COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2008-04

Program Support Bureau
550 S. Vermont, 10th Floor
Los Angeles, CA 90020

July 31, 2008

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Announcements

Next Keeper of Clinical Records Meeting:
Wednesday, August 6th 9:00am - 11:00am 10th Floor Conference Room-550 S. Vermont

MEDICATION SUPPORT SERVICES FORMS

New/Revised Forms Available on the Internet and in the Warehouse

http://dmh.lacounty.gov/Forms.asp

DMH Official Form Usage for Medication Support Service Forms

Directly-Operated Clinics: *must* use these forms, when medication support services are provided, in their original format.

Contractors: *may* use these forms in their original format by placing their agency name on the bottom of the form in place of "Los Angeles County-Department of Mental Health."

During the Medication Support Form revisions, there was extensive discussion with and comment from psychiatrists throughout the Department. This dialogue was instrumental in arriving at the final formats of the forms. The Bureau greatly appreciates the time taken by busy staff to enhance the required documentation process.

New Medication Support Forms were created and revised in order to clarify the documentation elements needed to satisfy all payer requirements for medication support services to ensure reimbursement. Similarly, it will also ensure the appropriate usage of Procedure Codes. The new and revised forms will also allow for a uniform method of documenting medication support services as described in this Bulletin. Furthermore, as the Department moves towards an Electronic Medical Record, these forms will provide the basis to which prompts will be developed in the new EMR.

Forms are available in both PDF Fillable format and NCR format. All non-NCR versions of forms can be found on the internet under Provider Tools/Forms/Medication Notes in a PDF Form Fillable format and must continue to be used along with a Daily Service Log. All NCR versions of forms must be ordered from the Department Warehouse and do not require the use of a Daily Service Log.

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. Does a non-English speaking client need to sign the English version of the Consent for Services?
2. When transferring Clinical Records and/or PHI from one site to another (e.g., from Clinic to DMH Headquarters or from the field to the Clinic), is it necessary to use a secure lockable container?

Answers on the last page

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New/Revised Forms and usage:

MH 657 - Initial Medication Support Service (90862): An optional form which may be used when prescribing medications during the first medication evaluation with a new client. This form should always be used if an Initial Assessment has not been completed at the time of the medication evaluation. The form allows for a more comprehensive evaluation of the client's history and current status.

MH 653 - Complex Medication Support Service (90862): A form used with clients not yet stable on medication which requires detailed assessment, history, and decision-making for prescribing medication. This form may be used in place of the Initial Medication Support Service (90862) form in cases where a detailed Initial Assessment has been completed by clinical staff, and the psychiatrist has determined that that level of assessment is not needed.

MH 655 - Brief Follow-Up Medication Support Service (M0064 or H2010): A form used when prescribing medications to clients stable on medication (M0064), or when prescribing medications based on a phone call or collateral contact (H2010).

MH 656 - Non-Prescription Medication Note: A form used when a non-prescription medication support service has been provided.

MH 654A - Medication Support Service Addendum: A form used when additional space is needed to complete any of the above forms. No claiming information should be included on this form.

MH 519 - Medication Log: An optional form for use as a reference for medication history. It may not be used in place of any of the above forms.

Key changes/revisions to the forms used for Medication Support Services include:

- Prompts to ensure all elements to meet payer requirements are included in the note
- Forms that distinguish medication support services by their associated procedure code
- One claimable service per note
- A cross-reference no longer has to be made in the Progress Note
- Physician orders have been incorporated into the form
- Uniform location and tracking of medications prescribed on all medication support service forms

OBSOLETE Medication Support Service Forms:

MH 504—Evaluation by Physician
MH 519—Medication Note
MH 519 NCR—Medication Note
MH 504—Physician's Orders

Key points to remember:

- Diagnosis should only be found on the Initial Assessment or Diagnosis Information form.
- Any time a diagnosis is added or changed from what is listed on the Initial Assessment or Diagnosis Information form, a new Diagnosis Information form must be completed.
- All BOLDED areas on the medication support service forms MUST include detailed information. Checking boxes or writing "Ø" is not appropriate. When using the Initial Medication Support Service form, boxes may be checked if relevant parts of the Clinical Record have been reviewed and referenced.

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Key points to remember (continued from previous page)

- The documentation for all medication support services should be on the revised forms filed in the Medication Support Section (for directly operated clinics only).
- No Shows should be documented on the Non-Prescription Medication Note.
- The use of the Medication Log must be determined at the Program level. If used, the form may be printed on colored paper at the discretion of the Program Manager so that it is easily distinguishable in the Medication Section of the chart.
- If at anytime it is determined that no medications will be prescribed, the H2010 code, which is an available option on each of the prescription forms, must be chosen.
- If NCR forms are used, note that the last page of the form has been placed on top in order to prevent writing from going through to other pages due to the carbon paper used on the last page of the NCR forms.
- The preparation of reports or letters, even though medications may be a part of the report/letter, should continue to be documented on a Progress Note form using Procedure Code 90889 and filed in the Progress Note Section of the Clinical Record.
- Time spent by MD/DO, NP, RN, PT, LVNs discussing medications for an individual client during a consultation/team conference should be documented using the Non-Prescription Medication Note and Procedure Code H2010.
- Only the Physician/Nurse Practitioner's time will be claimed on the three new prescription forms. Any other staff who participates in the contact should document any claimable service in a separate note.

Implementation of New Medication Forms:

1. New forms were presented at both District Chiefs Meeting (July 9th) and Program Heads Meeting (July 31st)
2. Training will be provided to all physicians in each Service Area by the end of August
3. Programs should immediately implement the use of the new forms once training has been provided in their Service Area
4. Forms MUST be in use by September 1, 2008

Please direct any questions regarding the above information to Jennifer Eberle at (213) 738-3770.

c: Executive Leadership Team, District Chiefs, All DMH Physicians, Program Heads, Provider Record Keepers, ACHSA, Revenue Management Division

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. No, a non-English speaking client may sign a Consent for Services in their native language if such a document is available. In order to prevent any confusion, there should be an "unfilled" English version of the form either on the back of or attached to the non-English signed version of the form that the client signed with a notation written, signed and dated by the staff at the bottom of the English version form indicating "*The attached Consent for Services form was signed by the client in his/her own native language.*"
2. Yes, a secure lockable container (lockbox) is required and should be locked in the trunk during transportation of a Clinical Record and/or PHI. In addition, each clinic should have their own policy and procedures regarding safeguarding Clinical Records and/or PHI during transportation. Some situations apply in which Clinical Records and/or PHI do not fit in a large secure lockable container, and an alternative cannot be found. In these situations, please contact Rose Esquibel at (213) 739-6335 for assistance.