**HWLA Documentation Requirements-Community Partners**
**Quality Assurance Division**
**Version 4: 5/15/12**

## Clinical Records

Community Partners providing mental health services must ensure that there is a mental health clinical record for all clients receiving services under Healthy Way Los Angeles (HWLA) to document the services the client received. The clinical record shall be maintained by the Community Partner and it is up to the Community Partner to ensure that all federal, state and local laws and regulations regarding the mental health clinical record are adhered to. Community Partners may have either a paper clinical record or an electronic medical record (EMR) which shall include complete, accurate and current documentation of any and all information related to the client's mental illness. Clinical records are considered legal documents.

Some of the purposes of a clinical record are as follows:

- To evaluate and plan the client's individual treatment and care
- To analyze, study and evaluate the quality of care rendered to clients
- To serve as a means of communication for continuity of care and to link past and current services
- To protect the legal interest of the client, facility/program and/or the therapist

All information contained in the clinical record is considered confidential information and is protected under Welfare & Institutions Code 5328. Professionals may share Protected Health Information (PHI) with other professionals providing care to a person without client authorization. Information in the clinical record must adhere to all HIPAA Privacy and Security regulations. The Los Angeles County Department of Mental Health (DMH) does not provide legal advice to its contractors; Community Partners must seek legal advice from their own legal counsel in order to interpret laws or regulatory codes and to answer any questions regarding release of information.

The clinical record shall include complete, accurate and current documentation of any and all information related to a client. It must contain demographics, history, support for the diagnosis and/or condition of the client, treatment provided and the current status/condition of the client.

Community Partners are responsible for creating their own chart structure for the HWLA program.

## Clinical Forms

DMH provides official clinical forms for use within a paper clinical record. Official clinical forms have been designed in order to meet required elements based on:

- Clinical Record Guidelines
- Clinical need
- Funding source reimbursement rules
- HIPAA Procedure Code definitions
- Integrated System (IS) fields
- State Contract requirements

- LACDMH Policy and Procedures

Approved forms are categorized into four different categories noted below. Please note that these are described in terms of having a paper clinical record. For Community Partners with an EMR, please refer to Clinical Records Bulletin Edition 2011-03 located at http://dmh.lacounty.gov/ToolsForAdministrators/Agency_Administration/clinical_records_bulletins.html for information regarding how to incorporate the below category of forms into an EMR.

1. **Required (R):** Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.
2. **Required Data Elements (RDE):** Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy; however, the layout and presentation of the form is up to Contractors.
3. **Optional (OP):** Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. While the forms and their specific data elements are not specifically required, the concept encompassed by the form's title is. This means that Contractors must have a method of documenting the concept captured by the title of the form.
4. **Ownership (OW):** Forms which are required by state or federal law/code or County/Department policy/procedure but because of their potential legal implications cannot be "DMH Required" forms. These forms require the contractor to be familiar with the relevant authority and to design a form based on their agency's understanding/interpretation of the authority and its plan to implement compliance with the law/code.

Many approved Clinical Forms can be found on the DMH internet at www.dmh.lacounty.gov under Clinical Tools. Below is a sample listing of clinical forms that may be found in the Community Partner Mental Health Clinical Record and the associated category of form.

**Sample Forms**

Client Face Sheet MHMIS or IS – MH 224A - (RDE)
Contact Information - MH 525 - (OP)
Close Outpatient Episode – MH 224B - (RDE)
Open Outpatient Episode – MH 224B - (RDE)
Payor Financial Information (PFI) – MH 281 - (R)
Consent for Services – MH 500 - (OW)
Consent to Photograph/Audio Record – MH 528 - (OW)
Consent for Telemental Health Services – MH 652 - (OW)
Advance Health Care Directive – MH 635 - (OW)
Acknowledge of Receipt (Privacy Notice) – MH 601 - (OW)
Client's Request for Restriction of Use & Disclosure of Health Information – MH 614 - (OW)
Letter of Denial Regarding Client's Request for Confidential Communications – MH 616 - (OW)
Client's Request for Confidential Communications – MH 615 – (OW)

**HWLA Documentation Requirements-Community Partners**
**Quality Assurance Division**
**Version 4: 5/15/12**

Accounting Tracking Sheet – MH 612 (OW)
DMH Response to Primary Care Provider – MH 649B - (OP)
Primary Care Provider Referral to DMH – MH 649A - (OP)
Auth for Request or Use/Disclosure of PHI - MH 602 - (OW)
Final Letter to Client for Review of Denial - MH606 - (OW)
Client Request for Review of Denial to PHI - MH 605 – (OW)
Letter Response to Client Request for PHI - MH 604 – (OW)
Client Request for Access to PHI - MH 603 – (OW)
Letter Responding to Request to Amend/Correct Health Information – MH 608 - (OW)
Request to Amend/Correct PHI – MH 607 - (OW)
Letter Responding to Client's Request for Accounting of Disclosures – MH 613 - (OW)
Request for Accounting of Disclosures – MH 611 - (OW)
DMH FAX Cover for Transmitting PHI – MH 617 - (OW)
Representation of Researcher to Review PHI Held by LAC DMH to Prepare for Research – MH 619 - (OW)
Representation of Researcher to Review PHI of Decedents Held by LAC DMH to Prepare for Research – MH 620 - (OW)
Diagnosis Information – MH 501 - (RDE)
Special Program Client Care Coordination Plan (CCCP) – MH 651 - (R)
Co-Occurring Joint Action Council (COJAC) Screening Instrument – MH 659 - (R)
Adult Short Assessment – MH 678 - (R)
Adult Assessment Addendum – MH 532A - (OP)
Discharge Summary - MH 517 - (OP)
Progress Notes - MH 515 (the audit trail for all services) - (OP)
Case Presentation - MH 514 - (OP)

## General Documentation Guidelines

The clinical record must clearly identify that the client meets Medical Necessity in order for mental health services to be reimbursed. Medical Necessity is comprised of three criteria:

1. An included Mental Health diagnosis from DSM
2. Impairments that result from the included mental health diagnosis
3. Interventions that are directed towards improving the client impairments, symptoms or behaviors.

These three criteria of Medical Necessity are supported throughout the "clinical loop" which is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are claimable for reimbursement. The sequence of documentation on which Medical Necessity requirements converge is:

1. The Assessment
2. The Client Care Plan
3. The Progress Note

## Assessment Guidelines:

An assessment must be present in the Clinical Record of each client receiving mental health services. The Assessment must document the symptoms, behaviors and impairments in life functioning for the client and a 5 Axis DSM diagnosis.

**HWLA Documentation Requirements-Community Partners**
**Quality Assurance Division**
**Version 4: 5/15/12**

The DMH approved **"Required"** Adult Short Assessment form (MH 678) must be used for the Assessment and must be completed by the end of the 2nd claimed session for the client.

**Client Care Plans:**

A client care plan must be present in the Clinical Record of each client receiving mental health services. The Client Care Plan must document the short-term goals (objectives) of mental health treatment in specific, measurable, attainable, realistic, and time-bound terms. The Client Care Plan must also document the interventions mental health staff will provide in order to assist the client in achieving the identified objective for the client. The client must participate in the development of their Client Care Plan and must sign the plan that is developed.

The DMH approved Required Special Program CCCP form (MH 651) must be used for the Client Care Plan and must be completed by the end of the 2nd claimed session for the client.

**Progress Notes:**

A progress note must be present in the Clinical Record for each service provided to the client prior to a claim being submitted. The Progress Note must clearly document:

1. Date of service
2. Procedure Code (if the service is being claimed)
3. Length of service for all participating staff including face-to-face time and other time
    a. Face-to-face time is the amount of time in which services were directed towards the client
    b. Other time is the amount of time spent providing a service that was not directed towards the client, travel time, and documentation time
4. Description of the service provided
    a. The intervention that was attempted or accomplished by each participating staff
5. Any changes in the client's status
6. Signature of the Rendering Provider

Community Partners may use the DMH approved Progress Note (MH 515) or they may create one of their own so long as it captures the above information.