



Quality Assurance Bulletin

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Program Support Bureau

County of Los Angeles - Department of Mental Health
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RECORDING AND REPORTING A MENTAL HEALTH DIAGNOSIS

The page in the Organizational Provider's Manual that addresses mental health diagnosis has been revised and is attached. The revision has been included in the Organizational Provider's Manual posted on the DMH Internet under Administrative Tools for Providers, Agency Administration. The text regarding included diagnosis as part of Medical Necessity reminds directly-operated and contract clinical staff that they **must have an "included" diagnosis as the Primary diagnosis when claiming to Medi-Cal as the Primary Diagnosis is the only diagnosis that is transmitted to the State on claims.**

When opening an episode, clinicians must determine and report the below three diagnostic codes:

- 1. Primary Diagnosis** which should reflect the primary condition for which a person is treated at a specific site, that is, the condition toward which services/goals are being directed:
 - **For those agencies entering data directly into the Department IS**, up to three diagnostic codes on Axis I and two diagnostic codes on Axis II can be selected. A single Primary Diagnosis must then be selected from the first listed Axis I diagnosis or the first listed Axis II diagnosis.
 - **For those agencies transmitting claims data to the Department electronically**, the only diagnosis transmitted on the claim into the Department database is the Primary Diagnosis. Internal diagnostic data collection for agencies transmitting claims electronically to the Department may vary from agency to agency.
- 2. Secondary Diagnosis (if applicable):**
 - Clinicians may also choose a Secondary diagnosis from the remaining (non-Primary) diagnoses on Axis I and Axis II. A Secondary Diagnosis is not required.
- 3. Dual Diagnosis Code** related to Substance Use/Abuse is selected from a set of Department Dual Diagnosis codes.

Diagnosis for Opening and Closing Episodes

Medical Necessity does not need to be established prior to opening a record. An episode may be opened with a Deferred diagnosis as long as the diagnosis is updated both in the clinical record and the IS when the Initial Assessment is completed. An episode may not be closed with a Deferred diagnosis but may be closed with V71.09 "No Diagnosis on Axis I or II" or any other appropriate diagnosis. If an excluded diagnosis is used to close an episode, only those services provided prior to establishing the excluded diagnosis should be claimed to Medi-Cal.

Please Note: If a Medi-Cal client has an "included" diagnosis, s/he must be provided services to treat that condition. Clients who do not have Medi-Cal must be seen and/or treated in accord with current Department practice for funding sources available to the client.

If you have any questions, regarding this Bulletin, please contact your Service Area QA liaison.

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