CHART REVIEW CHECKLIST

For Review of Legal Entity (LE) Contract Provider Clinical Records

Date of Review: _____ **LE Name:** _____ **LE Number:** _____

Provider Number: _____ **Name of Reviewer:** _____

Client ID or Assigned # for Redacted Record: _____ **Review Period:** Start Date _____ End Date _____

REQUIREMENT	YES	NO	N/A	COMMENTS
Assessment/ Diagnosis				
1. Is there a current finalized Full Assessment/Initial Assessment or Re-Assessment?	☐	☐		
2. Are all the required elements of the most recent assessment completed based on the <u>type</u> of most recent assessment?	☐	☐		
3. <u>Medical Necessity</u>: Is there an included ICD-10 primary diagnosis covering the review period? a. If no, was a Notice of Adverse Benefit Determination issued? b. If yes, is the diagnosis consistent with the presenting problems, history, mental status exam and/or other clinical data in the assessment?	☐ ☐ ☐	☐ ☐ ☐		
4. <u>Medical Necessity</u>: Are impairments in life functioning and the relationship of those impairments to the client's mental health symptoms/ behaviors documented?	☐	☐		
5. Was the most recent assessment completed and finalized in a timely manner (i.e. within 60 days, 5 days for STRTP)?	☐	☐		
6. Is the assessment signed by someone within scope of practice? a. If the assessment is signed by a student, is it co-signed by a licensed staff within scope of practice? b. Do all signatures on the assessment include the staff's license/registration number (if applicable), and the date?	☐ ☐ ☐	☐ ☐ ☐	☐	
7. Does the client/collateral have any cultural considerations and/or special service needs (i.e. hearing, visual, transportation accommodations)?	☐	☐	☐	
8. Does the client/collateral have a preferred language other than English? a. If yes, Preferred Language: _____	☐	☐		
9. General comments: Are there any other identified administrative or clinical concerns found regarding the assessment?	☐	☐		

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For Review of Legal Entity (LE) Contract Provider Clinical Records

REQUIREMENT	YES	NO	N/A	COMMENTS
Consent for Medications				
10. Was the client prescribed medications during the review period? ***If yes, complete questions 11-14*** ***May include in the COMMENTS whether medications were prescribed by the provider being reviewed*	☐	☐		
11. Is there a completed Medication Consent/Outpatient Medication Review with all the required elements covering the review period? **For minors who were dependents/wards of the Courts, a Medication Consent, JV220 and JV223 must be present*	☐	☐		
12. Are the medications prescribed included on the Medication Consent/Outpatient Medication Review or JV220/223?	☐	☐		
13. If the client has a Medication Consent/Outpatient Medication Review is it signed by the client/legal representative?	☐	☐		
14. If the client has a Medication Consent/Outpatient Medication Review is it signed by someone authorized to prescribe within the County's Local Mental Health Plan (LACDMH directly operated or contracted)? a. If yes, does the prescriber's signature include their license number (if applicable) ,and the date?	☐ ☐	☐ ☐		
Client Treatment Plan				
15. Were treatment services provided during the review period? ***If yes, complete questions 18-27*** ***(Note:** Services for the purpose of assessment, crisis intervention, and plan development are not considered treatment services**)***	☐	☐		
16. Is there a finalized Client Treatment Plan covering the review period?	☐	☐		
17. Medical Necessity: Are all the objectives in the Client Treatment Plan related to the symptoms/behaviors or impairments that are identified in the Assessment?	☐	☐		
18. Are all the objectives specific observable and/or specific quantifiable objectives related to the client's mental health needs and functional impairments?	☐	☐		
19. Are there specific interventions (with detailed description), modalities (e.g. individual therapy, group rehab) and frequencies identified for each related objective?	☐	☐		
20. Does the Client Treatment Plan contain all the required staff signatures including that of the AMHD? a. Do all staff signatures include the staff's discipline/title, relevant identification number (if applicable) and date?	☐ ☐	☐ ☐		

REQUIREMENT	YES	NO	N/A	COMMENTS
21. Were medication support service interventions related to prescriptions identified? a. If yes, is there an MD, DO, and/or NP signature present?	☐ ☐	☐ ☐	☐	
22. Has the client/legal representative signed the Client Treatment Plan? a. If no, is there a documented reason for the lack of signature?	☐ ☐	☐ ☐		
23. If preferred language is other than English, does the Client Treatment address linguistic and interpretive needs? a. Was the Client Treatment Plan interpreted in the client's preferred language? **See #8a. for preferred language*	☐ ☐	☐ ☐	☐ ☐	
24. Were cultural considerations and/or special service needs addressed by staff in the Client Treatment Plan? **Only required if yes to number 7*	☐	☐	☐	
25. Was the Client Treatment Plan completed in a timely manner (finalized and submitted prior to treatment services provided)?	☐	☐		
26. Was a copy of the Client Treatment Plan offered to the client?	☐	☐		
27. General comments: Are there any other identified administrative or clinical concerns found regarding the treatment plan?	☐	☐		
Progress Notes				
28. Were all Progress Notes reviewed finalized in a timely manner?	☐	☐		
29. In each Progress Note reviewed did the Procedure Code appropriately match the service documented?	☐	☐		
30. Did all the Progress Notes reviewed include the staff 's signature with their discipline/title, relevant identification number (if applicable) and date? a. If signed by a student, was the note co-signed by a licensed staff within scope of practice?	☐ ☐	☐ ☐	 ☐	
31. For any service involving multiple staff, was the intervention of each staff identified?	☐	☐		
32. Medical Necessity: Is there a billable staff intervention identified for any Progress Notes with a billable procedure code?	☐	☐		
33. Medical Necessity: For treatment services, does the service relate back to the Client Treatment Plan?	☐	☐		
34. For Progress Notes that documented activities performed/services provided while the client was hospitalized (on a non-admission or non-discharge day) or placed in an IMD, jail, or similar setting, did the note or Procedure Code used indicate the service was not claimed to Medi-Cal?	☐	☐	☐	

REQUIREMENT	YES	NO	N/A	COMMENTS
35. For clients with a Child and Family Team (CFT) in place, are there Progress Notes documenting the provision of ICC and IHBS that include the appropriate procedure codes?	☐	☐	☐	
a. Do Progress Notes indicate that a CFT meeting took place to reassess strengths and needs at least every 90 days?	☐	☐	☐	
36. For STRTP clients, are there Progress Notes documenting the provision of ICC and IHBS that include the appropriate procedure codes?	☐	☐	☐	
37. General Comments: Are there any other identified administrative or clinical concerns found within the progress note? **Examples: Face to face time and other time do not appear appropriate for what is documented in the progress note*	☐	☐		
38. Was client in a Day Treatment Intensive or Day Rehabilitation program during the review period? **If yes, please complete the Chart Review Checklist – Day Programs Supplement.*	☐	☐		

ADDITIONAL COMMENT/NOTES

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