FULL CHART REVIEW TOOL

Last Revised 6/08/2026

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:** _____

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

REQUIREMENT	YES	NO	N/A	COMMENTS
Assessment/Diagnosis *(Please see Organizational Provider's Manual, Ch. 1 – Criteria to Access SMHS, Assessment, Needs Evaluation, CANS/CANS-IP and PSC-35, Level of Care Evaluations LACDMH Policy 250.01, 302.01, 302.03, 302.13, 305.01, 312.01, 400.02, 401.02, 401.03)*				
1. Contained a current assessment covering all 7 of the required assessment domains.	☐	☐		
2. The Assessment contains information that reasonably supports the member's entry into the SMHS system.	☐	☐		
3. The Assessment identifies a mental health diagnosis (e.g., Bipolar Disorder) or suspected mental health disorder (e.g., depression). a) The identified diagnosis is clinically supported and is consistent with the symptoms, functional impairments, history, and other clinical information documented in the assessment.	☐ ☐	☐ ☐		
4. The clinical documentation identifies co-occurring disorders (e.g., substance use, cognitive, medical, or other behavioral health conditions). a) If yes, the impact of the co-occurring disorder is reflected in the member's assessment, diagnosis, and treatment planning.	☐ ☐	☐ ☐	☐	
5. There was documentation/information in the clinical record indicating that the member has a clinical need for ICC and/or IHBS services. a) If yes, ICC and/or IHBS services were initiated and documented. i. If ICC and/or IHBS services were indicated but not provided, this was clearly documented in the clinical record.	☐ ☐ ☐	☐ ☐ ☐	☐	
6. Contained the complete signature(s) of the practitioner(s) allowed to perform a Psychiatric Diagnostic Assessment.	☐	☐		
7. Included a co-signature when documented by a student of a discipline allowed to perform a Psychiatric Diagnostic Assessment.	☐	☐	☐	
8. The Assessment includes documentation of the date the document was finalized.	☐	☐		

REQUIREMENT	YES	NO	N/A	COMMENTS
9. Documentation includes an evaluation of the member's functioning and ancillary needs to support determination of the need for TCM services, when required (i.e., at time of Initial Assessment, annually for existing members receiving TCM, or whenever new TCM needs arise). ***Note:*** *For members under age 21, completion of the LACDMH version of the CANS 0-5 or CANS-IP, including the narrative sections addressing strengths, needs, and linkage/referral planning, may satisfy this requirement.* ***Note:*** *For members ages 21 and over, completion of the Needs Evaluation Tool (NET) may satisfy this requirement.*	☐	☐	☐	
10. For members between the ages of 6 and 20, contained a Child and Adolescent Needs and Strengths (CANS) when required (i.e. at time of Initial Assessment, when an existing member turns 6 years old, every 6 months, at discharge). ***Note:*** *For routine CANS re-assessment, ratings should be completed during the service closest to the 6-month mark, with a flexibility window of 2 months prior to or after the due date.*	☐	☐	☐	
11. For members between the ages of 3 and 18, contained a Pediatric Symptom Checklist (PSC-35) when required (i.e. at time of Initial Assessment, every 6 months, at discharge). ***Note***: *For routine PSC-35 re-assessment, ratings should be completed during the service closest to the 6-month mark, with a flexibility window of 2 months prior to or after the due date.*	☐	☐	☐	
12. For members ages 21 and over, contained the Level of Care Utilization Scale (LOCUS) when required (i.e., at time of Initial Assessment, every 6 months). a) If the LOCUS was completed, clinical documentation demonstrated that the LOCUS findings informed treatment planning and/or level of care determination (e.g., program type, service type/frequency). b) Based on the LOCUS, the member was receiving services at the appropriate level of care. ***Note:*** *LOCUS may be used at discharge to show the member's recovery or readiness for transition.*	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	
Problem List *(Please see Organizational Provider's Manual, Ch.1 – Problem List; LACDMH Policy 302.03, 302.13, 312.01, 401.03)*				
1. Contained a Problem List that included the member's symptoms, conditions, diagnoses, and/or risk factors identified through the Assessment, diagnostic evaluation, crisis encounters, or other types of service encounters.	☐	☐		

REQUIREMENT	YES	NO	N/A	COMMENTS
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 member's condition and as new problems were identified.	☐	☐		
5. Problem list items were supported by documentation in the clinical record.	☐	☐		
Care/Treatment Plans *(Please see Organizational Provider's Manual, Ch.1 – Care Plans, Ch.2 – TCM, PSS, and Services Specific to EPSDT Clients; LACDMH Policy 302.03, 312.01, 400.02, 401.03)*				
1. If TCM, ICC, TBS, TFCS 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 *(Please see Organizational Provider's Manual, Ch.1 – General Service and Reimbursement Rules, Progress Notes, Service Components, Ch.2 – Services Based on Units of Staff Time; A Guide to Procedure Codes; LACDMH Policy 302.03, 312.01, 400.02, 401.02, 401.03)*				
1. The Progress Notes describe the interventions provided and their connection to the member's symptoms, impairments, or behavioral health needs documented in the member's assessment and/or other information in the clinical record.	☐	☐		
2. The service selected matched the service/activities described in the Progress Note.	☐	☐		
3. Contained a brief description of the service, including how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).	☐	☐		
4. Contained the date that the service was provided to the member.	☐	☐		
5. Contained the duration of the Direct Care for the service.	☐	☐		
6. Contained the location of the member at the time of receiving the service.	☐	☐		

REQUIREMENT	YES	NO	N/A	COMMENTS
7. Contained next steps related to addressing the member's identified clinical needs (e.g., planned actions by the practitioner and/or member, coordination and/or collaboration with other provider(s), or updates to the Problem List).	☐	☐		
8. Contained a typed or legibly printed name, signature of the service practitioner and date of signature.	☐	☐		
9. Services documented in the Progress Note that were provided when a Medi-Cal Lockout applied utilized a non-billable code.	☐	☐	☐	
10. Progress Notes documented the provision of ICC and/or IHBS services for STRTP members.	☐	☐	☐	
11. For ICC and/or IHBS services, Progress Notes contained documentation that a CFT meeting occurred at least every 90 days.	☐	☐	☐	
12. The duration of time listed in the Progress Notes was for documented direct care activities (i.e., covered SMHS activities) and did not include non-direct care activities (e.g., travel time, chart review, leaving telephone messages, scheduling appointments, or other administrative tasks).	☐	☐		
13. The Interventions documented in the Progress Notes were provided by a practitioner within scope of practice.	☐	☐		
14. When more than one practitioner participated in the same service, the names of each practitioner participating in the service were included in the Progress Note with their specific intervention/contribution and time.	☐	☐	☐	
15. Progress Notes included co-signatures when documented by a student or practitioner requiring co-signature, per Organizational Provider's Manual requirements.	☐	☐	☐	
16. Progress Notes were finalized within the required time frame.	☐	☐		
17. Progress Notes included documentation of the date the document was finalized.	☐	☐		
18. For Group Progress Notes, documentation included the interventions provided, the member's response to those interventions, and how the intervention reduced impairment, restored functioning, or prevented deterioration in life functioning.	☐	☐	☐	

REQUIREMENT	YES	NO	N/A	COMMENTS
19. For members receiving TBS, IHBS or TFCS for the dates covered by the Progress Notes being reviewed, there was evidence/record of an active authorization in the clinical record. ***Note***: Members in FSP, IFCCS or Wrap programs are pre-authorized for IHBS services for one year upon program enrollment, no verification of authorization for IHBS is needed during this period.	☐	☐	☐	
Consents and Authorizations *(Please see Organizational Provider's Manual, Ch.1 – Informed Consent; LACDMH Policy 302.01, 302.03, 305.01, 352.10, 401.02, 401.03)*				
1. Consent for services was obtained prior to providing Outpatient SMHS. ***Note**: If services were provided due to an emergency psychiatric condition, consent for services was obtained at the next contact once the emergency psychiatric condition resolved.*	☐	☐		
2. If telehealth and/or telephone services were provided, consent for services was obtained prior to service delivery and included all required elements (i.e., voluntary agreement, right to withdraw consent, option to receive services in person, availability of transportation for in-person services).	☐	☐	☐	
3. If consent for services was obtained verbally or electronically, the consent form used was made available to the member and there was documentation of it being made available in the clinical record.	☐	☐	☐	
4. When psychotropic medications were prescribed, the clinical record included documentation of medication informed consent containing the required elements described in the Organizational Provider's Manual.	☐	☐	☐	
5. For minors who are wards/dependents of the court, the required court authorization forms (e.g., JV220 and JV223) were present in the clinical record when medications were prescribed.	☐	☐	☐	
6. When medication informed consent was documented, there was evidence in the clinical record that the nature, risks, benefits, and alternatives to treatment were discussed with the member.	☐	☐	☐	
7. When medications were administered or prescribed in a residential setting, there was verbal consent documented in the clinical record.	☐	☐	☐	

ADDITIONAL COMMENTS/NOTES