COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

CLINICAL RECORDS BULLETIN

Edition 2009-02

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

February 3, 2009

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Announcements

Telemental health services are used when appropriate mental health staff cannot be physically present with a client to evaluate his/her mental health needs and, if needed, prescribe medications. Mental health staff at another location can now provide services to a client through newly-available technology. A new specialized consent form is available for use when Telemental health services are provided:

MH 652— Consent for Telemental health services for use upon initial provision of telemental health services.

REMINDER: Required DMH forms should not be changed in any way. Forms that are required by both Directly-Operated and Contract providers (such as the Initial Assessments, Client Care Coordination Plan, and Diagnosis Information) are designed to ensure compliance with Clinical Record Guidelines, Medicare and Medi-Cal reimbursement rules, HIPAA Procedure Code definitions, Integrated System (IS) fields, and State DMH contract requirements. Any changes to the forms may result in audit disallowance. If changes are needed or desired, please direct them to Jennifer Eberle at jeberle@dmh.lacounty.gov.

MH 501 - DIAGNOSIS INFORMATION FORM

Revised Form Available on Internet

(http://dmh.lacounty.gov/Forms.asp—see Diagnosis Information)

DMH Official Form Usage

Directly Operated Clinics: *must* use these forms, when applicable, in their original format.
Contractors: *must* use these forms, when applicable, without alteration in their original format.

The former *MH 501- Change of Diagnosis* form has been renamed and revised in order to help ensure the diagnosis in the clinical record is consistent with the diagnosis in the Integrated System (IS). The form has been re-named to *MH 501 - Diagnosis Information* and has been broadened in its use to allow for greater flexibility in documenting changes or additions to a client's diagnosis. Additionally, during the revisions of the Medication Support Service forms, it was determined that the form be simplified to assist users (both clinicians and doctors) in completing the form.

PURPOSE OF THE DIAGNOSIS INFORMATION FORM

The Diagnosis Information form is designed to facilitate greater diagnostic consistency between the clinical record and the Integrated System (IS) by providing a unique place where a new or revised diagnosis can be recorded in the clinical record and then updated in the IS. The form documents the client's current diagnosis and is the means in which the diagnosis gets updated in the IS.

For further information, click on the "?" on the top of the form located on the internet.

It is important to remember that the *Diagnosis Information* form must be completed each time there is

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. Who is authorized to release a minor's PHI in a case where the minor consented to the mental health services provided to him/her? The parent/legal guardian? The minor?
2. When the Court has awarded both parents joint custody of a child, are both parents required to sign the Consent for Services for the child?

Answers on the next page

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a change or addition to a client's diagnosis on any of the five axes to ensure the change/addition is also documented in the IS. This allows for the proper diagnosis to be associated with claims sent to the State for reimbursement.

To ensure coordination of care, the clinical staff on a team working with an individual client should be communicating with one another regarding the client's diagnosis. **Should there be incongruity regarding the client's diagnosis (this often happens between the medication notes and the initial assessment), those involved in the client's care should discuss the diagnosis and complete a *Diagnosis Information* form should the diagnosis in the IS need to be changed.** If an agreement cannot be reached, it is a responsibility of the Program Manager to mediate a resolution. It is important that the goals and behaviors that each member of the team are working on are consistent with the client's five axes diagnosis listed in both the clinical record and the IS. A review of the diagnosis in the clinical record and the IS should be included in QA reviews.

Listed below are key revisions and things to remember about the use of this form. Please refer to the instructions attached to the form for additional information on how to complete the form.

Key Revisions to the Diagnosis Information form:

- Broadened the types of diagnosis information to allow for greater flexibility in the use of the form
- Added check boxes to the types of diagnosis information
- Changed the listed diagnosis to the five axes diagnosis to match the diagnosis on the Initial Assessments and reduce confusion regarding what the diagnosis was, should be changed to, etc.
- Added references to other source documents justifying the change/addition in diagnosis

Key things to remember:

- Any time a diagnosis is changed or added this form must be completed
- If the diagnosis in the clinical record does not match the diagnosis in the IS, this form must be completed
- If an episode is opened with "Deferred Diagnosis," this form must be completed as soon as a diagnosis is determined but never later than 1) 60 days following admission or 2) upon completion of the Initial Assessment
- The full diagnosis, as it currently is, should be included on the form; there is no need to list what the diagnosis used to be
- This form may only be completed by an MD/DO, NP/CNS, licensed or registered and waivered psychologist, licensed or registered LCSW/MFT, or Mental Health Counselor RN/Senior Mental Health Counselor RN
- A client's diagnosis should only be listed in two places: the Initial Assessment and this form

Any questions regarding this form and its use should be directed towards Jennifer Eberle at (213) 738-3770.

c: Executive leadership Team, District Chiefs, Program Heads, Provider Record Keepers, ACHSA, RMD

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. A minor is authorized to release PHI if he/she has signed the Consent for Services. (A minor may only sign the Consent for Services if a Consent for Minor has been completed.) If a minor's parent/legal guardian initially consented for services, once the minor signs the Consent of Services he/she takes subsequent ownership of all his/her clinical information and is authorized to sign for the release of information.
2. Only one (1) signature is required on the Consent of Services; both parents who hold joint custody are not required to sign the Consent for Services. If the parents do not agree, the Court who issued the Order appointing the Joint Custody would have to decide what is best for the minor.

MH 501
Revised 1/5/09

DIAGNOSIS INFORMATION

Type of Diagnosis Information:

☐ Admission Diagnosis ☐ Clerical Revision to Admission Diagnosis ☐ Clerical Revision to Current Diagnosis
☐ Clinical Update to Current Diagnosis ☐ Other (please specify): _____

New/Updated Diagnosis: (include full *Current* Five Axes Diagnosis)

Note: The medication monitoring computer program will compare both the Principle and Secondary Diagnosis with any prescribed medication. A diagnosis consistent with the usual use of a given medication MUST appear as either the Principle or Secondary Diagnosis in the current/discharge diagnosis fields of the IS. If a diagnosis is inconsistent for the usual use of a medication, the medication MUST be specifically authorized through review and approval procedures.

Axis I ☐ Prin ☐ Sec Code _____ Nomenclature _____
(Medications cannot be prescribed with a deferred diagnosis)
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____
Code _____ Nomenclature _____

Axis II ☐ Prin ☐ Sec Code _____ Nomenclature _____
☐ Sec Code _____ Nomenclature _____
Code _____ Nomenclature _____

Axis III _____ Code _____
_____ Code _____
_____ Code _____

Axis IV Psychological and Environmental Problems which may affect diagnosis, treatment, or prognosis

Check as many as apply:

1. ☐ Primary Support Group 2. ☐ Social Environment 3. ☐ Educational 4. ☐ Occupational
5. ☐ Housing 6. ☐ Economics 7. ☐ Access to Health Care 8. ☐ Interaction with Legal System
9. ☐ Other Psychosocial/Environmental 10. ☐ Inadequate information

Axis V Current GAF: _____ DMH Dual Diagnosis Code: _____

Justification:

☐ See Initial Medication Support Service dated _____ ☐ See Assessment Addendum dated _____
☐ Justification from current Diagnostic Manual:

_____ _____ _____ _____
Signature & Discipline Date Co-signature & Discipline (when required) Date

☐ Diagnosis has been entered in the IS by _____ (initials) on _____ (date).

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

DIAGNOSIS INFORMATION

DIAGNOSIS INFORMATION

Purpose: To facilitate greater diagnostic consistency between the clinical record and the Integrated System (IS), the Department's claiming system, by providing a unique place where a new or revised diagnosis can be recorded in the clinical record and subsequently the IS.

Who can complete this form: This form may only be completed by an MD/DO, NP, licensed or registered and waivered Psychologists, licensed or registered LCSW/MFT, CNS, or Mental Health Counselor RN/Senior Mental Health Counselor RN

Recording Procedure: A client's diagnosis should only appear on two documents within the clinical record:

- Initial Clinical Assessment
- Diagnosis Information Form (this form)

To ensure the correct diagnosis is available in the Clinical Record and IS, follow these instructions regarding completing the Diagnosis Information Form:

Type of Diagnosis Information:

There are two types of diagnosis visible in the IS:

A. Admission Diagnosis – the diagnosis established at admission and appearing on the Initial Assessment, or in a few approved situations, the admission diagnosis appears on this form. There is never more than one admission diagnosis in the IS but it can be changed in two circumstances by marking one of the appropriate boxes on the form:

1. **"Admission Diagnosis" box:** 1) When an Initial assessment has not been completed but an Initial Medication Support Service form has been completed use this form in association with the Initial Medication Support Service form to open the episode documenting the admission diagnosis or 2) When an Initial Assessment has been completed and based on subsequent review of information available at admission, it is determined that a different diagnosis would have been more appropriate.
2. **"Clerical Revision to Admission Diagnosis" box:** When a clerical mistake was made during data entry when the admission diagnosis was entered (the diagnosis was incorrectly entered into the IS) the admission diagnosis should be changed rather than a new diagnosis added.

B. Current/Discharge Diagnosis – this is the diagnosis that can be assigned anytime during the course of a client's treatment by the Department and finally at discharge. The IS will keep a sequential history of diagnosis assigned to a client throughout his/her treatment episode. The current diagnosis can be updated in two circumstances by marking the appropriate box indicated below:

1. **"Clinical Update to Current Diagnosis" box:** When it is decided that the current diagnosis is not accurate based on new or more complete information, a new current diagnosis can be added to the IS.
2. **"Clerical Revision to Current Diagnosis" box:** When the current diagnosis was incorrectly entered into the IS (a clerical mistake was made during data entry when the current diagnosis was entered), the current diagnosis should be changed rather than a new diagnosis added.

New/Updated Diagnosis:

Enter the complete diagnosis on the five axes. This represents the current five axis diagnosis for the client and the diagnosis as it should be in the IS.

Justification:

When the "Admission Diagnosis" or "Clinical Update to Current Diagnosis" box is marked for change in diagnosis, the rational must be validated in the "Justification" section of this form and/or on the Initial Medication Support Service form or Assessment Addendum. Justification should be made based on the current Diagnostic Manual.

Entering in the IS:

The completed form should be submitted to data entry staff. If a data entry error occurred when either the admission or current diagnosis was entered, the pencil icon is clicked to make the change and the date associated with the diagnosis is not changed. If there is a clinical update to a diagnosis, the blue plus sign icon is clicked and the revised diagnosis with a new date is entered. When the diagnostic information has been entered into the IS, data entry staff should initial and date the form.

Filing Procedure for Directly Operated Programs: This form should be filed sequentially by date (most recent on top) in the Assessment/Plan section of the clinical record after data entry staff have entered the diagnostic information in the IS.