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Documentation 101: It's All in the Details

In the outpatient setting, documentation of services, which we simply refer to as "notes", is intended to demonstrate that quality care is being delivered to clients and serves as the basis of coordination of care with providers outside the agency.

Because notes act as a record of each service, they also serve the important purpose of justifying insurance reimbursement in the event of an audit. Therefore, documentation must contain certain details and information and **each note for each session should be original and individualized.**

Intake Notes

The purpose of an intake is to:

1. Establish medical necessity.
   For our purposes, we'll define this as demonstrating the appropriateness of treatment using psychotherapy sessions given the client's diagnosis, symptom severity, goals, history, and other needs.
2. Gather information regarding the presenting concern and other past/present biopsychosocial information.
3. Establish a billable diagnosis.
4. Begin formulating a treatment plan by identifying client goals.

Intake note requirements:

- The intake is where the therapist begins to form a narrative for treatment and demonstrate the need for sessions by establishing medical necessity. A diagnosis along with a diagnostic rationale is one part of establishing necessity.
- The ICD-10 diagnosis (F code) must be present for every client using insurance. (You can assume every client on your caseload needs a diagnosis.)
  - Diagnostic rationale using DSM 5 language must also be included. This provides supporting evidence for the diagnosis by demonstrating why/how the client meets criteria for the given diagnosis.
  - Z and V codes are not reimbursable. They can be added as supporting information but do not replace an F code and must always be listed in last position.
- A diagnosis can always be changed as new information is gathered.
  - Remember that a new rationale must also be given. Use a routine progress note or a QuickNote to make a notation of a change in diagnosis along with a few contextual details, such as the additional information and how the information came to light.
  - A new intake (90791) should not be billed except in rare instances, such as when a client returns from a mental health-related hospitalization and has not had a billed intake in the last several months.
- Treatment goals listed in the intake note as discerned from the assessment form the foundation of the client's treatment plan. A treatment plan does not need to be articulated in the intake note- listing goals is sufficient.
- Recommendations for treatment include session frequency, therapeutic approaches/modalities and extratherapeutic services to be received concurrent to therapy, for example medication management. Recommendations should be clearly tied or able to be tied to treatment of the presenting concern and given diagnosis.

Treatment Plan

- Information from the assessment such as the diagnosis, symptoms, treatment recommendations and the client's stated goals are used to create the treatment plan. All information in the treatment plan should point back to the client's diagnosis/presenting concern and should align with best practices for treating diagnosis/presenting concern.
- For clients who do not have Medicaid, a simple and brief plan entered in TA is sufficient.
  - At least 1 goal and 2 objectives should be added to the client's chart under the Records tab in TA. This will allow the treatment plan to be pulled into each progress note. This is the structure used for this purpose:
    Goal:
    Objective 1:
    Objective 2:
  - When completing a progress note, check the box to include the treatment plan as part of the note. This only needs to be done once per client and the setting will be saved.
- Please see the Medicaid Requirements document for detailed information about treatment plans for clients with Medicaid.

Progress Notes

Progress notes are considered part of a client's permanent health record. This is true as well of intake notes, discharge summaries, treatment plans and anything else uploaded to the client's chart and entered/signed by the clinician.

- Notes in the chart can be audited (reviewed by insurance), subpoenaed, and requested by the client.
- Content needs to be objective and free from the therapist's interpretations, opinions, judgments and potential biases.
- Notes should be written with the client's well-being in mind.
  - Consider potential for legal ramifications, future records requests, and the way the client or others may perceive the notes. Act as if you know the client will read each note.
- Notes should be a balance of sufficient factual information with minimal detail.
- Progress notes should be non-specific (especially related to client behavior) and brief
  For example: *Client was asked about high-risk behavior.*
  Instead of… Client was asked about his decision to sell his prescription medication.

Progress notes should include:

- Narrative summary of session: Primary topics, major themes, insights verbalized by client
- Modalities, interventions and approaches used by therapist
- Client presentation including functional status/impairment, symptom severity, orientation, mood/affect
- Progress toward treatment goals
- Client's response to interventions/session as a whole
- Plan for follow up/next session/future sessions

Process/Psychotherapy Notes

- Process notes, also known as psychotherapy notes, are not part of a client's electronic health record.
- These notes cannot be subpoenaed if stored correctly and de-identified.
- Need to be kept separate from the EHR.
  - Do **NOT** use the psychotherapy note section of TA.
- This type of note usually contains the therapist's subjective thoughts and interpretations, hypotheses, and statements of clinical judgment and intuition.
- Meant for the therapist to access and review only.
- If you wish to keep process notes, please collaborate with leadership to ensure a compliant process that minimizes risk to you, your clients and the company.

Crisis Session Notes

Crisis notes are reimbursed at a higher rate, therefore documentation requirements are held to a higher standard.

- Notes for crisis sessions (90839) must be completed within 24 hours.
- A client discharged after crisis (or a higher acuity client in general) should be discharged as soon as possible, as opposed to using more of the 30 day allotment.
- Make sure to change the CPT code and, if appropriate, use the 90840 time-based add-on code. (Ask Ashley Shaw for assistance if needed.)

Crisis notes should include:

- Efforts taken to ensure client safety. If consultation was sought with another clinician/leadership, include this.
- Plans made collaboratively with client or discussed with client to assist with safety. Document resources given such as a suicide hotline or contact information for a crisis center.
- Outcome of session and the next planned contact with the client.
  Examples: Therapist and client have a scheduled phone call in two days.
  Client verbally agreed to attend the next scheduled appointment on [date].

QuickNotes

QuickNotes are specific to TherapyAppointment.They are similar to memos and require less information than session notes.

QuickNotes should include:

- Date and approximate time event occurred, if relevant. (QuickNotes are timestamped with the time/date it's completed.)
  Example: *"Client contacted clinician at approximately 5:15pm on Sunday May 12, 2022 via text message…"*
- Individuals involved in interaction.
- Reason for contact plus brief description of interaction, if applicable.
  - Topics, requests, and/or concerns discussed; actions taken by therapist or others; include if consultation was sought with another clinician/leadership.
- Outcome and the impact or relation to the client's treatment goals.

Complete a QuickNote for the following:

- Therapist outreach attempts, for example following a cancellation or no show.
- Coordination of care efforts, such as phone calls and emails to other providers.
- Parent interactions outside of billing and scheduling that are not part of a scheduled session.

- ❖ Professional meetings attended such as a meeting for an IEP (for clients with Medicaid, a case management H code can be billed; no other insurance can be billed for this).
- ❖ Other interactions with client, client's relatives/loved ones, or other providers that rise to the level of documenting in the record.

Discharge Summary

Written at the completion of therapy to indicate that the client is no longer under the care of the therapist and Four Points.

- ❖ There are 3 options to complete discharges summaries Discharge Guide
- ❖ Please review the guide on the Therapist Access site for information on completing discharge summaries as well as instructions for making a client inactive.

The Bottom Line

The mentality, "If it isn't written down, it didn't happen," is a liability.

It encourages over-documenting which creates risk for you and for clients. It fosters fear, creating barriers to timely completion of documentation and contributes to overwhelm from a growing pile of unfinished notes.

Notes should be the easy breezy part of your day (once you've found your groove).

If a progress note for a "typical" session takes more than 5 minutes, step back and consider whether you're including too much detail. Remember, more information is *not* better. It creates risk for your client and you.

Why? Here's one example:
Each detail is an opportunity to be challenged in court. However, there's only so far an attorney can take their questions when documentation is non-specific.

If notes routinely take longer than 5-7 minutes each, ask for help. Our team has lots of tips to help you write compliant, ethical, and *brief* notes!

Progress note outline

This demonstrates a breakdown of content and the ratio of information in each section. The intention is to highlight, for example, that multiple paragraphs are not needed to convey the content of a session in the summary section.
Examples of complete notes shared during orientation

Session summary: 3 sentences

Interventions: 2-3 interventions, 4 max
Ex: DBT- Interpersonal effectiveness, CBT- cognitive distortions, insight-oriented work

Client presentation: Mood, affect, orientation
Ex: Euthymic mood, congruent affect, oriented x3

Status of symptoms & functioning: 1 sentence (2 max)

Treatment progress: 1 sentence (2 max)

Risk status: State applicable information or simply "client denied" or "no indication of active risk"

Plan: 1-2 sentences