



Quality Assurance Bulletin

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Program Support Bureau

County of Los Angeles - Department of Mental Health

Marvin J. Southard, DSW, Director

ACCURATELY REFLECTING SERVICES PROVIDED WHEN DOCUMENTING & CLAIMING

The purpose of this Bulletin is to communicate and clarify the Department's current position on the documentation and claiming for services rendered by any Department staff. The basic principle of all documentation and claiming is that it must accurately reflect the services provided. **Documentation and claiming shall be completed based on the service provided regardless of payer source for the service, financial eligibility of the client or job title of the practitioner.**

The procedures for each category of service provided are as follows:

Direct Services: Interventions such as Rehabilitation and Targeted Case Management performed pursuant to a completed Assessment and Client Treatment Plan, and in accord with the mental health objectives identified on the Client Treatment Plan (i.e., the "Clinical Loop");

- Complete a progress note to document the service
- Claim as a direct service using the appropriate procedure code

Community Outreach Services: Outreach and engagement activities prior to an Assessment and Client Treatment Plan or reengagement activities for clients that have disengaged from ongoing treatment;

- Complete a COS note to document the service
- Claim as a COS service using the appropriate COS code

Note for Directly Operated Only: Although historically Mental Health Advocates have been limited to documenting and claiming only COS, this restriction has been lifted to support the accurate representation of services within the medical record. The provision of Direct Services, as well as Community Outreach Services, is within the classification job specification for Mental Health Advocates. To be fully consistent with the basic principle of documentation and claiming, Mental Health Advocates may document and claim for Direct Services. As with all practitioners, if a Mental Health Advocate is still in the process of learning to document (or learning the Clinical Loop) and the employee's supervisor is not yet comfortable with claiming the services to Medi-Cal, the appropriate Non-Billable to Medi-Cal procedure code (e.g. 00001 or 00002) may be used instead of the usual procedure code (e.g. H2015 or T1017) in conjunction with ongoing supervision and support.

If agencies have any questions regarding this Bulletin, please contact your Service Area QA Liaison.

c: Executive Management Team
District Chiefs
Program Heads
Department QA staff
QA Service Area Liaisons

Judith Weigand, Compliance Program Office
Nancy Butram, Central Billing Office
Pansy Washington, Managed Care
TJ Hill, ACHSA
Regional Medical Directors