

<p style="text-align: center;">QUALITY OF DOCUMENTATION</p> <p style="text-align: center;">IOP</p>	<p style="text-align: center;"><u>GUIDELINES FOR SCORING INDIVIDUAL RECORDS</u></p> <p style="text-align: center;">1 = Poor, 2 = Below Standard, 3 = Standard, 4 = Above Standard, 5 = Excellent</p> <p style="text-align: center;">Y = Meets Standard N = Does Not Meet Standard</p> <p style="text-align: center;">N/A = Not Applicable</p>	<p style="text-align: center;">GUIDELINES FOR DETERMINING PROGRAM COMPLIANCE WITH STANDARDS</p> <p style="text-align: center;"><i>Programs are expected to strive to achieve all quality of documentation standards in 100% of the instances. Programs that are compliant in less than 75% of the charts reviewed will be required to develop a Program Improvement Plan (PIP) in conjunction with the CSA, ValueOptions®, MHA, or any other auditing agency.</i></p>
<p>1. Has the consumer (or their legal guardian) consented to treatment? 10.21.17.04 A</p>	<p>Y = Consent for services is documented by signature of the consumer or, when applicable, legal guardian. In instances when this is not possible, the program shall document the reasons why the individual cannot give written consent; verify the individual's verbal consent; and document periodic attempts to obtain written consent.</p> <p>N = Consent for treatment is not present in the chart OR there is a consent form signed by an individual as the consumer's guardian, but there is no documentation to support this individual's ability to sign as legal guardian.</p>	<p>75% of all medical records reviewed have documented consent for services.</p>
<p>2. If the consumer is a child for whom courts have adjudicated their legal status or an adult with a legal guardian, are there copies of court orders or custody agreements? 10.21.17.08 B (10) 10.21.17.04 A (1)(c)</p>	<p>Y = Court orders and custody agreements regarding healthcare decision-making are present in the chart OR there is a letter from the agency naming a specific person to make healthcare decisions, If an agency such as DSS has custody.</p> <p>N = There are no court orders or custody agreements establishing healthcare decision-making responsibility present in the medical record.</p> <p>N/A = The consumer is an adult without a guardian or a minor child in the care/custody of his/her biological parent(s).</p>	<p>75% of all applicable medical records reviewed have the required documentation necessary to confirm custody and health-care decision-making authority by the guardian consenting to treatment</p>

<p>3. Is there documentation present indicating that the consumer (over the age of 18) has been given information on making an advance directive for mental health services? 10.21.17.04 C</p>	<p>1 = There is no documentation in the medical record indicating that the provider has given the consumer information about advanced directives.</p> <p>2 = There is documentation that the consumer has received information about advanced directives either verbally or in writing, but not both.</p> <p>3 = There is documentation that the consumer was given information on making an advance directive OR documentation that the consumer declined assistance with or making an advanced directive.</p> <p>4 = There is documentation in the medical record that the consumer received information on making an advanced directive, there is documentation as to whether or not the consumer has a current directive, or staff has been assigned to assist the consumer with making a directive if so requested OR documentation that the consumer declined assistance with or making an advanced directive.</p> <p>5 = There is documentation in the medical record that the consumer has been given information on advanced directives by the provider, staff was assigned to assist the consumer in making a directive, and/or a copy of their advance directive is included in the record OR documentation that the consumer declined assistance with or making an advanced directive.</p> <p>N/A = The consumer is a child/adolescent under the age of 18.</p>	<p>75% of all medical records reviewed have a score of 3 or better and have documented information that the consumer has received information on advanced directives.</p>
<p>4. Is the consumer receiving a minimum of three (3) hours of IOP therapeutic services per day? 10.21.20.04 E (2) (a)</p>	<p>Y= IOP services are delivered by a multidisciplinary team for a minimum of 3 hours of therapeutic services per day.</p> <p>N= IOP services are not delivered by a multidisciplinary team for a minimum of 3 hours of therapeutic services per day.</p>	<p>75% of all medical records reviewed have a score of 3 or above and contain documentation that IOP services are provided by a multidisciplinary team at a minimum of 3 hours per day.</p>
<p>5. Do daily IOP therapeutic services include at least two (2) group therapies and as needed, physician services? 10.21.20.04 E (2) (b) (i-ii)</p>	<p>Y = The consumer receives IOP services that include at least two (2) group therapies (required) and physician services (as needed).</p> <p>N = The consumer does not receive IOP services that include at least two (2) group therapies (required) and physician services (as needed).</p>	<p>75% of all medical records reviewed have a score of 3 or above and contain documentation that IOP services include at least 2 group therapies (required) and physician services (as needed).</p>

<p>6. Does the diagnosis match the Utilization Guidelines for the Target Population and is there supporting documentation for establishing medical necessity? 10.21.25.03 (19) & (20)</p>	<p>1 = There is no diagnosis in the record OR the diagnosis was made by an individual unlicensed to do so.</p> <p>2 = A diagnosis has been assigned, but with no information in record regarding symptoms, behaviors or history of occurrence.</p> <p>3 = Present in the record is a diagnosis that meets target population for the PMHS as outlined in the Utilization Guidelines AND there is clear documentation of the rationale for the rendered diagnosis and medical necessity AND the diagnosis was rendered by a professional licensed to do so.</p> <p>4 = Everything in #3 plus there is information in the assessment/mental health professional and/or psychiatrist's notes/ VO CareConnect® that reflects symptoms/ behaviors related to the diagnosis and support for medical necessity.</p> <p>5 = Everything contained in #3 that establishes that the level of care is medically necessary plus an ongoing review process to review treatment effectiveness, and re-organize, reduce, or increase the type/intensity/frequency of services.</p>	<p>75% of all medical records reviewed have a score of 3 or above and have documentation that meets the standard for establishing the diagnosis and medical necessity for services</p>
<p>7. Are screening assessments scheduled and assigned a priority based upon the clinical acuity of the individual's mental health disorder? 10.21.20.05 B</p>	<p>Y = Screening assessments are scheduled within 5 working days of the receipt of a referral for a consumer discharging from an inpatient facility. There is documentation present indicating why an assessment did not occur within the 5 working days. For all other referrals, in collaboration with the medical director, a procedure to review clinical acuity, as described by the referral source, will be developed and screening assessments are scheduled according to the individual's clinical acuity.</p> <p>N = There is no documentation of a referral source and/or date, so there is no way to determine if the screening assessment was scheduled appropriately OR Referrals appear to be scheduled on a "first come, first served basis". Referrals for new consumers who are referred by an inpatient unit are rarely seen within 5 days of the date of referral; or requests for urgent care are routinely referred to an emergency room or mobile crisis program. There is no documentation stating why an assessment did not occur in the required timeframe.</p>	<p>75% of all medical records reviewed have documentation indicating when assessment screenings are scheduled.</p>

<p>8. Is the assessment completed by the 2nd visit? 10.21.20.06 A</p>	<p>Y = There is an assessment present that is dated and was completed by the consumer's 2nd visit. OR there is documentation that an OMS provider had requested an additional visit(s) in which to complete the assessment.</p> <p>N = There is no assessment present; there is no date on the assessment; OR the assessment was not completed by the consumer's 2nd visit.; OR there is no documentation showing an OMS provider requested an additional visit(s) to complete the assessment.</p>	<p>75% of all medical records reviewed document that the assessment was completed by the 2nd visit.</p>
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<p>9. Is there a comprehensive assessment? 10.21.20.06 A(1)(2) & C (2) CMS State Medicaid Manual Part 4 4221 B</p>	<p>1 = There is no assessment in the medical record.</p> <p>2 = The assessment is present, but is missing some of the required components listed below.</p> <p>3 = There is documentation that a licensed mental health professional formulated and documented in the individual's medical record information that includes:</p> <ul style="list-style-type: none"> (a) A description of the presenting problem; (b) Relevant history, including family history and somatic problems; (c) Mental status examination; and (d) A diagnosis and the rationale for the diagnosis; or the reason for not formulating a diagnosis; and a plan, including time frame, for formulating a diagnosis. <p>Additional Assessment for a Minor. In addition to the requirements outlined above, before a minor's fifth visit, the minor's assigned treatment coordinator shall:</p> <ul style="list-style-type: none"> (1) Conduct a face-to-face evaluation with the minor to assess the minor's level of functioning and availability of family and other social supports; and (2) If a comprehensive assessment, that includes the elements listed below, has not been completed within the 6 months before enrollment, assure the completion of an assessment, that includes, at a minimum, the minor's: <ul style="list-style-type: none"> (a) Developmental history; (b) Educational history and current placement; (c) Home environment; (d) Family history and evaluation of the current family status, including legal custody status; (e) Social, emotional, and cognitive development; 	<p>75% of all medical records reviewed have a score of 3 or above, meet the standard for documenting assessments, and have all of the required criteria.</p>
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	<p>(f) Motor, language, and self-care skills development;</p> <p>(g) History, if any, of substance abuse;</p> <p>(h) History, if any, of physical or sexual abuse;</p> <p>(i) History, if any, of out-of-home placements; and</p> <p>(j) Involvement, if any, with the local department of social services or Department of Juvenile Services.</p> <p>4 = Everything in #3 plus a comprehensive assessment process which is individualized, holistic, and accurate. It includes the consumer's current and potential support system, motivation, and goals. The assessment documents a synthesis of the information into an overall picture.</p> <p>5 = Everything in #4 plus the documentation of process for informing the consumer regarding the nature of their illness, the treatment options and effectiveness, and their role in illness management and wellness.</p>	
<p>10. Was a Substance Abuse Screening Assessment completed? <i>10.21.20.06 B</i></p>	<p>Y = There is documentation in the medical record of a face-to-face diagnostic assessment that includes a scientifically validated/age-appropriate screening tool to determine whether or not the individual has a co-occurring substance abuse disorder.</p> <p>N = There is no documentation that a substance abuse screening was performed.</p> <p>N/A = A substance abuse screening was not needed due to age of consumer.</p>	<p>75% of all medical records reviewed have documented that a diagnostic substance abuse screening was performed.</p>

<p>11. Is there evidence of integration of, or collaboration with, Substance Abuse services? 10.21.20.08 D (1)(2)</p>	<p>Y = There is a face-to-face diagnostic assessment conducted using a scientifically validated and age appropriate tool to determine whether the individual has a co-occurring substance abuse disorder and either a referral for substance abuse treatment or an integrated SA/MH rehabilitation/treatment plan.</p> <p>N = There is no documented substance abuse assessment and there is no documented SA/MH integrated treatment plan or a referral to a substance abuse treatment provider.</p> <p>N/A = There is information available from the clinical chart that indicates the consumer does not use substances and has not in the past OR the consumer refuses SA treatment.</p>	<p>75% of all medical records reviewed have documentation of a substance abuse assessment and integration of or collaboration with Substance Abuse services.</p>
<p>12. Was the ITP completed on or before the consumer's 7th visit?</p>	<p>Y = The initial ITP was completed by the individual's 7th visit.</p> <p>N = There is no initial ITP present in the record or the ITP was not completed before the individual's 7th visit.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have documented that an ITP was completed before the 7th visit.</p>

<p>13. Is the ITP reviewed weekly by the individual and the individual's treatment coordinator? 10.21.20.04 E(3)</p>	<p>1 = There are no ITP's in the record or the consumer and/or treatment coordinator did not sign and/or date the ITP.</p> <p>2 = There are signed and dated ITP's in the record but they are not reviewed with the individual every 2 weeks.</p> <p>3 = The individual's ITP is reviewed weekly and is signed and dated by the individual and the individual's treatment coordinator.</p> <p>4 = The individual's ITP is reviewed weekly and is signed and dated by the individual and the individual's treatment coordinator. The consumer's input into the ITP is documented by the consumer/service provider.</p> <p>5 = Everything in #4 plus the treatment coordinator utilizes a person-centered planning process results in an integrated treatment/recovery plan.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have documented that treatment coordinator reviewed the ITP on a weekly basis with the consumer.</p>
<p>14. Does the ITP include the following: diagnosis, presenting needs, strengths, recovery, and treatment expectations and responsibilities? 10.21.20.07 A(1)(b)(i-vi)</p>	<p>Y = The ITP includes all of the following required elements: diagnosis, presenting needs, strengths, recovery, and treatment expectations and responsibilities.</p> <p>N = There is no current ITP in the record OR the ITP present does not contain all of the required elements.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed contain a current ITP with all of the required elements.</p>

<p>15. Does the medical record document active participation in establishing the goals, objectives, and interventions of the ITP and is it documented that the consumer accepted or declined a copy of the ITP? 10.21.20.07 A(4)</p>	<p>1 = There is no ITP in the record or the consumer did not sign/date the ITP.</p> <p>2 = The consumer signed/dated the ITP, but it is not documented that the consumer accepted or declined a copy of the plan.</p> <p>3 = The consumer signed/dated the ITP and it is documented that the consumer received or declined a copy of the plan.</p> <p>4 = The consumer signed/dated the ITP. There is documentation that the consumer accepted/declined a copy of the plan. The consumer's input into the ITP is documented by the consumer/service provider.</p> <p>5 = Everything in #4 plus techniques for assisting consumers and family members in articulating goals and identifying incremental steps for recovery. A person-centered planning process results in an integrated treatment/recovery plan.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for documenting active participation in establishing the goals, objectives, and interventions of the ITP and offering a copy of the ITP to the consumer.</p>
<p>16. Are the ITP goals/objectives related to the assessment? {strengths, symptoms, skill deficits, resources} 10.21.17.08 B (8) 10.21.20.07 A (1)(b)</p>	<p>1 = There is no ITP in the record.</p> <p>2 = Goals/objectives have no relationship to the current assessment.</p> <p>3 = At least 75% of the goals/objectives have been developed directly from the assessment, which identified strengths, symptoms, skills deficits, and resources.</p> <p>4 = <u>All</u> of the goals/objectives have been developed directly from the assessment.</p> <p>5 = Everything in #4 plus a comprehensive assessment is incorporated into the treatment planning process and integrated with consumer and family involvement to result in a treatment services/recovery plan.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the relationship between the goals/objectives of the ITP and the most recent assessment.</p>

<p>17. Does the ITP contain goals/objectives that are individualized, specific and measurable with an achievable timeframe? 10.21.20.07 A (1)(b)(v) CMS State Medicaid Manual Part 4 4221 C</p>	<p>1 = There is no ITP in the record.</p> <p>2 = Goals/objectives are written as general statements with vague language and no measures of accomplishment AND/OR all consumers reviewed in this service have the same goals/objectives.</p> <p>3 = At least 75% of the goals/objectives are written as individualized, specific, and measurable an achievable timeframe. The goals/objectives listed are individualized and not the same for all other consumers reviewed in this service.</p> <p>4 = All goals/objectives are written as individualized, specific and measurable with an achievable timeframe. New and revised objectives reflect changes in the consumer's symptoms, behaviors, emotions, thoughts, or quality of life and are a next step to achieving the long-term goal.</p> <p>5 = All goals/objectives are written in observable terms that can be measured with a timeframe for demonstration. The objectives are individualized to this consumer based on their assessment and directly related to a consumer-driven individualized recovery.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the ITP containing goals, objectives or outcomes that are individualized, specific and measurable with an achievement timeframe</p>
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<p>18. Are the interventions on the ITP congruent with goals/objectives? 10.21.20.07 A (1)(b)(viii)</p>	<p>1 = There is no ITP in the record.</p> <p>2 = Interventions of the ITP are unrelated to the goals/objectives of the IRP (i.e. skill building objective with intervention related to medication compliance).</p> <p>3 = The interventions of the ITP are congruent with the stated goals/objectives.</p> <p>4 = There is a description of needed and desired treatment and congruent interventions to be provided, specifying the modality, frequency, and responsible staff.</p> <p>5 = Interventions named in the ITP reflect evidenced-based or promising practice for consumers with specified diagnosis, symptom profile, and/or psycho-social stressors.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the interventions on the ITP being congruent with goals/objectives.</p>
<p>19. Does the record reflect a transition/discharge plan consistent with the services provided? 10.21.17.10 C ValueOptions® MD Provider Manual</p>	<p>Y = A transition/discharge plan is present that has a recommendation for transition/discharge to a lower level of care that includes the client's functioning at the time of transition/discharge, the supports that will be required at time of transition/discharge, and a timeframe to accomplish the transition/discharge and a transition/discharge plan was developed upon initiation of IOP services.</p> <p>N = There is no transition/discharge plan OR all of the required elements of a discharge plan are not present.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all medical records reviewed meet the standard for the record documenting a transition/discharge date and plan consistent with the services provided.</p>

<p>20. Does the ITP include all required signatures with dates? 10.21.20.07 A (3)</p>	<p>Y = All required signatures; the consumer and/or parent/guardian, treatment team members, and the psychiatrist (if meds are prescribed); with dates, are present OR there is documentation that the consumer verbally agreed to the ITP and the rationale for refusal to sign is also documented.</p> <p>N = A signature and/or date is missing and/or there is no documentation of a verbal agreement or rationale for refusal to sign OR there is no ITP in the record.</p> <p>N/A = The consumer is a new referral and an ITP has not yet been developed.</p>	<p>75% of all applicable medical records reviewed had the required signatures on the ITP.</p>
<p>21. Do the ITP and contact notes reflect recommendations for and/or collaboration with other MH services to support the individuals recovery? 10.21.20.07 A (1)(vi) 10.21.20.09 B</p>	<p>1 = There is no ITP in the record or there are missing contact notes.</p> <p>2 = Clinical information indicates that multiple mental health services are needed or currently being provided and there is no information documented to refer and collaborate with other mental health services.</p> <p>3 = There is documentation showing referrals for or collaboration with other mental health services that the consumer may need or in which the consumer is involved. Examples of documentation could include: an IRP from a PRP AND documentation in a note demonstrating collaboration. (just a copy of an IRP is not enough)</p> <p>4 = There is documentation showing referrals for or collaboration with other mental health services that the consumer may need or in which the consumer is involved. The interventions of the other MH services (e.g. PRP, SEP) are documented in the ITP. There is documentation of face-to-face or telephonic meetings between the OMHC and the other mental health provider(s).</p> <p>5 = In addition to documentation of the other program's service plan and interventions, there is documentation in the contact notes of collaboration regarding jointly planning and implementing changes in the goals and interventions of each service</p> <p>N/A = There are either no additional mental health services needed; OR there is documentation that the consumer has refused referrals/collaboration with other service providers.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the ITP and contact notes reflecting recommendations for and collaboration with other MH services to support the individuals recovery.</p>

<p>22. Are the Contact notes complete? 10.09.59.03 J(1)(2)(3)(4) 10.21.20.07 B (1)(e)(f)(g) CMS State Medicaid Manual Part 4 4221 D 6</p>	<p>1 = There are no contact notes in the record.</p> <p>2 = Contact notes do not contain all of the following items: date, start time, end time (or duration), chief medical complaint/reason for the visit, consumer’s mental status, the delivery of services specified by the ITP, a brief description of the service provided, the plan for changes in treatment (if any), the consumer’s progress towards goals, and a legible signature with job title or MH professional license (if applicable).</p> <p>3 = At least 75% of the reviewed contact notes for the audit period contain all of the listed items above and no contact notes are missing.</p> <p>4 = 100% of the reviewed contact notes <u>for the audit period</u> contain all of the listed items above and no contact notes are missing.</p> <p>5 = 100% of the contact notes <u>in the record</u> contain all of the listed items.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for contact notes being complete.</p>
<p>23. Do Contact Notes reflect goals and interventions on the ITP are being addressed and implemented? 10.09.59.03 (3) 10.21.20.07 B(1)(e)(f)(g) CMS State Medicaid Manual Part 4 4221 D 6</p>	<p>1 = No contact notes document that goals and interventions from the ITP are being addressed and implemented OR the contact notes are missing.</p> <p>2 =Less than 75% of the contact notes document that the goals and interventions are being addressed and implemented.</p> <p>3 = At least seventy-five percent (75%) of the contact notes document that the goals and interventions from the ITP are being addressed and implemented.</p> <p>4 = All of the contact notes document that goals and interventions from the ITP are being addressed and implemented.</p> <p>5 = All contact notes document all of the consumer’s goals and interventions from the ITP and show that all goals/interventions are being addressed and implemented. Changes in interventions or objectives are included in progress/contact notes, and documentation is present as to why specific goals/interventions are not being addressed.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for contact notes reflecting that interventions on the ITP/IRP are being implemented.</p>

<p>24. Do the Contact Notes reflect the consumer's progress towards the goals of the ITP? 10.21.20.07 B(1)(h) CMS State Medicaid Manual Part 4 4221 D 7</p>	<p>1 = No contact notes contain the consumer responses to interventions and their progress towards goals included in the ITP OR there are contact notes that are missing OR there is no ITP.</p> <p>2 = Very few or less than 75% of the contact notes mention consumer responses to the interventions and their progress towards goals mentioned on the ITP.</p> <p>3 = At least seventy-five percent (75%) of the contact notes mention consumer responses to the interventions and their progress towards goals mentioned on the ITP.</p> <p>4 = All contact notes contain staff interventions and consumer responses to the staff's intervention. Changes in interventions or objectives are included in contact notes, as needed.</p> <p>5 = Reviewing progress towards goals and treatment effectiveness with the client includes celebrating success, flagging consumers who are not making progress, and convening a recovery team to reorganize treatment.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the contact notes reflecting the consumer's progress towards the goals of the ITP.</p>
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<p>25. Are the Assessment, ITP, Contact Notes, and discharge/transition plan consistent with the current APS CareConnection® form? <i>ValueOptions® Provider Manual</i></p>	<p>1 = The record is missing an assessment, ITP, or contact notes.</p> <p>2 = Neither the assessment nor any of the goals/objectives relate to the current APS CareConnection®. Contact notes document interventions unrelated to those indicated on the APS CareConnection® or give a different picture than the APS CareConnection® assessment.</p> <p>3 = The assessment and more than half the goals/objectives have correlation to the current APS CareConnection® form and more than half the contact notes reflect staff interventions consistent with those indicated on the APS CareConnection® form. All of the goals and interventions are being addressed through services documented in the medical record OR changes to the plan are documented and why specific goals and interventions will not be addressed.</p> <p>4 = The assessment and <u>all</u> goals/objectives on the ITP are directly related to the current APS CareConnection® and contact notes contain information and interventions matching the APS CareConnection® form.</p> <p>5 = The assessment, all goals/interventions of the ITP, and contact notes contain the same information that is documented on the APS CareConnection® form.</p> <p>N/A = The APS CareConnection® form is an initial authorization, which does not include clinical information.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the assessment, ITP and contact notes being consistent with the current APS CareConnection®.</p>
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<p>26. Is there documentation of the consumer's past and current somatic/medical history and documentation of ongoing communication and collaboration with the PCP? 10.21.20.06 D</p>	<p>1 = There is no documentation regarding the consumer's somatic status, nor is there communication/collaboration with the consumer's PCP (or no referral to for a PCP).</p> <p>2 = There is documentation present regarding the consumer's somatic status, but no documentation of communication/collaboration with the PCP (or no referral for a PCP).</p> <p>3 = A licensed mental health professional has documented pertinent past and current somatic medical history, including:</p> <ul style="list-style-type: none"> a. The individual's somatic health problems, if any; b. Relevant medical treatment, including medication; and c. A recommendation, if needed, for somatic care follow-up; <p>and</p> <p>An exchange of medical information with the primary care provider has been documented OR the plan, if indicated, including the time frame, for the individual's referral to a primary care provider for evaluation and treatment.</p> <p>4 = There is documentation present showing consistent outreach to the consumer's PCP by the provider, but not necessarily information from the PCP.</p> <p>5 = There is documentation present showing consistent outreach to the consumer's PCP by the provider AND documented evidence of information being received from the PCP on a consistent basis.</p>	<p>75% of all medical records reviewed have a score of 3 or above and meet the standard for the evidence of collaboration with a Primary Care Physician.</p>
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