



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS	POLICY NO. 104.8	EFFECTIVE DATE 09/01/04	PAGE 1 of 5
APPROVED BY:  <div style="text-align: right;">Director</div>	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) 2

PURPOSE

- 1.1 To provide general guidelines related to the organization and contents of the clinical record.
- 1.2 To provide minimum documentation guidelines applicable to all mental health services provided by the Department of Mental Health (DMH) regardless of payor source.

POLICY

- 2.1 Employees of DMH must adhere to established guidelines related to the organization and contents of the clinical record (Sections 4.1 and 4.2).
- 2.2 Employees of DMH must adhere to general documentation guidelines as set forth in this policy (Sections 4.3, 4.4 and 4.5).

PROCEDURE

3.1 GENERAL GUIDELINES APPLICABLE TO THE CLINICAL RECORD

- 3.1.1 A paper copy clinical record of all services provided shall be maintained in all facilities with the exception of Jail Mental Health Services.
 - 3.1.1.1 Protected Health Information (PHI), which includes all clinical documentation, shall not be saved on any disk or any other electronic medium until such time as the Department implements its electronic record.
- 3.1.2 The contents of charts must be firmly attached to the folder in which the documents are maintained.
- 3.1.3 All direct services must be documented in the Clinical Record within 24 hours or by the close of the next business day following the delivery of service and prior to submission of claims for reimbursement.



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS	POLICY NO. 104.8	EFFECTIVE DATE 09/01/04	PAGE 2 of 5
---	----------------------------------	--	------------------------

3.1.3.1 All other documents related to a client must be filed in his/her clinical record within five (5) working days in accordance with the Department's chart order format.

3.1.4 The client's name and number must be on all documents in the chart.

4.1 CONTENTS OF CLINICAL RECORD

4.1.1 All clinical records shall contain:

- ♦ an acknowledgement of receipt of the Health Insurance Portability and Accountability Act (HIPAA) "Notice of Privacy" form signed by the client;
- ♦ a Consent of Services and when required, a Consent for Minor;
- ♦ all applicable release and access documents, including the Accounting Tracking Sheet;
- ♦ administrative forms, i.e., Integrated System Face Sheet; UMDAP;
- ♦ an Initial and Annual Assessment update, and when seen for medications, a Physician Evaluation;
- ♦ Psychological Testing reports;
- ♦ Client Care/Coordination Plan;
- ♦ correspondence;
- ♦ progress notes, including case conferences/team consultations;
- ♦ Discharge Summary;
- ♦ Outpatient Medication Review form(s), in accordance with Department procedures;
- ♦ physician orders;
- ♦ laboratory test results;
- ♦ prescriptions;
- ♦ administration of meds; and
- ♦ documentation indicating whether or not the client has executed an Advanced Directive.

4.2 DIAGNOSIS GENERAL GUIDELINES

4.2.1 The Five Axis DSM diagnosis on the assessment shall be consistent with the assessment information and all other documentation in the clinical record, including any co-occurring diagnosis.

4.2.2 The Principal Diagnosis must be one of the diagnoses identified by the State Specialty Mental Health codes as a diagnosis eligible for Medi-Cal reimbursement through the mental health system of care, otherwise known as an "included diagnosis."



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS	POLICY NO. 104.8	EFFECTIVE DATE 09/01/04	PAGE 3 of 5
---	----------------------------------	--	------------------------

4.2.3 Diagnoses that support medical necessity under Medicare, according to National Heritage Insurance Company (NHIC) are:

4.2.3.1 Any diagnosis consistent with those specified in **Indications and Limitations of Coverage and/or Medical Necessity**, or the ICD-9-CD descriptors in the list of **ICD-9-CM Codes that Support Medical Necessity**.

4.2.4 If the diagnosis is changed during the course of treatment, a “Change of Diagnosis” form shall be filed in the chart (with the exception of Jail Mental Health) and the information entered into the DMH Integrated System (IS).

4.3 DOCUMENTATION GENERAL GUIDELINES

4.3.1 Documentation must be complete and legible.

4.3.2 DMH Programs shall use only those forms approved by the Department.

4.3.3 Progress notes must include:

- ♦ date, including the day, month and year of service delivery;
- ♦ type of service delivered, as indicated by a pertinent procedure code/description of service;
- ♦ location of service;
- ♦ time spent by the rendering provider in the delivery of the service, which for some services must be broken out into face-to-face and other time;
 (“Face-to-face time” is defined literally as the actual time a client is visually in the presence of and interacting in some way with staff. “Other time” includes non-face-to-face contacts with the client, documentation, and travel time. “Total time” is a combination of “face-to-face time” and “other time”.)
- ♦ names of all staff participating in the service and each of those staff’s “total time”;
- ♦ for groups, the number of the clients for which claims will be submitted (clients present or represented in the group);
- ♦ each entry must contain a description of what was attempted and/or accomplished during the contact toward the attainment of a treatment goal;
- ♦ a description of changes in medical necessity, when appropriate;
- ♦ signature of the service provider, including full name, license/payroll title; and



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS	POLICY NO. 104.8	EFFECTIVE DATE 09/01/04	PAGE 4 of 5
---	----------------------------------	--	------------------------

- ♦ co-signatures when required:
 - ♦ Mental Health Services – no Bachelor’s Degree and less than two (2) years; and students;
 - ♦ Day Treatment Intensive, daily progress notes – MH related BA; two (2) years experience in MH, no BA or two (2) years experience; and students.
 - ♦ Day Treatment Intensive, weekly summary – Licensed Vocational Nurse; Psychiatric Technician; MH Rehabilitation Specialist; MH related BA; two (2) years experience; and students.
 - ♦ Day Rehabilitation – MH related BA; two (2) years experience in MH, no BA or two (2) years experience; and students.
 - ♦ Targeted Case Management – No BA or two (2) years experience and students.

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

4.3.5 The use of correction fluid or correction tape is not permitted. If a documentation error is made, it should be lined-through with a single line, the word “error” noted next to the line-through, initialed and dated and, when appropriate, the correct information charted.

4.3.6 In situations where documentation of services does not occur on the day the service was provided:

4.3.6.1 The service date is to be placed in the left column of the note;

4.3.6.2 The date on which the note was written should appear at the beginning of the note followed by the appropriate documentation for the service provided.

4.4 OTHER DOCUMENTATION ISSUES

4.4.1 Interventions to accommodate the needs of the visually and hearing impaired, as well as those with limited English proficiency, must be documented.

4.4.2 When the client’s primary language is not English, there is to be documentation to show that services were offered in the client’s primary language and/or that interpretive services were offered. Clients should not be expected to provide interpretive services through friends or family members. **(See DMH Policy #202.21 Language Interpreters for further information.)**



DEPARTMENT OF MENTAL HEALTH POLICY/PROCEDURE

SUBJECT: CLINICAL RECORD GUIDELINES: CONTENTS AND GENERAL DOCUMENTATION REQUIREMENTS	POLICY NO. 104.8	EFFECTIVE DATE 09/01/04	PAGE 5 of 5
---	----------------------------------	--	------------------------

- 4.4.3 When cultural or linguistic issues are present, they must be documented along with the actions to link the client to culturally and/or linguistically specific services.
- 4.4.4 In order to obtain culturally and linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the same page. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record.

AUTHORITY

California Code of Regulations, Title IX, Chapter 11, Medi-Cal Specialty Mental Health Services
National Heritage Insurance Company, Final Local Medical Review Policies, Psychopharmacology and
Psychotherapy, effective 10/1/2003

RELATED POLICIES

DMH Policy No. 104.10 Medicare Clinical Documentation

DMH Policy No. 104.9 Clinical Documentation for Medi-Cal and non-Medi-Cal/non-Medicare Services.

REVIEW DATE

This policy shall be reviewed on or before September 15, 2009.