DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT **CLINICAL RECORDS MAINTENANCE, ORGANIZATION, AND CONTENTS**	POLICY NO. **401.02**	EFFECTIVE DATE **08/31/2015**	PAGE **1 of 7**
APPROVED BY: Director	SUPERSEDES **104.08** **10/16/2012**	ORIGINAL ISSUE DATE **09/01/2004**	DISTRIBUTION LEVEL(S) **1, 2**

PURPOSE

1.1 To provide Los Angeles County Department of Mental Health (LACDMH) directly-operated programs with policy and procedures related to clinical record keeping practices including maintenance, organization, and contents of the clinical record for all specialty mental health services.

1.2 To inform contract providers of the policy and procedures in Section 1.1 above with the expectation that similar policy and associated procedures are established in their programs.

DEFINITIONS

2.1 **Billing Provider:** A distinct service delivery setting with a unique organizational national provider identifier number within the National Plan and Provider Enumeration System (NPPES) and a unique four-digit identifying number and program name within the LACDMH electronic system, under which the program establishes episodes, identifies clients, and submits claims to the State's reimbursement system.

2.1.1 **Reporting Unit:** Billing Providers may have one (1) or more associated Reporting Units represented by an alphabetic character attached to the four-digit identifying number which designates or distinguishes either the mode of service being delivered at the Billing Provider or a unique service site.

2.2 **Chart Order:** A listing of clinical documents and their location within the clinical record.

2.3 **Clinical Record:** The official record containing all clinical information and services related to a client.

2.3.1 **Paper Clinical Record:** The official record containing all clinical information and services related to a client in paper format and stored in a secured file cabinet.

2.3.2 **Electronic Health Record (EHR):** The official record containing all clinical information and services related to a client in an electronic format and stored in an electronic database.

2.4 **Clinical Forms Inventory:** For directly-operated programs, a listing of all LACDMH approved clinical forms with the latest revision date(s) that may be used, without alteration, in the clinical record. For Contract Providers, the Clinical Forms Inventory includes the clinical forms with the latest revision date(s) as well as the type of forms which are listed below (Reference 2).

2.5 The clinical record requirements are applicable for both paper and EHR formats.

2.5.1 **LACDMH Required Data Elements Clinical Record Forms:** Forms which contain data elements that Contract Providers must collect, as applicable to the situation.

2.5.2 **LACDMH Required Concept Clinical Record Forms:** Forms designed to capture a specific category of information (as indicated by the title and data elements of the form) that Contract Providers must also address, as applicable to the situation, although not necessarily through the use of the exact form.

2.5.3 **LACDMH Ownership Clinical Record Forms:** Forms that require specific information in compliance with applicable federal, State, and local laws, regulations, codes, policies and procedures. Because the content of these forms carry potential legal implications, Contract Providers must implement the concepts/principles associated with these forms through their own understanding/interpretation of the applicable authority.

2.6 **LACDMH Approved Clinical Forms:** Paper or electronic (for directly-operated programs) forms within the EHR which are approved and issued by the Quality

Assurance (QA) Division of LACDMH and used for the entry of clinical information.

POLICY

3.1 Directly-operated staff must comply with the provisions of the LACDMH Clinical Records Guidelines manual which establish specific procedures for the proper organization and maintenance of client records and the disclosure of Protected Health Information (PHI) based on federal, State, and local laws and regulations including Health Insurance Portability and Accountability Act (HIPAA), Privacy and Welfare and Institutions Code 5328, and accepted standards of professional practice (Reference 3).

3.2 Contractors of LACDMH are not subject to the provisions of the LACDMH Clinical Records Guidelines, but are subject to their own relevant policies and all relevant provisions of federal, State, and local laws and regulations including Privacy and Welfare and Institutions Code 5328 as well as accepted standards of professional practice.

3.3 All billing providers must maintain a clinical record containing **all** information related to the services provided to a client in accord with LACDMH Policy Nos. 401.03 and 401.04 (References 4 and 5).

3.3.1 Consistent with contract language, the clinical record must be accessible within three (3) business days for inspection, review and/or audit by authorized representatives and designees of County, State, and/or federal governments.

3.3.2 Contract Providers may have a paper clinical record or an EHR provided it meets all requirements of the Short-Doyle/Medi-Cal Organizational Providers Manual (Organizational Providers Manual), this Policy, and LACDMH Policy No. 401.03 (References 4 and 6).

3.3.3 For directly-operated billing providers, in all cases, the official clinical record is a LACDMH approved EHR.

3.4 For directly-operated programs, all clinical documentation within the clinical record must be on clinical forms approved by the QA Division of LACDMH with the exception of standardized screening/measurement tools and Evidence-Based Practice worksheets.

3.5 Contract Providers may use the LACDMH approved paper clinical forms as is or develop their own forms (electronic or paper) so long as the requirements of the type of form, as designated within the Clinical Forms Inventory and indicated below, are met (Reference 2).

3.5.1 For LACDMH Required Data Elements Clinical Record Forms, Contract Providers must maintain all required data elements present in these forms although the layout and presentation of the forms may be altered. Contract Providers with an EHR must be able to produce a printable e-report with all required data elements although the layout and presentation may be of their own format.

3.5.2 For LACDMH Required Concept Clinical Record Forms, Contract Providers must have a method of capturing the specific category of information that is indicated by the title and data elements of the form.

3.5.3 For LACDMH Ownership Clinical Record Forms, Contract Providers must have a method for complying with all laws/regulations encompassed by the forms.

PROCEDURE

4.1 All directly-operated programs must follow the procedures set forth in this section.

4.2 All clinical documentation (documentation of direct services and supporting direct services including progress notes, medication notes and any other supporting documentation) must be completed and finalized or scanned into the EHR by the end of the next scheduled work day following the delivery of service unless specific exception is made by the program manager or their designee prior to submission of claims for reimbursement.

4.2.1 All clinical documentation requiring supervisor approval must be approved within two scheduled work days following the delivery of service unless specific exception is made by the program manager or their designee.

4.3 All clinical correspondence and correspondence received from outside sources related to a client must be scanned into the EHR within five (5) working days of receipt and must minimally contain the client's full name.

4.4 Clinical documentation and clinical correspondence shall not be kept or stored (paper or any electronic media other than an EHR) outside of the record storage secure area.

4.5 Clinical documentation and clinical correspondence may be saved in draft within the EHR while in the process of being completed or while awaiting supervisory approval, but must immediately be finalized after completion in accord with the timeframes identified in Section 4.2 of this Policy.

4.5.1 While in the process of completing an assessment that takes multiple service contacts, the partially-completed assessment form must be saved in draft in the EHR, along with a final progress note documenting the assessment-related service provided that day, within the timeframes identified in Section 4.2 of this Policy. When information is to be added to a saved draft assessment form prior to finalization, the form must be edited in the EHR and a progress note referencing the added sections must be filed in the clinical record in accord with Section 4.6 of this Policy.

4.6 Once a final document is filed in the clinical record, all documentation is considered final and may not be altered except for error correction methods approved by the QA Division.

4.6.1 If clarification or additional information is needed, it may be added provided that there is clear documentation referencing when the information was added and by whom.

4.6.2 If a documentation error is made, any corrections must be made through the approved error correction process.

4.7 Clinical records shall minimally contain the following clinical forms (see LACDMH Policy No. 401.03 and the Organizational Providers Manual for additional requirements) unless specific exception has been made by the LACDMH Health Information Manager:

- MH 601-LACDMH Notice of Privacy Practices: Acknowledgment of Receipt Form;
- MH 500-Consent for Services;
- MH 635-Advanced Health Care Directive Acknowledgement Form (clients eighteen [18] years and older only);
- MH 281-Payer Financial Information;
- An Assessment on a LACDMH approved Assessment form;
- A Client Treatment Plan, if applicable per LACDMH Policy No. 401.03;
- Progress Notes/Medication Notes per LACDMH Policy No. 401.03; and
- Outpatient Medication Review form(s), if applicable per LACDMH Policy No. 306.02.

4.8 Clinical Records shall not contain the following information:

- Raw data from psychological testing
- Administrative documents for the internal use of the program
- Critical incident reports/investigations
- Suspected abuse reports
- Staff conflicts and disagreements
- Staffing and workload problems
- Other clients' full name(s)

4.9 The clinical record must be complete, accurate, current, and legible.

4.10 A signature and title and/or discipline must be present on all documentation (see the Organizational Provider's Manual, Reference 5, for more information).

4.11 The client's name and applicable identification number must be on all clinical forms in the chart.

4.12 If abbreviations are used, they should be standard, industry-accepted abbreviations.

4.13 All documentations in the clinical record must be in English.

4.13.1 Whenever non-English forms are used or non-English documentation is completed, an English version must be attached to the non-English version.

AUTHORITY

1. California Code of Regulations, Title IX, Chapter 11, Medi-Cal Specialty Mental Health Services
2. 45 Code of Federal Regulations, Section 164, Security and Privacy

REFERENCES

1. LACDMH Policy Nos. 500.01, 500.02, 500.03, 500.04, 500.05, 500.06, 500.07, 500.08, 501.01, 501.02, 501.03, 501.04, 501.05, 501.06, 501.07, 501.08, 501.09, 502.01, 503.01, 504.01, 505.01, 506.01, 506.02, 506.03, 507.01, 508.01, 509.01
2. Clinical Forms Inventory
3. Clinical Records Guidelines
4. LACDMH Policy No. 401.03, Clinical Documentation for All Payer Sources
5. LACDMH Policy No. 401.04 , Clinical Documentation: Medicare
6. Short-Doyle/Medi-Cal Organizational Providers Manual
7. LACDMH Policy No. 306.02, Standards for Prescribing and Furnishing of Psychoactive Medications
8. LACDMH Policy No. 312.02, Closing of Service Episodes

RESPONSIBLE PARTY

LACDMH Program Support Bureau, Quality Assurance Division