GUIDE TO QUALITY ASSURANCE CHART REVIEW REQUIREMENTS

FOR DIRECTLY-OPERATED PROGRAMS

September 10, 2012

Program Support Bureau
Quality Assurance Division

1.0 Purpose

1.1 To establish a systematic process for reviewing *clinical records* (hereinafter and for purposes of this document referred to as *charts*) to ensure compliance with Federal, State and local laws and regulations and DMH standards, policies and guidelines.

1.2 To ensure that medical necessity criteria is met and drives the specialty mental health services received by the client.

1.3 To provide guidelines for evaluating and monitoring clinical documentation as well as developing processes for enhancing staff training and service delivery.

2.0 Requirements

2.1 All Short-Doyle/Medi-Cal Organizational Providers shall have a Quality Assurance process and a *Quality Assurance Committee* (hereinafter referred to as Committee).

2.2 All Short-Doyle/Medi-Cal Organizational Providers shall have a written description of their QA process which includes their protocol for accomplishing each of the requirements set forth in Section 2.0.

a. The written description shall be approved by the Program Manager and submitted to the Quality Assurance Division.

b. If any substantial changes in the protocol are subsequently made, the QA Division shall be notified of the changes and provided with a copy of the new written description.

2.3 Each Provider shall have a Committee Chairperson who is a licensed MD/DO, NP, PsyD/PhD, LCSW, LMFT, CNS or RN.

2.4 The Committee Chairperson shall be responsible for determining the Committee procedures and membership terms.

a. The Committee shall meet at least monthly to conduct chart reviews.

b. The Committee shall consist of members who are claiming Specialty Mental Health Services throughout the Provider, including supervisory staff.

c. All direct claiming staff regardless of discipline and/or licensure status shall rotate on the Committee in order to maintain consistent membership.

d. Each member shall attend the Committee at least once annually.

2.5 The Committee Chairperson shall serve as a resource person to all agency staff for documentation, procedure codes, and claiming questions.

a. In the event that the Committee Chairperson is unable to respond to a particular QA-related question, the Service Area QA Liaison may be contacted for assistance.

2.6 The Committee Chairperson shall implement a method to ensure 100% of new client charts have the following elements completed at least 15 days prior to the end of the intake period:

- Assessment
- Included diagnosis as the Primary Diagnosis - if the case is to remain open
- Client Care Coordination Plan (CCCP) - if the case is to remain open
- Signature of the Client/Representative on the CCCP - if the case is to remain open

See the Short-Doyle/Medi-Cal Organizational Provider's Manual for the definition and requirements related to Intake Periods.

Note: Utilizing the Brief Screener Log (Attachment 1) is an optional method of ensuring the above elements are completed.

2.7 The Committee shall complete initial intake chart reviews on at least 30% of charts opened at least 15 days prior to the end of the intake period on a quarterly basis.

a. The review shall be based on a random selection of charts and shall include at least one chart from each Primary Contact.

2.8 The Committee shall complete annual chart reviews on at least 5% of charts within one month prior to the cycle month on a quarterly basis.

a. The review shall be based on random selection of charts and shall include at least one chart from each Primary Contact.

b. The Review Period shall be 3 months prior to the Annual Cycle Month. See the Short-Doyle/Medi-Cal Organizational Provider's Manual for the definition and requirements related to the Annual Cycle Month.
Example: If the Annual Cycle Month is April 2012, then the Review Period is January, February, and March of 2012.

2.9 The Committee shall use the Chart Review Tool as the minimum standard for all chart reviews completed by the Committee.

a. The Chart Review Tool may not be altered. However, at the Committee Chairperson's or Program Manager's discretion additional elements may be used to review charts. Any additional element must be attached separately to the tool.

b. The Chart Review Tool may be completed by any staff authorized by the Committee Chairperson. However, those items on the Chart Review Tool that are designated by an asterisk (*) must be completed by an Authorized Mental Health Discipline (AMHD).

c. All staff utilizing the Chart Review Tool shall be familiar with all items on the tool.

2.10 Chart review activities conducted by the Committee shall ensure that the requirements of the following items are met:

a. DMH Policies & Procedures (located on the DMH Website and accessed through the following link: http://dmhhqportal1/sites/DMHPAP)
   - 104.09 – Clinical Documentation: For All Payor Sources
   - 104.08 – Clinical Records: Maintenance, Organization & Contents
   - 104.05 – Closing of Service Episodes

b. Short-Doyle/Medi-Cal Organizational Provider's Manual and the Guide to Procedure Codes (located on the DMH Website and accessed at: http://dmh.lacounty.gov/wps/portal/dmh/admin_tools)

2.11 The Committee Chairperson shall implement a method to address all items found missing or incomplete through the chart review process. (See Section 3.0 Procedures for additional information).

a. Clinical concerns discovered during the course of the chart review shall be reported to the Committee Chairperson, Supervisor, and/or Program Manager for resolution.

b. Concerns involving incomplete medication notes and/or the lack of medication objectives on the Client Care Coordination Plan (CCCP) shall be reported to the Supervising Psychiatrist by the Committee Chairperson, Supervisor or Program Manager.

2.12 The Committee Chairperson shall maintain an ongoing QA log of all reviewed charts with the following identification information of each chart:
- Client's name
- Review date
- Review period
- Type of review (e.g., Initial Intake, Annual)

2.13 The QA Chairperson on a quarterly basis shall submit the following documents to the DMH QA Division via fax (213-252-8776) or email (QA@dmh.lacounty.gov):
- Quarterly Monitoring Report including a brief report of chart review trends, findings and plans of action (see Section 2.14).
- Five (5) completed Chart Review Tools WITHOUT any client identifiable information (i.e. redact client name and IS number).

2.14 The Committee Chairperson and Program Manager shall implement a process of analyzing outcomes of chart reviews to identify any trend(s) and/or charting deficiencies. Such analyses shall be recorded along with the plan for using this information to improve ongoing charting/documentation practices.

a. This process may be a component of the QA Process or a separate Quality Improvement Process / Committee.

2.15 No reference to the QA process shall be made within the clinical record.

2.16 All materials generated through the QA process shall be safeguarded against unauthorized access.

2.17 All Chart Review Tools, along with all materials related to the QA process, must be stored in an administrative file and maintained for three years.

2.18 Committee members shall claim for QA activities in accord with the Quality Assurance Reimbursable Guide.

3.0 Procedures

3.1 The Committee Chairperson provides the Direct Service Detail Report from the STATS Dashboard or other appropriate IS Report for the Review Period for each chart being reviewed..

3.2 All items on the Chart Review Tool, including those to be performed only by an AMHD, are reviewed by the Committee.

3.3 The Committee Chairperson refers items found to be missing or incomplete (i.e. follow-up items) to the Supervisor of the Primary Contact.

3.4 The Supervisor addresses follow-up items with Primary Contacts in order to identify the most effective plan of action and verifies the plan of action has been completed in accord with DMH Policy No. 106.08 – Clinical Rehabilitative and Case Management Service Delivery Supervision.

3.5 Any unresolved follow-up items shall be referred to the Program Manager for resolution.

4.0 Authority

4.1 Committee activities are conducted according to the:

a. Health Insurance Portability and Accountability Act (HIPAA) under Health Care Operations, as noted in the Los Angeles County DMH Notice of Privacy Practices;

b. DMH Policy and Procedure 104.09 Clinical Documentation: For All Payor Sources;

c. DMH Policy and Procedure 104.08 Clinical Records: Maintenance, Organization & Contents; and

d. State Contract with the Department of Health Care Services (DHCS).

BRIEF SCREENER LOG

Program Support Bureau
Quality Assurance Division
County of Los Angeles – Department of Mental Health

New Admissions (IS#)	Admit Date	Date Initial Assessment completed	Does client have an Included Dx?	Date CCCP completed	Did client or representative sign the CCCP?	Date all intake elements completed	Primary Contact's Signature
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							