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Audit Findings Summary - 3rd Quarter 2024

This *Audit Findings Summary* reflects findings for seventy-two (72) total Provider audits, conducted in the 3rd Quarter of 2024.

The summary reflects audit data, in terms of averages by both scored quality line item and overall average by Provider. Quality line items scoring N/A are not included in the data.

A Program Improvement Plan (PIP) was required of a Provider for any section(s) of quality line items that resulted in an average score of less than 85%, calculated across total records reviewed in an audit.

Certain audit findings result in the recommended recovery of funds and/or referral to the Office of Inspector General (OIG).

Individual Provider: LCPC, LCADC, LCPAT	
Quality Line Item	**Average Score**
Each participant has a separate record.	92%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	57%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	60%
The record is clearly legible to someone other than the writer.	100%
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the participant or parent/legal guardian, in advance of treatment. When consent is signed by someone other than the participant or parent, the record contains legal documentation to verify that the consent was given by the appropriate person.	75%
The record contains documentation that the provider informed the participant of all of the following: the purpose and nature of an evaluation or treatment process; the additional options to the proposed treatment; the potential reactions to the proposed treatment; the right to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal; and the fees for service, including that Maryland Medicaid are exempt from any additional out-of-pocket fees (when additional fees are listed).	30%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/legal guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	67%
The record contains an individualized assessment, completed by the provider.	97%
The assessment includes the participant or family's presenting problem.	78%
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.	68%
The assessment contains a complete mental status exam.	73%
The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	22%
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	40%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	72%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	0%
For children and adolescents: The assessment documents prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual, and academic).	38%
The assessment documents both spiritual and cultural variables that may impact treatment.	40%
The record documents the presence or absence of relevant legal issues of the participant and family.	57%
For participants 12 and older: The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.	48%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	80%

Each treatment plan (initial and update) is individualized.	82%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; measurable short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.	32%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; and signature by both the provider and either the participant or parent/legal guardian.	3%
All progress/contact notes document the start time and end time the service was rendered.	73%
All progress/contact notes document the location where service was rendered.	42%
All progress/contact notes document clearly who is in attendance during each session.	82%
All progress/contact notes document the participant's mental status.	65%
All progress/contact notes contain a summary of interventions.	65%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	57%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	5%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention when an active risk is identified.	42%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	2%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	17%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	50%
Overall Average	56%

Individual Provider: LCSW-C	
Quality Line Item	**Average Score**
Each participant has a separate record.	91%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	38%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	87%
The record is clearly legible to someone other than the writer.	93%
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the participant or parent/legal guardian, in advance of treatment. When consent is signed by someone other than the participant or parent, the record contains legal documentation to verify that the consent was given by the appropriate person.	82%
The record contains documentation that the provider informed the participant of all of the following: the purpose and nature of an evaluation or treatment process; the additional options to the proposed treatment; the potential reactions to the proposed treatment; the right to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal; and the fees for service, including that Maryland Medicaid are exempt from any additional out-of-pocket fees (when additional fees are listed).	18%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/legal guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	54%
The record contains an individualized assessment, completed by the provider.	69%
The assessment includes the participant or family's presenting problem.	67%
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.	60%
The assessment contains a complete mental status exam.	35%
The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	15%
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	45%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	42%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	0%
For children and adolescents: The assessment documents prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual, and academic).	58%
The assessment documents both spiritual and cultural variables that may impact treatment.	40%
The record documents the presence or absence of relevant legal issues of the participant and family.	49%
For participants 12 and older: The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.	40%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	51%

Each treatment plan (initial and update) is individualized.	65%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; measurable short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.	7%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; and signature by both the provider and either the participant or parent/legal guardian.	0%
All progress/contact notes document the start time and end time the service was rendered.	84%
All progress/contact notes document the location where service was rendered.	27%
All progress/contact notes document clearly who is in attendance during each session.	93%
All progress/contact notes document the participant's mental status.	42%
All progress/contact notes contain a summary of interventions.	64%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	100%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	27%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention when an active risk is identified.	44%
When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing provider.	0%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	75%
Overall Average	49%

Outpatient Mental Health Center (OMHC)	
Quality Line Item	**Average Score**
Each participant has a separate record.	100%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	80%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	100%
The record is clearly legible to someone other than the writer.	100%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	68%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	35%
For participants being prescribed medication by this provider: The record contains documentation that the provider educated the participant and parent/legal guardian about the risks, benefits, side effects, and alternatives of each medication, and the participant or parent/legal guardian understands the medication(s) being prescribed.	100%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	72%
The record contains an individualized assessment.	84%
The assessment includes the participant or family's presenting problem.	88%
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.	88%
The assessment contains a complete mental status exam.	88%
The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	56%
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	84%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	92%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	0%
For children and adolescents: The assessment documents prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual, and academic).	75%
The assessment documents both spiritual and cultural variables that may impact treatment.	32%
The record documents the presence or absence of relevant legal issues of the participant and family.	72%
For participants 12 and older: The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.	71%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	80%

Each treatment plan (initial and update) is individualized.	84%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.	52%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; signature by both the provider and either the participant or parent/legal guardian; and that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined. For OMHC: If medications are prescribed through the OMHC, each treatment plan (initial and review) is signed by the therapist and the prescriber.	40%
All progress/contact notes document the start time and end time the service was rendered.	88%
All progress/contact notes document the location where service was rendered.	100%
All progress/contact notes document clearly who is in attendance during each session.	92%
All progress/contact notes document the participant's mental status.	100%
All progress/contact notes contain a summary of interventions.	64%
All progress/contact notes document that services were rendered appropriate to the level of care/program, and in accordance with the treatment plan.	100%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	100%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	44%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	100%
Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.	100%
If the participant was prescribed a controlled substance, there was evidence in the record the prescriber utilized the Chesapeake Regional Information System for our Patients (CRISP) prior to prescribing.	80%
If the participant is on medication, there is evidence of medication monitoring in the treatment record.	100%
When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing provider.	0%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	50%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	100%
Overall Average	76%

SUD Level 1 Outpatient Program (SUD OP)	
Quality Line Item	**Average Score**
Each participant has a separate record.	88%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	28%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	80%
The record is clearly legible to someone other than the writer.	90%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	30%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	23%
For participants receiving substance use treatment from this provider: The 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 refused to sign the form.	46%
For uninsured participants: The record contains a completed MDH Documentation for Uninsured Eligibility Registration form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.	0%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	53%
The record contains an individualized assessment.	70%
The assessment includes the participant's presenting problem.	80%
The assessment includes the diagnosis, based on DSM-V.	80%
The assessment contains a complete mental status exam.	70%
The record contains comprehensive documentation of the participant's medical history, including the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	28%
The record contains comprehensive documentation of the participant's behavioral health history, including: the dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	58%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	70%
The assessment documents both spiritual and cultural variables that may impact treatment.	16%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	62%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment, and is enrolled in the recommended level of substance use treatment.	42%
The assessment contains referrals for physical and mental health services.	41%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate; and received infectious health education.	34%

An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	90%
Each treatment plan (initial and update) is individualized.	70%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; a schedule of clinical services, including individual, group, and family; and discharge/transition planning (when applicable).	20%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: progress towards goals; signature by both the provider and either the participant or parent/legal guardian; that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined; and was reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	10%
All progress/contact notes document the start time and end time the service was rendered.	80%
All progress/contact notes document the location where service was rendered.	20%
All progress/contact notes document clearly who is in attendance during each session.	90%
All progress/contact notes document the participant's mental status.	67%
All progress/contact notes contain a summary of interventions.	80%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	80%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	50%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	30%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	34%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	81%
The record contains evidence that toxicology tests were ordered, and the results.	53%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	11%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	10%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	11%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes: documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	36%
Overall Average	53%

SUD Level 2.1 Intensive Outpatient Program (SUD IOP)	
Quality Line Item	**Average Score**
Each participant has a separate record.	88%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	42%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	59%
The record is clearly legible to someone other than the writer.	89%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	37%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	34%
For participants receiving substance use treatment from this provider: The 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 refused to sign the form.	53%
For uninsured participants: The record contains a completed MDH Documentation for Uninsured Eligibility Registration form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.	0%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	28%
The record contains an individualized assessment.	57%
The assessment includes the participant's presenting problem.	75%
The assessment includes the diagnosis, based on DSM-V.	62%
The assessment contains a complete mental status exam.	53%
The record contains comprehensive documentation of the participant's medical history, including the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	27%
The record contains comprehensive documentation of the participant's behavioral health history, including: the dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	55%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	70%
The assessment documents both spiritual and cultural variables that may impact treatment.	24%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	58%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment, and is enrolled in the recommended level of substance use treatment.	52%
The assessment contains referrals for physical and mental health services.	40%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate; and received infectious health education.	33%

An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	71%
Each treatment plan (initial and update) is individualized.	59%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; a schedule of clinical services, including individual, group, and family; and discharge/transition planning (when applicable).	14%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: progress towards goals; signature by both the provider and either the participant or parent/legal guardian; that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined; and was reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	5%
All progress/contact notes document the start time and end time the service was rendered.	74%
All progress/contact notes document the location where service was rendered.	23%
All progress/contact notes document clearly who is in attendance during each session.	87%
All progress/contact notes document the participant's mental status.	63%
All progress/contact notes contain a summary of interventions.	66%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	76%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	48%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	25%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	40%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	64%
The record contains evidence that toxicology tests were ordered, and the results.	57%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	22%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	15%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	21%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes: documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	40%
Overall Average	50%

SUD Level 2.5 Partial Hospitalization Program (SUD PHP)	
Quality Line Item	**Average Score**
Each participant has a separate record.	100%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	100%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	67%
The record is clearly legible to someone other than the writer.	100%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	67%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	33%
For participants receiving substance use treatment from this provider: The 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 refused to sign the form.	67%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	10%
The record contains an individualized assessment.	93%
The assessment includes the participant's presenting problem.	93%
The assessment includes the diagnosis, based on DSM-V.	87%
The assessment contains a complete mental status exam.	87%
The record contains comprehensive documentation of the participant's medical history, including the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	33%
The record contains comprehensive documentation of the participant's behavioral health history, including: the dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	80%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	87%
The assessment documents both spiritual and cultural variables that may impact treatment.	73%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	67%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment, and is enrolled in the recommended level of substance use treatment.	73%
The assessment contains referrals for physical and mental health services.	83%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate; and received infectious health education.	33%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	87%

Each treatment plan (initial and update) is individualized.	87%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; a schedule of clinical services, including individual, group, and family; and discharge/transition planning (when applicable).	0%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: progress towards goals; signature by both the provider and either the participant or parent/legal guardian; that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined; and was reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	0%
All progress/contact notes document the start time and end time the service was rendered.	93%
All progress/contact notes document the location where service was rendered.	33%
All progress/contact notes document clearly who is in attendance during each session.	93%
All progress/contact notes document the participant's mental status.	100%
All progress/contact notes contain a summary of interventions.	60%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	87%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	71%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	67%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	87%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	80%
The record contains evidence that toxicology tests were ordered, and the results.	87%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	71%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes: documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	0%
Overall Average	66%

Psychiatric Rehabilitation Program for Adults (PRP-A)	
Quality Line Item	**Average Score**
Each participant has a separate record.	98%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	63%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	53%
The record is clearly legible to someone other than the writer.	98%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	70%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	80%
For PRP-A/M: The record contains documentation of entitlements that the participant receives, including amounts; that the participant or parent/legal guardian applied for the entitlements for which the participant may be eligible, including the outcome; and how the program assisted the participant or parent/legal guardian in applying for entitlements, if the application was not already submitted.	63%
For PRP-A/M: The record contains a referral for PRP services by a licensed mental health professional (who provides inpatient, residential, or outpatient services to the participant prior to referral and while enrolled in PRP services), that includes a diagnosis and date of diagnosis.	65%
For PRP-A/M: The record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the referring licensed mental health professional.	13%
For uninsured participants: The record contains a completed MDH Documentation for Uninsured Eligibility Registration form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.	50%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	74%
For PRP-A/M and Mobile Treatment: The record contains a screening assessment, to determine whether services are medically necessary.	62%
For PRP-A/M: The record contains documentation that the determination of appropriateness and admission to the program, following screening, was provided in writing to the participant or parent/legal guardian.	21%
The record contains an individualized assessment.	85%
The assessment includes the participant or family's presenting problem.	80%
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.	75%
The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	45%
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	63%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	80%
The assessment documents both spiritual and cultural variables that may impact treatment.	40%

The record documents the presence or absence of relevant legal issues of the participant and family.	93%
For participants 12 and older: The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.	70%
For PRP-A/M: The assessment includes documentation of the participant's age and strengths, skills, and needs for age-appropriate domains.	68%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	83%
Each treatment plan (initial and update) is individualized.	73%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.	50%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; signature by both the provider and either the participant or parent/legal guardian; and that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined.	25%
All progress/contact notes document the start time and end time the service was rendered.	85%
All progress/contact notes document the location where service was rendered.	73%
All progress/contact notes document clearly who is in attendance during each session.	85%
All progress/contact notes contain a summary of interventions.	73%
All progress/contact notes document that services were rendered appropriate to the level of care/program, and in accordance with the treatment plan.	73%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	50%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	50%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	25%
For PRP-A/M: The record contains monthly progress notes, which documents achievement of progress towards goals, incorporating the perspective of the participant and involved staff; changes in the participant's status; and a summary of rehabilitation services and interventions provided.	20%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.	23%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	25%
Overall Average	61%

Psychiatric Rehabilitation Program for Minors (PRP-M)	
Quality Line Item	**Average Score**
Each participant has a separate record.	100%
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.	70%
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.	80%
The record is clearly legible to someone other than the writer.	100%
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.	50%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	100%
For PRP-A/M: The record contains documentation of entitlements that the participant receives, including amounts; that the participant or parent/legal guardian applied for the entitlements for which the participant may be eligible, including the outcome; and how the program assisted the participant or parent/legal guardian in applying for entitlements, if the application was not already submitted.	20%
For PRP-A/M: The record contains a referral for PRP services by a licensed mental health professional (who provides inpatient, residential, or outpatient services to the participant prior to referral and while enrolled in PRP services), that includes a diagnosis and date of diagnosis.	60%
For PRP-A/M: The record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the referring licensed mental health professional.	35%
For uninsured participants: The record contains a completed MDH Documentation for Uninsured Eligibility Registration form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.	50%
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.	75%
For PRP-A/M and Mobile Treatment: The record contains a screening assessment, to determine whether services are medically necessary.	26%
For PRP-A/M: The record contains documentation that the determination of appropriateness and admission to the program, following screening, was provided in writing to the participant or parent/legal guardian.	0%
The record contains an individualized assessment.	55%
The assessment includes the participant or family's presenting problem.	70%
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.	44%
The assessment contains a complete mental status exam.	0%
The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.	15%
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.	70%
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.	70%

For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	46%
For children and adolescents: The assessment documents prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual, and academic).	45%
The assessment documents both spiritual and cultural variables that may impact treatment.	30%
The record documents the presence or absence of relevant legal issues of the participant and family.	65%
For participants 12 and older: The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.	77%
For PRP-A/M: The assessment includes documentation of the participant's age and strengths, skills, and needs for age-appropriate domains.	45%
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.	70%
Each treatment plan (initial and update) is individualized.	60%
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.	0%
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; signature by both the provider and either the participant or parent/legal guardian; and that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined.	6%
All progress/contact notes document the start time and end time the service was rendered.	80%
All progress/contact notes document the location where service was rendered.	90%
All progress/contact notes document clearly who is in attendance during each session.	95%
All progress/contact notes contain a summary of interventions.	89%
All progress/contact notes document that services were rendered appropriate to the level of care/program, and in accordance with the treatment plan.	95%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	50%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	42%
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.	40%
For PRP-A/M: The record contains monthly progress notes, which documents achievement of progress towards goals, incorporating the perspective of the participant and involved staff; changes in the participant's status; and a summary of rehabilitation services and interventions provided.	20%
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.	0%
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented. For PRP-A/M: May not score N/A	20%
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.	50%
Overall Average	54%