strategies and skills for the participant and parent/guardian, or individual who customarily provides cares to provide continuity of care when therapeutic behavioral services are discontinued; • Details emergency procedures to be implemented when the participant exhibits behaviors that pose harm to self or others; • Identifies the level or type of licensed healthcare professional responsible for monitoring the behavioral plan; • Documents that therapeutic behavioral services are needed. **N =** There is no initial therapeutic behavioral assessment in the medical record; or the initial therapeutic behavioral assessment is missing one or more of the required elements above.	85% of all medical records reviewed contain the required documentation.
4. Is the Behavioral Plan updated every 60 days? *COMAR 10.09.34.04 C* *COMAR 10.09.34.05 C* *Accreditation Standard* **YES / NO / NA**	**Y =** The Behavioral Plan is updated every 60 days and includes: • Documented progress towards the specific goals; **and** • Evidence that the therapeutic behavioral service continues to be effective; **or** • New goals and outcomes if progress is not being achieved. **N =** The Behavioral Plan is not updated every 60 days; and/or is missing all of the required elements above. **N/A =** The first update has not been documented, and it is within the required timeframe; or the participant discharged from TBS prior to the development of the updated behavioral plan.	85% of all applicable medical records reviewed contain the required documentation.

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5. Are the progress notes complete, and do they reflect implementation of goals and interventions from the behavioral plan, and progress towards goals? *COMAR 10.09.34.02 A (3)* *COMAR 10.09.34.03 B* *Accreditation Standard* **YES / NO**	**Y =** Each session and contact is documented in the record through written progress/contact notes, and includes all of the following: • The date of service; • The start time and end time; • The location of the service; • The name of the parent, legal guardian, or individual who customarily provides care present during the service; • A brief description of the service provided, including reference to the behavioral plan; • Evidence that therapeutic behavioral services are being rendered (see below); • A description of the participant's behaviors or symptoms; **and** • The signature of the behavioral aide. **TBS services** include: - One-to-one interventions in accordance with the behavior plan, which: o Assist the recipient in engaging in/remaining engaged in appropriate activities; o Minimizing the recipient's impulsive behaviors; o Providing immediate behavioral reinforcements; o Providing time structuring activities; and o Collaboration with/support for parent, guardian, or individual who customarily provides care in the effort to provide ongoing behavioral support. **N =** The record does not contain progress/contact notes; at least one progress/contact note is missing from the record; the record does not contain a behavior plan to refer to; or one of more of the progress/contact notes is missing one or more of the required elements above.	85% of all medical records reviewed contain the required documentation.