CHART REVIEW TOOL

Last Revised 02/01/24

For Review of LACDMH Directly Operated and Contracted Provider Clinical Records

Date of Review: _____ **Legal Entity Name:** _____ **Legal Entity Number:**_____

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

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

REQUIREMENT	YES	NO	N/A	COMMENTS
Assessment/ Diagnosis				
1. Contained a current assessment covering all 7 of the required assessment domains.	☐	☐		
2. The Assessment contains information that reasonably supports the beneficiary's entry into the SMHS system.	☐	☐		
3. Contained a mental health related diagnosis or suspected mental health disorder (e.g., Unspecified…).	☐	☐		
4. Contained the complete signature(s) of staff allowed to perform a Psychiatric Diagnostic Assessment.	☐	☐		
5. Included a co-signature when documented by a student of a discipline allowed to perform a Psychiatric Diagnostic Assessment.	☐	☐	☐	
6. Dates for when the Assessments were finalized were clear.	☐	☐		
7. Contained a Needs Evaluation when required (i.e., at time of Initial Assessment, annually for existing clients receiving TCM, or whenever new TCM needs arise).	☐	☐		
8. For clients under 21 there was a current CANS completed, or CANS information was incorporated into the assessment.	☐	☐	☐	
Problem List				
1. Contained a Problem List that included the client's symptoms, conditions, diagnoses, and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters.	☐	☐		

2. Contained the name and title of the practitioner that identified, added, or removed the problem.	☐	☐		
3. Contained the date the problem was identified, added, or removed.	☐	☐		
4. The Problem List was updated when there were relevant changes to a client's condition and as new problems were identified.	☐	☐		
5. Problem list items were supported by documentation in the chart.	☐	☐		
Care/Treatment Plans				
1. If TCM, ICC, TBS, TFC or Peer Support Services were provided, the development and periodic revision of a care plan for those services was documented in the Progress Notes.	☐	☐	☐	
2. For CCRP, MHRC, MHSA FSP-ISSP, SRP, and STRTP, have the specific documentation requirements related to the care plan been met?	☐	☐	☐	
Progress Notes				
1. Documentation in the Progress Notes of the actual interventions provided described the provision of medically necessary services based on the symptoms and impairments documented in the client's assessment and/or other information in the clinical record.	☐	☐		
2. Contained the procedure code for the service.	☐	☐		
3. The procedure code selected matched the service/activities described in the progress note.	☐	☐		
4. Contained a brief description of the service, including how the service addressed the client's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).	☐	☐		
5. Contained the date that the service was provided to the client.	☐	☐		
6. Contained the duration of the Direct Care for the service.	☐	☐		
7. Contained the location of the client at the time of receiving the service.	☐	☐		
8. Contained next steps, clearly related to addressing identified clinical issues of the client, including, but not limited to, planned action steps by the practitioner or by the client, collaboration with the client, collaboration with other provider(s) and any update to the Problem List as appropriate.	☐	☐		
9. Contained a typed or legibly printed name, signature of the service practitioner and date of signature.	☐	☐		

10. Services documented in the Progress Note that were provided when a Medi-Cal Lockout applied utilized a non-billable code.	☐	☐	☐	
11. Progress Notes documented the provision of ICC services (and IHBS if applicable) for STRTP clients.	☐	☐	☐	
12. Contained documentation of a CFT meeting taking place at least every 90 days where the provision of ICC services is being documented in the Progress Notes.	☐	☐	☐	
13. All services documented that were claimed were actual covered SMHS (e.g., no claims for leaving telephone messages).	☐	☐		
14. The Interventions documented in the Progress Notes were provided by a practitioner within scope of practice.	☐	☐		
15. When more than one practitioner participated in the same service, the names of each staff participating in the service was included in the Progress Note with his/her specific intervention/contribution and time.	☐	☐	☐	
16. Progress Notes included co-signatures when documented by a student or staff requiring co-signature per Guide to Procedure Code requirements.	☐	☐	☐	
17. Progress Notes were finalized within the required time frame.	☐	☐		
18. Dates for when the Progress Notes were finalized were clear.	☐	☐		
19. For any group Progress Notes there was a brief description of the client's response to the service.	☐	☐	☐	
20. For clients receiving TBS, IHBS or TFC for the dates covered by the progress notes being reviewed, there was evidence/record of an active authorization in the chart.	☐	☐	☐	
Consent for Medications				
1. If the client was being prescribed medications, there is documentation in the clinical record of the required elements for medication informed consent as described in the Organizational Providers Manual.	☐	☐	☐	
2. For those charts in which medications were prescribed to a minor who was a ward/dependent of the court, a JV220 and JV223 were present (with additional documentation in the clinical record if needed that supports meeting required elements for medication informed consent).	☐	☐	☐	
3. Documentation of verbal consent is present when medications are to be administered to the client or are prescribed in a residential setting.	☐	☐	☐	

ADDITIONAL COMMENT/NOTES