

HELPFUL HINTS FOR PASSING A CHART AUDIT

By

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In November 2007, CHN increased the amount of provider oversight and monitoring for our network by formalizing a chart audit process. Each month we are requesting a total of 8 charts from our provider network to randomly evaluate the quality of care and documentation for our Members. In addition, we also do chart audits at our Community Mental Health Center's (i.e, CMHC) to measure contract compliance. Finally, there are additional times we may ask our providers to send in their medical records which may be prompted by retro-authorization requests, claim irregularity, or consumer feedback. There is a high probability that you will be asked to participate in a chart audit. This summary document hopefully will help you understand what we are looking for, and thus make your audit process less stressful.

As a Managed Care organization responsible for the services to the Medicaid population, we endorse a brief, solution focused model of treatment. This is consistent with concepts of Recovery and self sufficiency for our members.

1. In a Chart we will first look at the diagnostic formulation or assessment process. In this process we are looking for symptoms that the member has presented to you for help. We look to see if the symptoms you identify are consistent with the diagnosis you have given the client. Be careful to avoid over using "BY HISTORY" diagnoses. When it is possible, avoid R/O (rule out diagnosis) and NOS (not otherwise specified diagnosis). Your assessment section should include precipitating stressors and provide a current mental status exam. Please document your initial risk assessment, and establish a protocol to assess risk throughout the course of treatment.

2. Next we look at your treatment plan. We are looking to see if measurable goals and timeframes have been established. We are looking to see your plan for bringing your client toward recovery, and suggest you incorporate patient strengths and resources as a part of this plan. Without a measurable and objective goal, we do not know when therapy is "done". Without a time frame, we do not know how to mark progress toward that discharge. *HINT:* Have your client sign the established treatment plan which indicates that the plan was agreed upon, and that you are working collaboratively towards the same end point.

3. The progress notes should obviously be dated and signed. The content of the note(s) should identify interventions that are being tried to obtain the goals established and written in the treatment plan (See #2). Some therapists use a D.A.P. or S.O.A.P. format for writing their progress notes. We find that most of the charts that use this kind of format pass the audit with ease.

4. Do not forget the demographics. This includes Medicaid #, Gender of Client, and emergency contact for patient. Make sure that patient consent forms are signed, member's rights are incorporated in disclosure statements, and release of information forms are used when coordinating care with outside agencies or personnel.

You are not in this alone. CHN has developed forms for your perusal that will help you meet the documentation requirements outlined above. You can access the Chart Audit tool that we employ, and the forms we have developed on this website.

<http://www.chnpartnerships.com>. You may also contact a Care Manager at 1-800-804-5008 for consultation and suggestions regarding diagnostics, treatment planning, and medical record charting.