Revised
7/23/13

CHART REVIEW TOOL

County of Los Angeles – Department of Mental Health

Type of Review:
☐ Initial Intake
☐ Annual

Provider Number_____ **Service Area** ____

Admission Date: _____ **Review Date**_____

Primary Contact_____ **Review Period for Annual (3-month period prior to cycle month)**_____

Supervisor's Name_____ **Date of Last Claimed Service**_____

Yes = Meets Requirements **No =** Requires Follow-Up Corrective Action Plan (CAP) **N/A =** Not Applicable

***Items marked with an asterisk (*) are to be completed by an AMHD ONLY**

REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
ADMINISTRATIVE / REQUIRED FORMS		
1. Ensure the following DMH forms are present and completed, if applicable: a. ☐ MH 224A Client Face Sheet b. ☐ MH 224B Open Episode Form (does current diagnosis match the IS diagnosis?) c. ☐ MH 281 Payor Financial Information (PFI) (renewed annually) d. ☐ MH 500 Consent for Services e. ☐ MH 635 Advanced Health Care Directive (clients over 18 years old) f. ☐ MH 612 Account Tracking Sheet g. ☐ MH 601 Acknowledgement of Receipt – HIPAA "Notice of Privacy" Form	☐ All present and completed, if applicable ☐ Missing	
ASSESSMENT (A)		
2. a. Is there a complete Assessment **(Initial Intake)**? OR Is there a complete Annual Assessment Update **(Annual Review)**? b. Is it signed by an AMHD with his/her license number present?	Yes ☐ No ☐ Yes ☐ No ☐	
If No to #2, staff must be required to complete the assessment immediately.		
3. Is the documentation legible?	Yes ☐ No ☐	
4. Are allergies or lack of known allergies documented?	Yes ☐ No ☐	
5. For the **Initial Intake Review,** a. Is the **COJAC** form complete (adults) or Is the Self-Evaluation and Parent/Caregiver Questionnaire complete (child/adol.) (Under age 11, not required to do substance abuse screener unless substance use suspected). b. Is the **COD Assessment** complete, if indicated by the Substance Use/Abuse sections on either the Adult or Child/Adolescent Assessment forms?	Yes ☐ No ☐ Yes ☐ No ☐	
6. * Is the diagnosis supported by the information in the Assessment?	Yes ☐ No ☐ **AMHD Initials**: _____	
7. If the **Annual Assessment Update (AAU)** indicates that the diagnosis has changed (**see item #5 on the AAU**) then answer the following: a. has a Diagnosis Information form been completed? **and** b. is the diagnosis changed in the IS?	No change in dx ☐ Yes ☐ No ☐ Yes ☐ No ☐	
If No to # 6 or # 7, staff must be required to correct the disconnect and/or complete necessary documentation immediately.		

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REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
ASSESSMENT (A)		
8. If client is identified as Non-English speaking in the Assessment, is there documentation showing that services were provided in his/her preferred language in the Client Care Plan and/or Progress Notes?	Yes ☐ No ☐ English is Primary Language ☐	
9. Other than language, if cultural considerations (e.g., cultural identity, client's cultural explanation of his/her illness, role of religion/spirituality in providing support) **or** special service needs (e.g., hearing impaired, blind, access issues) were identified in the Assessment, is there documentation showing that services addressed these issues in the Client Care Plan and/or Progress Note?	Yes ☐ No ☐ No cultural considerations identified ☐	
10. **Medical Necessity:** Is there an "Included" Diagnosis?	Yes ☐ No ☐	
11. * **Medical Necessity:** Are impairments in life functioning and their relationship to the client's symptoms/behaviors documented?	Yes ☐ No ☐ **AMHD Initials**: ____	
If No to #10 or #11, claiming must be immediately discontinued and **services not claimed to Medi-Cal.**		
CLIENT CARE / COORDINATION PLAN (CCCP)	**Not Required per:** ☐ Episode will be closed prior to intake/review period ☐ Other (please specify)_____	
12. Is there a completed CCCP for the period being reviewed?	Yes ☐ No ☐	
If No to #12, complete and date at next client contact. Please Note: A Client Care Plan should be in place when treatment is provided within 30- or 60-day period		
13. *Are the objectives in the CCCP related to the symptoms/behaviors or impairments that are identified in the Assessment?	Yes ☐ No ☐ **AMHD Initials**: ____	
If No to #13, staff must be required to correct the disconnect immediately (i.e., add to Assessment, rewrite/add objective to CCCP)		
14. Is there a SMART (specific, measureable, attainable, realistic, and time bound) objective associated with each type of service provided or expected to be provided?	Yes ☐ No ☐	
15. a. Are there specific interventions and modality (e.g. individual therapy, group rehab) identified for the types of services checked (e.g., MHS, TCM, MSS)? b. Is the frequency of each type of service documented?	Yes ☐ No ☐ Yes ☐ No ☐	
16. Is there an AMHD signature present for all objectives?	Yes ☐ No ☐	
17. For medication support objectives, is there a MD, DO, and/or NP signature present?	Yes ☐ No ☐	
18. Is documentation legible?	Yes ☐ No ☐	
19. a. Has the client/representative signed the CCCP? b. If not, is there regular documentation of attempts to obtain signature?	Yes ☐ No ☐ Yes ☐ No ☐	
If No to #16, #17, #18 and/or #19, claiming must be immediately discontinued until signature(s) and/or appropriate / legible documentation is in place.		

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REQUIREMENT	FINDING	CORRECTIVE ACTION PLAN
CLIENT CARE / COORDINATION PLAN (CCCP)		
20. Is it documented (box checked) that a copy of the CCCP was either given to or declined by the client?	Yes ☐ No ☐	
21. If client is Non-English Speaking, was the CCCP interpreted in his/her preferred language? (box checked)	Yes ☐ No ☐ English is Primary Language ☐	
PROGRESS NOTES (PN)		
22. a. Is there a completed Progress Note for each claimed service provided? (Refer to appropriate IS Report and Direct Service Detail Report), AND b. Is the Rendering Provider eligible to use that procedure code (scope of practice)?	Yes ☐ No ☐ Yes ☐ No ☐	
23. a. Is the Procedure Code accurate for the service documented? b. Are all data element fields complete (date of service, face-to-face/other time, telephone contact?	Yes ☐ No ☐ Yes ☐ No ☐	
24. a. Is there a staff intervention noted? b. Is the staff intervention an assessment contact, crisis service or service related to the CCCP? c. Is the client's response to the intervention noted?	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐	
25. For any service involving multiple staff, is the intervention of each staff identified?	Yes ☐ No ☐	
26. Is the service **SOLELY** vocational, socialization, recreational, clerical, transportation or personal care?	**Yes ☐ No ☐	
**If Yes to #26, then these services should NOT be claimed to Medi-Cal.		
27. Is each note signed, dated and discipline/payroll title, and license number (if applicable) indicated by the Rendering Provider (RP)?	Yes ☐ No ☐	
28. Is documentation legible?	Yes ☐ No ☐	
If No to #27 and/or #28, signature(s), missing discipline/payroll titles, license numbers and/or appropriate or legible documentation must be completed.		
MEDICATION SUPPORT SERVICES (MSS)	**N/A** ☐	
29. Is the Outpatient Medication Review form completed and signed by client/representative and staff?	Yes ☐ No ☐	
30. Are all prompts in the medication notes complete?	Yes ☐ No ☐	
31. Is the medication note signed by MD/DO, NP, RN, CNS or LPT and his/her license number present?	Yes ☐ No ☐	
32. Is a procedure code present?	Yes ☐ No ☐	
33. Is documentation legible?	Yes ☐ No ☐	
If No to any of the above, signature(s), missing discipline/payroll titles, license numbers and/or appropriate or legible documentation must be completed. (Concerns involving incomplete medication notes and/or lack of medication objectives on the Client Care Plan should be reported to the Supervising Psychiatrist by the Committee Chairperson, Supervisor or Program Manager).		

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Please submit completed review tool to QA via fax (213) 351-7688 or email at QA@dmh.lacounty.gov

STAFF SIGNATURE PAGE

TO BE COMPLETED BY REVIEWER(S):

_____	_____	_____
Reviewer's Signature/Discipline/Title	Printed Name of Reviewer	Date of Review
_____	_____	_____
Reviewer's Signature/Discipline/Title	Printed Name of Reviewer	Date of Review

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TO BE COMPLETED BY SUPERVISOR: **Date**

1. Received Primary Contact's Chart Review Tool from Committee Chairperson: ☐ YES ☐ NO _____
2. Reviewed Corrective Action Plan with Primary Contact: ☐ YES ☐ NO _____
3. Verified Primary Contact's completed/resolved Corrective Action Plan: ☐ YES ☐ NO _____

_____	_____
Supervisor's Signature	Printed Name Supervisor

Comments: _____

_____

TO BE COMPLETED BY PRIMARY CONTACT: **Date**

1. Reviewed Corrective Action Plan with Supervisor: ☐ YES ☐ NO _____
2. Completed/resolved Corrective Action Plan: ☐ YES ☐ NO _____

_____	_____
Primary Contact's Signature	Printed Name Primary Contact

Comments: _____

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