



COUNTY OF MONTEREY HEALTH DEPARTMENT

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Administration Clinic Services Public Health
 Behavioral Health Emergency Medical Services Public Administrator/Public Guardian
 Environmental Health/Animal Services

Policy Number	129
Policy Title	Health Records Documentation
References	California Code Of Regulations, Title IX, Chapter 11, Medi-Cal Specialty Mental Health Services; National Heritage Insurance Company, Final Local Medical Review Policies; Psychopharmacology And Psychotherapy, Effective 10/1/2003; Notice of Action (BHD Policy 120); Approved Abbreviations (BHD Policy 420); Interpretation And Translation (BHD Policy 451); Change Of Diagnosis (BHD Policy 464); Translation Of Beneficiary Materials (BHD Policy 452) Monterey County Health Department Policies Monterey County Health Department Confidentiality Acknowledgment
Form	Admission Onset of Services Assessment Diagnosis Progress Note Authorization for use, exchange, and/or disclosure of confidential behavioral health information within Monterey County Behavioral Health UMDAP - Uniform Method of Determining the Ability to Pay Etc.
Effective	March 1, 2005 Revised: July 1, 2007 Revised: September 26, 2011 Revised: October 19, 2011 Revised: February 15, 2012 Revised: April 24, 2015 Revised: April 28, 2016 Revised: January 26, 2017 Revised: June 21, 2019

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It is the policy of MCBHB that all services will be delivered using a client and/or family centered approach that recognizes the diversity and strengths of clients and their family. All services must be documented in a consistent and standard format within appropriate timelines. This policy provides minimum documentation guidelines applicable to all mental health services provided by the MCBHB regardless of payer source. Employees of MCBHB shall adhere to established guidelines related to the organization and contents of the clinical record. All individuals who are granted access to the beneficiary's medical record are required to adhere to all Health Department policies and MCBHB policies. All are required to adhere to the general documentation guidelines as set forth in this policy and other policies.

12 All individuals are required to adhere to privacy and compliance regulations noted within the
13 Monterey County Health Department's Confidentiality and Non-Disclosure Acknowledgment. All
14 individuals are required to maintain strict privacy and follow safeguards to protect log in and
15 password information used to access Monterey County Health Department's information systems
16 to conduct business operations. This includes access to confidential records pertaining to
17 beneficiaries within the electronic medical records.

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19 The access code and/or passwords given to you should never be shared and should solely be
20 used for business operations. Documentation in the electronic health record shall only be done
21 using your personal access codes. Your personal access code will serve as your signature that the
22 information is accurate is in compliance with Monterey County Health Department and Behavioral
23 Health policies.

24 25 **A. GENERAL GUIDELINES APPLICABLE TO THE CLINICAL RECORD**

- 26 1. All services will be provided using a client-centered approach.
- 27 2. An electronic record of all services provided shall be documented in the electronic health
28 record (EHR) for all programs where EHR is available. A paper copy clinical record of all
29 services provided shall be maintained in all programs, where applicable.
- 30 3. All individuals who have permission to access client/patient information shall follow all State,
31 Federal, and county-wide confidentiality regulations and shall access client data in according
32 to such regulations.
- 33 4. All individuals who have permission to access client/patient data shall be issued a secure,
34 password-protected, unique identification to access client/patient records for the purpose of
35 mental health treatment provided through Monterey County Behavioral Health.
- 36 5. Protected Health Information (PHI), which includes all clinical documentation, shall not be
37 saved on any disk or any other electronic medium until such time as the Department
38 implements its electronic medical record. Any paper documents will be kept in a double
39 locked cabinet
- 40 6. When a practitioner submits forms and/or "finalizes" documents in the electronic medical
41 record, EHR, this function serves as a legal signature for that individual. For progress notes,
42 the submission or finalizing function will serve as a legal signature that the information
43 contained in the progress note is accurate. For paper charts, the documentation must be
44 legible, complete, and signed with a license credential or job title.
- 45 7. MCBHB programs shall use only forms approved by the Division and/or provided within the
46 EHR.
- 47 8. A client is considered to be a "Long Term client" when the client has been opened to and
48 receiving services for over 60 days from date of admission and meets the Medi-Cal
49 reimbursement for Outpatient/Specialty Mental Health Services requirement.
- 50 9. A client may be assigned a "Case Coordinator" to help the client reach their maximum
51 potential in the least restrictive environment; to help the client navigate his/her needs in the
52 community; and to ensure client receives necessary services without duplication.
- 53 10. The Coordinator can be a county or contract provider staff
 - 54 a. The Coordinator will work together with the client and their treatment team to
55 deliver a full range of services that assist individuals to reach their full potential.
 - 56 b. The Coordinator, alongside the client, is responsible for coordinating care with the
57 client's larger community and social support systems.

- 58 c. The Coordinator is responsible for ensuring that all services are medically
59 necessary and for ongoing assessment and approval of services in the community
60 including those from contracted providers.
61 d. The Coordinator ensures completion of client's reassessment and completion of all
62 required documents on an annual basis.
63 e. After an assessment, if the Coordinator determines that client does not meet
64 Medical Necessity or that the client is no longer eligible for services based on an
65 alteration in the services provided, the coordinator will consult with his/her
66 supervisor and complete a Notice of Action (refer to Policy 120).
- 67 11. All direct services must be documented in the Clinical Record within 72-hours business hours
68 of service; Submission of this documentation will result in a claim for reimbursement.
69 12. All other documents related to a client must be filed/scanned in his/her clinical record within
70 72 business hours of service, in accordance with the Division's policy.
71 13. For entries submitted after 72 business hours of service, the documentation should include a
72 reason for late entry.
73 14. In paper charts, the client's name and medical record number must be on all documents.
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75 **C. CONTENTS OF CLINICAL RECORD**

76 All clinical records shall contain:

- 77 1. Onset of services
78 a) Informed Consent
79 b) Notice of Privacy Practices
80 c) Consumer Rights
81 d) MCBH Problem Resolution
82 e) Authorization for use, exchange, and/or disclosure of confidential behavioral health
83 information within Monterey County Behavioral Health
84 f) Authorization to bill private insurance or Medicare
85 g) Offer a copy of "Guide to Medi-Cal Mental Health Services"
86 h) Minor Consent, if applicable
87 i) Authorization to use, exchange, and/or disclosure of confidential behavioral health
88 information (as indicated)
- 89 2. All applicable Authorization for use, exchange, and/or disclosure of confidential behavioral
90 health information within Monterey County Behavioral Health
91 3. Any correspondence related to client treatment
92 4. An Initial and Annual Re-assessment update;
93 a) including Medical Necessity (refer to policy 421);
94 b) a Physician Evaluation, when seen for medication support services
95 5. Psychosocial Assessment
96 6. Mental Status Examination
97 7. Diagnosis (DSM-5 AND ICD-10 code set)
98 8. Child Assessment of Needs and Strengths (CANS) or Adult Needs and Strengths
99 Assessment (ANSA)
100 9. MORS (if applicable)
101 10. Monterey County Treatment Plan (finalized)
102 11. Treatment Plan Participation Consent
103 12. Special Considerations (if applicable)
104 13. Client Case Coordinator form
105 14. Client Relationships

- 106 15. UMDAP - Uniform Method of Determining the Ability to Pay
107 16. Unlicensed Clinician form (at the start of services provided by an unlicensed (licensed-
108 eligible clinician) (MCBH Policy 144)
109 17. Psychological Testing reports (if applicable);
110 18. Progress notes, including case conferences/team consultations;
111 19. Discharge Summary (when applicable);
112 20. Physician evaluation, when applicable to determine need for medication support services
113 21. Medication consent forms and other supporting documentation. May include physicians
114 orders, laboratory tests, prescriptions, administration of medication;
115 22. Advance Health Care Directive Advisement (If applicable);
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117 **D. DIAGNOSIS GENERAL GUIDELINES**
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- 119 1. Each episode must include a diagnosis using Diagnostic Statistical Manual (DSM-5) criteria
120 and a must include a corresponding ICD10 code set.
121 2. The diagnoses shall be consistent with assessment information and all other documentation in
122 the clinical record, including any co-occurring diagnosis
123 3. The Principal Diagnosis must be one of the diagnoses identified by the State Specialty Mental
124 Health codes as a diagnosis eligible for Medi-Cal reimbursement through the mental health
125 system of care, otherwise known as an "included diagnosis."
126 4. Diagnoses that support medical necessity under Medicare, according to National Heritage
127 Insurance Company (NHIC) are:
128 a. Any diagnosis consistent with those specified in Indications and Limitations of
129 Coverage and/or Medical Necessity, and/or the ICD-9-CM (or the most up to date ICD
130 code as noted in regulations) descriptors in the list of ICD-9-CM Codes (or the most up to
131 date ICD code as noted in regulations) that support Medical Necessity.
132 b. If the diagnosis is changed during the course of treatment, the diagnosis form shall
133 be updated to reflect assessment information. The changes shall be documented within
134 the diagnosis form and/or clinical progress note.
135 5. Medical Necessity: Medical Necessity is established at the time of assessment and throughout
136 the course of treatment thereafter. To be eligible for Medi-Cal reimbursement for
137 Outpatient/Specialty Mental Health Services, documentation for medical necessity must be
138 documented at every encounter or service delivered based on the following 3 criteria
139 (diagnostic, impairment, and intervention related):
140 a. Diagnostic Criteria: The focus of the services should be directed to functional
141 impairments related to an Included Diagnosis
142 b. Impairment Criteria: The client must have at least one of the following as a result of the
143 mental disorder(s) identified in the diagnostic (A) criteria:
144 1. A significant impairment in an important area of life functioning, or
145 2. A probability of significant deterioration in an important area of life
146 functioning, or
147 3. For children, is there is a probability the child will not progress
148 developmentally as individually appropriate. Children covered under EPSDT
149 qualify if they have a mental disorder that can be corrected or ameliorated.
150 c. Interventions related to criteria: Must have at least 3 of the following
151 1. The focus of the proposed intervention is to address the condition
152 identified in impairment criteria (B) above, and

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2. It is expected the proposed intervention will benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; and/or for children, it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated).
 3. The condition would not be responsive to physical healthcare-based treatment
 - d. The primary responsible treating staff shall make inform the treatment team and/or providers to changes in the course of treatment, within confidentiality limits.
 - e. The primary responsible treating staff, as clinically appropriate, shall advise the individual/family of changes in diagnosis and/or course of treatment (within confidentiality limits).

167 **E. NEW INTAKES/ASSESSMENT**

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- 1) Regardless of payer source, the person receiving a mental health assessment shall be provided with the following information and the following requirements must be completed at time of intake/assessment:
 - a) New Client form (used to document “CSI Assessment Record” data elements, effective June 23, 2019
 - b) Admission form
 - c) Admission Part 2 (Bundle)
 - Client and Services Information (CSI)
 - d) Onset of Services
 - Informed Consent
 - Notice of Privacy Practices
 - Consumer Rights
 - MCBH Problem Resolution
 - Authorization for use, exchange, and/or disclosure of confidential behavioral health information (if necessary)
 - Authorization for use, exchange, and/or disclosure of confidential behavioral health information within Monterey County Behavioral Health
 - Authorization to bill private insurance or Medicare
 - Offer a copy of “Guide to Medi-Cal Mental Health Services”
 - Minor Consent, when applicable
 - e) Initial Assessment
 - f) Diagnosis (DSM 5 and ICD 10 code set)
 - g) Special Considerations (if applicable)
 - h) UMDAP - Uniform Method of Determining the Ability to Pay
 - i) Unlicensed Clinician form (at the start of services provided by an unlicensed, but licensed eligible clinician) (MCBH Policy 144)
 - 2) If determined the individual meets criteria for Specialty Mental Health Services (SMHS) as defined by MediCal “Medical Necessity,” (Policy 421) the following must also be completed:
 - a) Psychosocial Assessment demonstrating criteria for meeting “Medical Necessity” as noted in policy 421);
 - b) Mental Status Examination

- 200 c) Diagnosis (DSM-5 AND ICD-10 code set)
- 201 d) Child Assessment of Needs and Strengths (CANS) or Adult Needs and Strengths
- 202 Assessment (ANSA)
- 203 e) Recovery Needs Level (Reaching Recovery, Adults only, when applicable)
- 204 f) Monterey County Treatment Plan (finalized)
- 205 g) Treatment Plan Participation Consent
- 206 h) Special Considerations (if applicable)
- 207 i) Client Case Coordinator form
- 208 j) Client Relationships
- 209 k) UMDAP - Uniform Method of Determining the Ability to Pay
- 210 l) Unlicensed Clinician form (at the start of services provided by an unlicensed (licensed-
- 211 eligible clinician) (MCBH Policy 144)
- 212 m) Psychological Testing reports (if applicable);
- 213 n) Progress notes, including case conferences/team consultations;
- 214 o) Discharge Summary (when applicable);
- 215 p) Physician evaluation, when applicable to determine need for medication support services
- 216 q) Medication consent forms and other supporting documentation.
- 217 r) May include physician's orders, laboratory tests, prescriptions, administration of
- 218 medication;
- 219 s) Advance Health Care Directive Advisement (If applicable)
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221 F. REASSESSMENT/ RENEWAL

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- 223 1) The following documents need to be completed at time of renewal/reassessment:
- 224 a) Informed consent shall be discussed with the client
- 225 b) Update Client Data
- 226 c) Client Relationships
- 227 d) Mental Status MC
- 228 e) Psychosocial Assessment
- 229 f) Child Assessment of Needs and Strengths (CANS) or Adult Needs and Strengths
- 230 Assessment (ANSA)
- 231 g) Reaching Recovery tools, as applicable, Adults only)
- 232 h) Diagnosis DSM 5 AND ICD10 code set (make sure to select "update" option)
- 233 i) Monterey County Treatment Plan
- 234 j) Treatment Plan Participation Consent (must be completed every time information on the
- 235 treatment plan is added or updated
- 236 i) Defined as a verbal consent, followed by an electronic signature, of
- 237 acknowledgment, agreement, and participation in the treatment planning
- 238 process.
- 239 ii) Staff signature if required as acknowledgement of treatment planning
- 240 iii) A copy of the treatment plan shall be offered to the client. In the event the
- 241 client refuses, staff shall document the refusal and the reason on the form
- 242 and/or the progress note
- 243 k) Authorization to use, exchange, and/or disclosure of confidential behavioral health
- 244 information (as indicated-if expired)
- 245 l) Special Considerations (if applicable)
- 246 m) Unlicensed Clinician form (at the start of services provided by an unlicensed (licensed-
- 247 eligible clinician) (MCBH Policy 144)

- 248 n) UMDAP
- 249 o) MD Bundle (medical staff only, if applicable)
- 250 p) Case Coordinator assignment
- 251 q) Medication consent forms and other supporting documentation.
- 252 r) May include physician's orders, laboratory tests, prescriptions, administration of
- 253 medication;
- 254 s) Advance Health Care Directive Advisement (If applicable)
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256 **G. PROGRESS NOTES MUST INCLUDE**

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- 258 a. Date, including the day, month and year of service delivery;
- 259 b. Type of service delivered, as indicated by a procedure code/description of service;
- 260 c. Location of service;
- 261 d. Time, in minutes, the practitioner spent on the delivery of the services;
- 262 e. In the EHR, each staff providing a service must complete a progress note
- 263 indicating that staff's specific mental health interventions provided during the
- 264 service. For paper charts, staff names and credentials participating in the service
- 265 and "total time" in minutes for each staff shall be noted.
- 266 f. In the EHR, a group progress note for each client participant should be completed.
- 267 The progress note must clearly indicate the staff's specific and unique mental
- 268 health interventions provided during the service. For paper charts, the group
- 269 progress notes should include, the number of the clients for which claims will be
- 270 submitted (clients present or represented in the group);
- 271 g. Each entry must contain a description of what was attempted and/or accomplished
- 272 during the contact toward the attainment of a treatment goal; In the EHR, the
- 273 Treatment Plan should be "linked" to the progress note. For paper charts, the
- 274 service must be directly addressing a treatment goal identified on the treatment plan.
- 275 h. For changes in medical necessity, a description of the changes shall be
- 276 documented, when appropriate;
- 277 i. The practitioner's signature; In the EHR, by the practitioner "finalizes" the progress
- 278 note, this will serve as the practitioner's signature indicating the information being
- 279 submitted is accurate. For paper charts, include the practitioner's signature, print
- 280 full name, license/job title.
- 281 j. For documentation that requires co-signatures, follow the same criteria listed above
- 282 for signature requirements.
- 283 k. Only approved MCBHB abbreviations may be used (BHD [Policy 420](#))
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285 **FREQUENCY OF PROGRESS NOTES**

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- 287 Progress notes shall be documented at the frequency by type of service indicated below:
- 288 a. Every Service/Contact (claiming by the minute)
- 289 i. Mental Health Services
- 290 ii. Targeted Case Management
- 291 iii. Medical Support Services
- 292 iv. Crisis Intervention
- 293 b. Daily (claiming by the day)
- 294 i. Crisis Residential
- 295 ii. Crisis Stabilization (1x/23hr period)

- iii. Day Treatment Intensive
- c. Weekly (claiming by the week)
 - i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/ waived/ registered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service.
 - ii. Day Rehabilitation
 - iii. Adult Residential
- d. Other
 - i. Psychiatric health facility services: notes on each shift
 - ii. As determined by the MHP for other services

CORRECTING ERRORS WITHIN PROGRESS NOTES

1. In the EHR, errors within the content of the progress note, the progress note may be “appended” to reflect the accuracy of the services that were provided.
2. In the EHR, errors that are related to the accuracy for billing purposes, an “error report” must be submitted to make necessary corrections for the services billed.
3. In paper charts, the use of correction fluid or correction tape is not permitted. If a documentation error is made, it should be lined-through with a single line, the word “error” noted next to the line-through, initialed and dated and, when appropriate, the correct information charted.

G. OTHER DOCUMENTATION ISSUES

Cultural and Linguistic Considerations

Interventions to accommodate the needs of the visually and hearing impaired, as well as those with limited English proficiency, must be documented.

1. When the client’s primary language is not English, there shall be documentation showing what language services were offered and/or provided to the client and/or caregiver and/or that interpretive services were offered. Clients shall not be expected to provide interpretive services through friends or family members. (BHD [Policy 449](#))
2. When cultural and/or linguistic issues are present, documentation of issues and actions taken to link the client to culturally and/or linguistically specific services.
3. In order to obtain culturally and linguistically accurate information from clients who do not speak English as their first language, the MCBHB has translated forms and materials into the identified threshold languages. Whenever information is written in non-English language, the English translation must be included directly below the non-English statement. This includes the translation of the treatment plan into the client’s and/or caregiver’s preferred language.

Restricted Disclosure

Certain clinical progress notes may be designated “restricted disclosure” by individual providers and their supervisors/managers. Designating a clinical progress note as restricted disclosure alerts MCBH Quality Improvement staff to review the document and, if necessary, consult with the individual provider and/or their supervisor/manager prior to releasing the note as part of a client record request.

344 Client access to clinical progress notes marked restricted disclosure may be denied if the content
345 of the clinical progress note, if a licensed health care professional has determined, in the exercise
346 of professional judgement, that the access requested is reasonably likely to endanger the life or
347 physical safety of the individual or another person (Code of Federal Regulations, Title 45, Section
348 164.524). For minor clients who did not or could not have consented for their own services,
349 minor's representative access to the health records may be denied if such access would have a
350 detrimental effect on the provider's professional relationship with the minor or the minor's physical
351 safety or psychological well-being [California Health and Safety Code Section 123115(a)(2)].
352 However, final determination of whether or not client access to clinical progress notes will be
353 denied will be done by licensed clinical staff from MCBH Quality Improvement based on relevant
354 Federal, State, and local laws and regulations in effect at the time of the review.

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356 Types of clinical progress notes that may be designated "restricted disclosure" include but are not
357 limited to:

- 358 1) Clinical progress notes documenting fulfillment of a mandated reporting obligation (e.g., child
359 abuse reporting, elder abuse reporting) as disclosure of this information may reasonably
360 endanger the reporting provider.
- 361 2) Clinical progress notes containing information that might reasonably endanger the life or
362 physical safety of the client or another person.
- 363 3) For minor clients, clinical progress notes containing information that would have a detrimental
364 effect on the provider's professional relationship.

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366 Providers and/or supervisors/managers will contact MCBH QI if there are any questions as to
367 whether or not a specific progress note may be designated as restricted disclosure.