

**LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU**

**CLINICAL RECORD PREPARATION INSTRUCTIONS
SYSTEM REVIEW OUTPATIENT CHART AUDIT
CONDUCTED FEBRUARY 25-28 and MARCH 4-7, 2013**

These instructions are designed to assist providers in preparing their client record(s) for the System Review Outpatient Audit of Clinical Records noted above. The Reasons for Recoupment should also be helpful in this respect. The Department needs your cooperation in preparing for this audit in accord with these instructions to ensure the client record(s) are “reviewer friendly,” and that relevant information is as easy as possible for the auditors to find. **If State reviewers are unable to find information that is critical to the support of a paid claim at the time of the audit, the service will be disallowed. Providers will not be allowed to submit additional information supporting claims once the audit has begun and the Department will not be able to appeal disallowances that were based on information not found in the record at the time of the audit.**

This will be a hard-copy, paper record audit. Any Contract provider using an Electronic Medical Record (EMR) must provide a hard-copy, paper record for the audit. EMRs will not be reviewed during the Chart Audit. All documentation and supporting documentation related to services provided to a client during the audit period must be printed and provided in hard-copy format. This minimally must include the documents identified in the Preparation of Records section of this document. Any documents where the signature was obtained electronically via electronic signature must have a notation on the printed documentation that the document was signed electronically. Any questions related to the printing of an EMR for this audit should be directed to Charles Onunkwo, the LACDMH Health Information Management Assistant Director at (213) 251-6722 or conunkwo@dmh.lacounty.gov.

BACKGROUND/OVERVIEW

- State DMH will conduct the audit.
- The audit will be guided by **MHSD Information Notice No. 12-05** (Attachment #1) which includes these related materials:
 - Reasons for Recoupment (Attachment #1A)
 - Section J of the Review Protocol – used to audit all claims (Attachment #1B)
- The audit will be conducted at DMH Headquarters Annex, 695 S. Vermont, 15th Fl. Training Conference Room.
- **Audit Sample Information**
 - The State will randomly draw 80 adult and child clients from the entire Los Angeles service delivery system.
 - All claims regardless of service provider (direct or contract), within the audit period, will be audited for **each of the individual clients** in the State’s sample list.
- **Reasons for Recoupment** (Attachment to DMH Information Notice #12-05)
 - Only the Federal Financial Participation (FFP) will be recouped.
 - Be aware that while a particular claim may be supported by a good note, if the record does not clearly establish Medical Necessity for services or does not have a Client Care Coordination Plan (CCCP) covering the audit period, the claim will be disallowed by the auditors.

- **All Providers having records audited will be invited to the Exit Conference.** All Providers with records in the audit having disallowances should attend the Exit Conference. Other Providers will also find the information regarding the findings from the audit a helpful learning experience and are welcome to attend. The Exit Conference will be at DMH Headquarters, 695 S. Vermont Avenue, 7th floor Conference Room on March 7th from 9:00 to 11:00 a.m. There will NOT be an Entrance Conference.

PREPARATION OF RECORDS

If the record submitted is a paper copy of an electronic record, the cover of the record must note that this is a paper copy of an electronic record. Flag the following information in each record so that the auditors may easily find the required information. With the exception of “accommodations for clients with cultural/linguistic and/or hearing/visual issues”, the Consent for Medications, and Client Face Sheet as noted below, the absence of any of this information will result in an audit exception.

How to Color Code/Flag the Record (Attachment #2)

- The **Client Face Sheet** must be flagged with an **orange post-it**. Agencies with EMRs may submit a **report that includes the same data elements as the face sheet**.
- **Medical Necessity** – the auditors will be looking for all 3 criteria:
 - **Diagnosis** – it should be located and flagged with a **red post-it** on one of two documents: the Assessment or the Diagnosis Information Form (or, previously, Change of Diagnosis Form). If the individual has received ongoing services, the diagnosis should be consistent with a Medi-Cal Included Diagnosis (Attachment 2). There should be no case with a deferred diagnosis when ongoing services were provided.
 - **Evidence of Life Functioning Impairment/Risk of Deterioration** – there should be documentation within the last year that demonstrates the client’s impairments. Flag this information with a **red post-it**. If impairments are not clearly documented within the last year, services may be at risk of disallowance.
 - **Intervention** – Not on card. See Progress Notes for Mental Health, Targeted Case Management, and Medication Support Services below..
- **Service Direction** – services must be delivered under the direction of an Authorized Mental Health Discipline (AMHD): licensed MD/DO, certified NP, registered CNS, registered RN, licensed or waived PhD/PsyD, LCSW or registered/waivered ASW, and licensed MFT or registered/waivered MFT. If the staff signing the CCCP is one of these disciplines, the **red arrow post-it** should flag this signature.
- **Assessment and Addendums** – that cover services during the audit period should be complete and flagged with a **red post-it**. The Annual Assessment prior to the audit period should also be flagged with a **red post-it**.
- **CCCP(s)** – Required for all services by the end of the initial two-month Intake Period or within one month for clients with existing open episodes anywhere within the Los Angeles County DMH system of care. If the service was a one-time type of service, it does not need to be on the Client Care Page. However, if the service was provided again, it must be on a Client Care Page. All CCCP(s) covering the audit period and the CCCP prior to the audit period should be flagged with a **green post-it**

- **Client Participation in and Agreement with the CCCP** – is a critical element in the service planning process. If the client or another individual involved in the client’s care (such as a parent or guardian) has signed the CCCP, the State accepts this as documentation of participation/agreement, so flag this signature with a **green arrow post-it**. If this individual has not signed the CCCP, the green arrow must be placed with the Progress Note indicating the individual’s participation/agreement with the CCCP.
- **Progress Notes for Mental Health, Targeted Case Management, and Medication Support Services** – every note should be identified by the date of service, the Procedure Code, the duration of service for each staff involved in the service, and, for groups, the number of “clients represented.” The content of the note should include the interventions, that is, what was attempted or accomplished toward the goals/milestones established on the CCCP or a description of what was necessary at the time the service was delivered. A connection must be clear between the intervention and diminishing the impairment or preventing a significant deterioration. All Progress Notes must be signed by the staff person who wrote the note along with his/her discipline or title and, if applicable, the registration, certification or license number of the staff person (per QA Bulletin 12-06). The first note after first day of Audit Period through the last date of Audit Period should be flagged with a **blue post-it**. Note: Directly-Operated Providers will have to flag the audit period in both the Progress Note (Section 6) and Medication Support Service Notes (Section 8) of the Clinical Record. Contract Agencies which keep Medication Support Notes separate from Progress Note should also flag both sections.
- **Consent for Medications** – the consent for medications that covers the audit period for client’s prescribed medications should be flagged with a **yellow post-it**. For Directly-Operated programs, the Outpatient Medication Review form is the consent for medications.
- **Accommodations for clients with cultural/linguistic and/or hearing/visual issues** – if a client(s) selected for audit has any cultural, linguistic, hearing or visual issues that could limit or prevent access to services, documentation demonstrating accommodations were provided to allow for successful access to services and resources should be flagged with a **purple post-it**.

ANCILLARY FOLDERS

Each DMH client record that is submitted must be accompanied by an Ancillary Folder **labeled with the Client’s Name and IS number**.

- **Attachment #3.**

SUBMISSION, RETURN, AND SECURITY OF RECORDS

The Provider Chart Tracking Log contains these three elements in sequence: (Attachment #4)

- **List of client names for which records must be submitted for the audit.** If the client has multiple volumes, **PLEASE BE SURE TO SUBMIT ALL VOLUMES THAT HAVE RELEVANT INFORMATION ON THE CLIENT AND HIS/HER SERVICES DURING THAT AUDIT PERIOD OF** Audit Period that include all of the elements requested in the previous section.

- **Provider Contact Information:** Each Provider must identify a contact person should questions arise while their records are being audited. This person should be one who is knowledgeable regarding the Provider's records and documentation practices and should be one who can be available to come to 695 S. Vermont (DMH Headquarters Annex) on short notice during the audit.
- **Upcoming appointments:** To minimize impact on service delivery, if a record will be needed at the Provider prior to the end of the audit on March 6, 2013 specify the specific date and time the record is needed in the log. Unless a client is coming in for an appointment the morning of the first day of the audit, we anticipate being able to make records available for the Provider to pick-up if they are needed during that week. *We also recommend that providers copy relevant progress notes and other necessary information on those client records that have appointments during the audit period.* **Please also bring this information to the attention of the QA staff when the record is delivered.**

In accord with Department Policy, all records must be transported to QA at DMH Headquarters Annex in secured containers. The records should be placed in the order of the names on the Chart Tracking Log. Instructions are provided on the Tracking Log indicating to whom, where, and when records and ancillary information must be submitted. Providers must bring this Tracking Log with them when they submit their records. The QA staff will sign the records in and give the Provider a copy of the Tracking Log as a receipt. The recommended staff to bring in charts include: Program Head, Head of Service, Supervising Clinician, QA Coordinator. Provider *administrative staff will not be allowed to drop off records*. Delivery service staff will also not be allowed to drop off records. Staff dropping records should be prepared to remain at the office while the records are reviewed. Providers with 1-2 records may drop off their records and the Tracking Log at the end of their assigned workshop. QA staff will be available to review records and provide a copy of the Tracking Log as a receipt. The completed Ancillary Folder must also accompany the records.

The QA staff will review records when they are delivered to DMH Headquarters to ensure that records have been flagged and all information required for the Ancillary Folder has been included. QA staff will be responsible for securing records upon their delivery and during the course of the audit.

QA staff will return records directly to any Provider who attends the Exit Conference. All other records will be returned to Providers upon Provider pick-up from the QA Division. Staff picking up records will be required to sign for receipt of the records.