




**DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE**

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	1 of 8
APPROVED BY:  Director	SUPERSEDES 104.09 01/24/2014	ORIGINAL ISSUE DATE 09/01/2004	DISTRIBUTION LEVEL(S) 1, 2

PURPOSE

- 1.1 To provide policy and procedures for clinical record documentation related to the delivery of specialty mental health services within the Los Angeles County Department of Mental Health (LACDMH) directly operated and legal entity operated programs.

DEFINITIONS

- 2.1 **Assessment:** Documentation on any assessment form of the evaluation of a client’s mental, physical, and emotional health which is used to:
 - 2.1.1 Create a comprehensive description of the client, including the provision of a diagnosis;
 - 2.1.2 Determine whether a client meets medical necessity; and
 - 2.1.3 Guide the development of treatment goals.
- 2.2 **Authorized Mental Health Discipline (AMHD):** Eligible disciplines that may provide direction regarding the care of clients in the LACDMH System of Care. All services must be provided under the direction of an AMHD. The Short-Doyle/Medi-Cal Organizational Provider’s Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services (Organizational Provider’s Manual) identifies the disciplines eligible to be an AMHD.
- 2.3 **Client Treatment Plan:** A document that serves to guide client care and allows for the objective determination of:



SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	2 of 8

- 2.3.1 Treatment progress by establishing the mental health treatment goals and objectives for a client;
- 2.3.2 The mental health interventions to be provided to the client; and
- 2.3.3 The participation of the client in the course of his/her own treatment.
- 2.4 **Clinical Loop:** The sequence of documentation within the clinical record that ensures services (documented in progress notes) fulfill the clinical needs of the client by relating back to the client’s assessment and client treatment plan and includes all payer requirements for eligibility for reimbursement.
- 2.5 **Guide to Procedure Codes for Claiming Mental Health Services (Guide to Procedure Codes):** The Guide to Procedure Codes lists and defines the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant procedure codes that reflect the services provided within the LACDMH System of Care.
- 2.6 **Guide to Quality Assurance Chart Review Requirements for Directly Operated Programs (Guide to Quality Assurance):** The Guide to Quality Assurance establishes minimum standards for a quality assurance process which includes reviewing documentation and claiming within the clinical record for directly operated providers, and may serve as a model or guide for the written quality assurance protocol requirement for contract providers as described in Section 3.5.2 of this policy.
- 2.7 **Long-Term Client:** A client receiving treatment services pursuant to a completed assessment and treatment plan (See Section 4.4).
- 2.8 **Medical Necessity:** A specific set of criteria, required by third party payers for reimbursement of specialty mental health services, consisting of a covered diagnosis, impairments in life functioning, and interventions designed to address those impairments. For a complete description of Medi-Cal Medical Necessity criteria, see the Organizational Provider’s Manual.
- 2.9 **Newly Active Client:** A new client requiring the opening of a new clinical record or an existing client returning for services after the termination of services per



**DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE**

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	3 of 8

LACDMH Policy No. 312.01, Mutual and Unilateral Termination of Mental Health Services; or an existing client returning for services after one hundred eighty plus (180+) days of inactivity, requiring the resumption of documentation in an existing clinical record.

- 2.10 **Progress Notes:** Documentation of all services for or about a client, regardless of reimbursement.
- 2.11 **Rendering Provider:** An individual registered in the LACDMH electronic system to claim for services he/she provides to a client. If two (2) or more staff provide a service to a client and choose to write a single progress note, the rendering provider under whom services will be claimed is the person who takes responsibility for documenting the service; also referred to as “practitioner.”
- 2.12 **Short-Doyle/Medi-Cal Organizational Provider’s Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services (Organizational Provider’s Manual):** The Organizational Provider’s Manual describes the full array of services that may be delivered as Specialty Mental Health Services under the California Code of Regulations (CCR) Title 9, Chapter 11. The Organizational Provider’s Manual defines these services and describes minimal staffing and documentation requirements associated with these services and various claiming rules for Medi-Cal reimbursement.
- 2.13 **Treatment Services:** Services addressing client mental health concerns that are not primarily for the purpose of assessment, plan development, crisis intervention or, during the first sixty (60) days for newly active clients, linkage to other mental health programs.

POLICY

- 3.1 All staff, whether directly operated or contracted, must abide by the information in the Organizational Provider’s Manual.
 - 3.1.1 The Organizational Provider’s Manual has adopted Medi-Cal standards as the minimum standard for all services provided under the LACDMH



SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	4 of 8

System of Care, regardless of payer source, unless a specific exception is made in the Organizational Provider's Manual.

- 3.1.2 Fee-for-Service providers must adhere to the Network Providers Manual.
- 3.1.3 For clients with Medicare, staff must also adhere to LACDMH Policy No. 401.04, Clinical Documentation: Medicare, to ensure services are eligible for reimbursement by Medicare.
- 3.2 For all clients in the LACDMH System of Care, documentation in the clinical record must support medical necessity and the clinical loop for the services to be eligible for reimbursement, unless otherwise noted in the Organizational Provider's Manual or LACDMH Policy.
- 3.3 Each rendering provider is responsible for ensuring the documentation completed for a service meets the minimum documentation requirements as identified in this Policy and in the Organizational Provider's Manual.
 - 3.3.1 Each rendering provider may only document in the clinical record within the limits of their scope of practice and, if permitted, to render the service by the rules identified in the Guide to Procedure Codes, the Organizational Provider's Manual, LACDMH Policy and Procedures, and applicable licensing board requirements.
 - 3.3.1.1 Unless otherwise indicated in the Organizational Provider's Manual, all documentation by students and those staff not in possession of the minimum of a Bachelor's Degree in a mental health-related field or two (2) years of mental health-related experience require a co-signature.
 - For students: the co-signature must be by a licensed individual acting within their scope of practice.
 - For staff: the co-signature must be by a licensed individual acting within their scope of practice until the head of



SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	5 of 8

Service or designee has determined the staff member is competent to document in accord with the Organizational Provider’s Manual, and has attained either the education requirement, experience requirement, or both.

3.3.1.2 Co-signatures may never be used to authorize a staff person to perform a service that is not within his/her scope of practice.

3.3.2 Each rendering provider is responsible for making the determination of whether or not the service and its supporting documentation fulfills the requirements of medical necessity, the clinical loop, and any other requirements of the funding source as identified in the Organizational Provider’s Manual.

3.3.2.1 The determination that all requirements of the funding source are met must be made by the rendering provider prior to submitting a claim for a service to a payer(s). Data entry staff must never be expected to make this determination.

3.4 All forms used for documentation must be compliant with LACDMH Policy No. 401.02, Clinical Records Maintenance, Organization, and Contents.

3.5 Each legal entity must have a quality assurance process in place in order to ensure that all documentation requirements of the Organizational Provider’s Manual are met and occur within the established timeframes set forth within this policy.

3.5.1 For directly operated providers, the quality assurance process must be in accord with the standards set forth within the Guide to Quality Assurance Chart Review Requirements for directly operated programs.

3.5.1.1 Any exceptions made to the requirements of the Guide to Quality Assurance or the Chart Review Tool for individual directly operated providers must be authorized by the Quality Assurance Division.



SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	6 of 8

3.5.2 For contract providers, the quality assurance process must be written and on file with the Quality Assurance Division.

3.5.2.1 The quality assurance process must include annual chart reviews on at least 5% of open clinical records per quarter and incorporate a process for using review findings to inform and improve ongoing documentation practices.

PROCEDURE

- 4.1 A new assessment is required in the clinical record within sixty (60) days of initiation of any services related to assessment or treatment for all newly active clients and must clearly document all assessment elements as identified in the Organizational Provider's Manual.
- 4.1.1 The completion of the new assessment must include the provision of a psychiatric diagnostic interview performed by staff designated in the Guide to Procedure Codes.
- 4.1.2 If emergent treatment services are needed prior to the completion of the new assessment, a written plan regarding the need for services and interventions to be provided is required in the clinical record concurrent with providing the emergent services. The written plan does not negate the requirement to generate a client treatment plan upon completion of the assessment, in accord with Section 4.4 of this policy; however, it allows the emergent service to be reimbursed.
- 4.2 The diagnosis in the clinical record must be consistent with the most recent and up-to-date clinical information documented in the assessment.
- 4.3 For active clients, an assessment is required when there is a significant change in clinical information or, at a minimum, every three years.
- 4.4 Except as provided in Section 4.1.2 above, a client treatment plan is required in the clinical record after the completion of a new assessment and prior to providing treatment services, and must clearly document all client treatment plan elements as identified in the Organizational Provider's Manual. For newly active



SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	7 of 8

clients, the treatment plan is minimally required within sixty (60) days of initiation of services, excluding crisis interventions.

- 4.4.1 For active clients agreeing to continue services, a new client treatment plan must minimally be completed with the client at least once every three hundred sixty-five (365) days. If the client is unavailable by the conclusion of the one year period, the client treatment plan must be completed at the point of next service with the client.
 - 4.4.1.1 Within the three hundred sixty-five (365) days, each objective and associated intervention must be reviewed and updated as clinically appropriate or, at a minimum, in accord with timeframes identified in the Organizational Provider’s Manual.
- 4.4.2 The client treatment plan must be under the direction of, and in consultation with, an AMHD within scope of practice as evidenced by the presence of his/her signature.
- 4.4.3 The client must participate in the development of the client treatment plan as evidenced by providing a signature consistent with the requirements in the Organizational Provider’s Manual, unless clinically unable to do so.
- 4.5 A progress note must be completed for every service with and/or on behalf of the client, collaterals, or other agency staff regardless of reimbursement.
 - 4.5.1 A progress note must be in the clinical record for each service prior to the submission of a claim per LACDMH Policy No. 401.02, Clinical Records Maintenance, Organization, and Contents.
 - 4.5.2 The progress note must be completed with the frequency and required data elements identified in the Organizational Provider’s Manual.



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
CLINICAL DOCUMENTATION FOR ALL PAYER SOURCES	401.03	01/24/2014	8 of 8

- 4.5.3 Progress notes must be completed by staff who provided the service (rendering provider) and acting within their scope of practice and in accord with the Guide to Procedure Codes.
- 4.6 When special cultural and/or linguistic needs are present, there must be documentation in the assessment, client treatment plan or initial progress note indicating a plan to address the cultural and/or linguistic needs (e.g., linking the client to culturally and/or linguistically specific services in accord with LACDMH Policy No. 200.03, Language Interpreters).
- 4.6.1 If exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled.

AUTHORITY

1. Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services (Organizational Provider's Manual)
2. California Code of Regulations (CCR) Title 9, Chapter 11
3. Guide to Procedure Codes for Claiming Mental Health Services (Guide to Procedure Codes)
4. Guide to Quality Assurance Chart Review Requirements for Directly-Operated Programs

REFERENCES

1. LACDMH Policy No. 401.02, Clinical Records Maintenance, Organization, and Contents
2. LACDMH Policy No. 401.04, Clinical Documentation: Medicare
3. LACDMH Policy No. 200.03, Language Interpreters
4. LACDMH Policy No. 312.01, Mutual and Unilateral Termination of Mental Health Services

RESPONSIBLE PARTY

LACDMH Program Support Bureau, Quality Assurance Division