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private practice experts

Writing Great Progress Notes

with

Barbara Griswold, LMFT

Author, *Navigating the Insurance Maze: The Therapist's Complete Guide to Working With Insurance--And Whether You Should*

Handouts, downloads, links:

theinsurancemaze.com/ZM

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SPEAKER

Barbara Griswold, LMFT is a private practice coach and the author of *Navigating the Insurance Maze: The Therapist's Complete Guide to Working with Insurance—And Whether You Should*, now in its 9th edition.

Her experience includes 32 years in practice working with dozens of insurance plans. She served on the State Ethics Committee and Board of Directors for the California Assn. of Marriage and Family Therapists.

She provides *non-judgemental* trainings and consultations to therapists and groups nationwide about insurance, notes, and the business of private practice. She welcomes you to contact her at theinsurancemaze.com.

First, a few housekeeping notes….

- Information given is a general overview. Laws, regulations, and requirements regarding documentation vary by state, practice setting, and health plan
- Information presented does not take the place of independent legal advice and/or contacting the client's health plan
- Opinions expressed are those of the presenter and do not necessarily reflect those of zynnyme

TheInsuranceMaze.com

Why Are YOU Here?

- Most of us never got training in notes
- You're not proud of your notes (you're in good company: 70% of therapists in my survey of 500 therapists said they didn't feel confident about notes)
- Maybe you've heard insurance plans are more often asking for charts, *even those of out-of-network therapists*
- Goals: Help you
  - truly understand the importance of your notes
  - write notes that are more helpful
  - feel more confident if reviewed or notes requested

When you think of a licensing board or health plan reading your notes, how do you feel?

Why Don't We Keep Better Notes? My Survey of 500 Therapists

- "It's hard to sum up a session in a few sentences"(42%)
- "I don't have time" (31%)
- "I write less to protect client confidentiality" (34%)
- "It's hard coming up with new things to say" (30%)
- "By the time I do notes, I don't recall details" (15%)
- "My notes were never requested, and my memory is great"
- "I write notes for me. I'm the only one reading them"
- "I don't need to worry, I don't take insurance"

Why Are Good Notes Essential?

- **NOT JUST FOR INSURANCE**
- **<u>To Protect You</u>**
  - Required by
    - law (may be illegal / unprofessional conduct to fail to keep notes "according to standards of profession")
    - ethics codes
    - licensing boards can also cite you
- **In complaint,** notes may be only defense -- must justify facts, your thinking, actions
    - "If you didn't document it, it didn't happen"
- **Can prevent lawsuits**: Client's lawyer may encourage client not to file if your notes show proper care
- ***Health plans can ask for money back*** *(or not reimburse clients) if your documentation does not meet standards!!*

Why Are Good Notes Essential? (cont.)

To provide better care

- Provide history for treatment (or after client return)
- Coordination of care / continuity of care

And even if you have a great memory, remember It's not YOUR chart -- it is a client's medical record you are keeping

- Documenting symptoms and impairment for disability, legal, and worker's compensation cases
- Documenting "medical necessity" for treatment for insurance -- *even for out-of-network therapists*
- Plus, a client can ask for their chart at any time

What CLINICAL documentation should be in your chart?

- Initial Intake (can be narrative)
- Ongoing Progress Notes (emphasis here)
- Treatment Plan
- What about emails and texts?

HIPAA: Two Types of Notes

Records requests may say "send notes but don't send psychotherapy notes".... HUH?

1. **Progress Notes**: (**REQUIRED**), includes session start/stop times, modalities/frequencies of treatment, diagnosis, functional status, treatment plan, symptoms, prognosis, and progress
2. **Psychotherapy notes:** (aka "process notes") are **OPTIONAL** notes "...documenting or *analyzing* the contents of conversation during a private counseling session ... that are *separated from the rest of the individual's medical record*"[1]
   - Your thoughts about treatment / therapy journal; no facts

- Are they both confidential?
- Why some lawyers don't recommend psychotherapy notes

1 – HIPAA Privacy Rule 45 CFR 164.501

What Should be In Your Progress Notes?

This Applies to You Out-of-Network Providers, Too

- When client turns in an invoice, your chart and treatment can be reviewed – and they want details of symptoms, treatment
- For all, what follows is an outline of an ideal clinical record

INTAKE: Common Plan Requirements

- Symptoms, problem and problem history
- Psychiatric history, including hospitalizations
- Current medications, including over-the-counter meds, prescribing doc, contact info
- Psychosocial information
- Medical issues / relevant history, allergies
- Mental status exam
- Document risk and how assessed; Danger to self/others
- Substance use assessment: Alcohol/drug/cigarette
- Diagnosis and support for it
- Support system / emergency contact info
- Medical necessity / impairment

OTHER: document significant administrative discussions

PROGRESS NOTES: Common Plan Requirements

1. **Actual session start and end times**, ex. "1:05-1:55 pm:" *does not include time spent waiting, scheduling, notes*
   - ➢ *What if your Electronic Record puts in scheduled time?*
2. Date and client's name on each page
3. Service type, ex. individual, couples, group
4. Client description of problems, client symptoms
5. Interventions/modalities/homework (Recommend min. 3)
   - ➢ Why they are so important, and what to avoid
   - ➢ Sample Interventions List: theinsurancemaze.com/ZM
6. Client strengths/limitations in achieving treatment plan goals
7. Functional impairments (see article link at landing page)
8. Client in-session behavior/mood
9. Progress/lack toward treatment plan *(use of tests helpful)*
10. Support for diagnosis/medical necessity
11. Date of next appointment

Telehealth Documentation: Best Practices

- First, some info: The Federal COVID Public Health Emergency (PHE) will end May 11, 2023
- Document if video / phone
- Phone: May need to document “verified identity”
- Document client location – “Client at home” or STREET ADDRESS IN NOTE if not at home
- May need to write “telehealth consent obtained” and “appropriate for telehealth” in each note
- Recommend Telehealth Consent & Credit Card Auth. -- available in my Practice Forms Packet –purchase link: theinsurancemaze.com/ZM
- Must you document your location? Your telehealth platform?
- See my Telehealth Billing Webinar, link: theinsurancemaze.com/ZM

An increase in chart reviews?

Due to Federal Parity Act and Affordable Care Act

- Most clients now have unlimited sessions regardless of diagnosis (some exceptions)
- **BUT:** Plans can still refuse to cover visits they feel are not "medically necessary"
- Medical necessity reviews used to limit sessions, even for out-of-network folks
- Notes need to defend diagnosis and medical necessity

What Are Plans Looking For? Medical Necessity Criteria

- DSM diagnosis; Z-code can't be sole/primary
- Treatment necessary, not just desired
- Treatment goals can't be purely personal growth, self-esteem, feeling awareness, improve sex life -- must be reduction of mental health symptoms
- With couples/families, notes should focus more on Identified Client's symptoms
- Client is being impaired
- Client is improving (so document progress)
- Suggest you include "60 min session medically necessary as evidenced by…" (OPTUM/UHC/UBH & Medicare especially)

Let's Play, "What's Wrong with This Note?"

Client symptoms:

- [x] Depression
- [x] Sleep disturbance

Topics Discussed:

- [x] Relationship difficulties

Interventions:

- [x] Explored client thoughts/feelings
- [x] Cognitive Behavioral Therapy
- [x] Support/validation

Notes Templates

- SOAP/DAP/GIRP/BIRP usually not required
- Why I DON'T generally like them
- What really matters
- I'll show mine and SOAP;

You can download these templates and DAP template on landing page theinsurancemaze.com/ZM

Griswold Note Template

Topic

Symptoms and

Impairment

Risk

Interventions

Progress/Plan

Note w/Griswold Template (just 7 Sentences!)

2:07-2:54pm: Video, ct at home. Telehealth consent obtained.

Topics/Symptoms: Ct. reports moderate depression since divorce finalized last week, daily lack of motivation and loss of pleasure, sleep av. 6 hrs night. "When I got legal papers the sadness really hit me; I guess I'm destined to die alone."

Risk: Denies suicidal thoughts, says "I would not do that to my kids; I know I'll get through this."

Interventions: Educated client on normal stages of grief. Used CBT to help identify and challenge negative self-talk fueling depression ("since marriage failed, there is something broken about me"). Helped client write Daily Depression Self-Care Plan including journaling and exercise.

Progress/Plan Changes: Ct reports less obsessing about ex-wife and breakup; reports increase in av. sleep each night (from 5 to 6 hours per night). Next appt. (date), *(your name)*

Another Note (Griswold Template)

3:04-3:56 pm: Phone, ct at home, telehealth consent obtained.
Topic/Symptoms: Ct. discussed anxiety related to high-stress job and 12+ hr workdays. Says "I work 6 days a week, and can't keep up. There aren't enough hours in a day to do all I need to." States gets only 5 hrs. of sleep and wakes at night, worrying about job.
Risk: None presented/identified.
Interventions: Educated ct. about how lack of boundaries can lead to increased anxiety. Helped ct. identify boundaries she could set at work, ex. leaving desk for breaks/lunch, and asking boss to prioritize tasks. Discussed effects of sleep deprivation.
Progress/Plan: Ct. states she finds therapy helpful to problem-solve issues, to step back and see solutions. To combat insomnia, ct. assigned to listen to Calm.com sleep stories nightly. Next time: Explore history of ct. difficulty setting boundaries and codependency. Next appt (date) *(your name)*

A Couples Note (Griswold Template)

3:05 – 3:52 pm: Video couples session with ct. Beth and girlfriend Julie at their home. Telehealth consent obtained from both.

Topic/Symptoms: Ct. reports increased arguments -- 3 this week -- as holiday nears. Both shout, but deny violence. Ct. says "J. is pressing me to come out to Dad, but I can't risk he'll cut me off financially." Due to conflict, ct. reports anxiety, stomach distress, decrease in concentration and productivity at work. J. states "after 3 years together, I'm tired of being introduced as a friend."

Risk: None identified; will continue to monitor conflict levels.

Interventions: Taught active listening, utilized in session to increase insight of each others' feelings related to holiday visits and to calmly problem solve. Taught progressive relaxation techniques to self-soothe, de-escalate conflict, and decrease anxiety of both. Both reported they found techniques helpful.

Progress/Plan: Ct reported active listening helps her to hear J's anger without shutting down (improved distress tolerance). Homework: Clients will practice active listening and relaxation techniques. Next appt. (date) *(your name)*

Griswold Note Template (continued)

Your new client, Wendy D.

1:02 – 1:57 pm at office.
Topics: Explored ct's codependency and how it relates to anxiety. Ct: "why do I get involved with immature men and try to fix them? It leads to constant chaos in my life" and "when my boyfriend P. is around, I can't say no." States gets resentful when she agrees to fly away with him when she needs to do her homework or chores.
Symptoms/Impairment: Reports moderate anxiety. Boyfriend's unpredictable nighttime visits disrupt her sleep, leads to daily fatigue, affects concentration at school. Feels guilty about lying to parents when sneaks out. **Risk:** None presented/identified.
Interventions: Helped ct. identify how caretaking has been rewarded in past. Explored role played growing up with alcoholic father. Made interpretation that childhood role as overfunctioner may cause her to choose underfunctioning partners.
Progress/Plan: Ct. reports therapy is helping her see how often she takes care of others at the expense of her own mental health. Homework: Assigned ct. to start reading *Codependent No More.*
Next appt (date) *(your name)*

How About a Couples Note for Wendy in GRISWOLD format?

4:01-4:54pm, Video couples session, ct. with boyfriend Peter at his treehouse, 5 Pirate Ln, Neverland MA. Telehealth consent obtained.
Topics: Ct: "P. won't commit to marriage; we fight daily about this. Am I wasting my time with him?" P. gave no eye contact to ct., said little, except "I told her when we met I don't want to grow up."
Symptoms/Impairment: Ct reports tense arguments about marriage daily, both raise voices, shout, but denies violence. "P. flies away, avoids conflict, which makes me angrier." Ct. admits has begun drinking alone after fights, and taking meds for high blood pressure.
Risk: No danger risks identified, further assessment needed of alcohol.
Interventions: To disrupt escalation of conflicts, reviewed and had them sign Time Out Agreement. Facilitated conversation about their views of marriage and expectations based on family of origin. Gave them handouts on Anger Management and Fair Fighting.
Progress/Plan: Ct. broke down in tears but seemed to finally accept it when P. stated "I have no intention of EVER getting married." Will need support dealing with grief and anger, and need help to decide whether to stay in relationship. Next appt: Indiv. session on (date), will at that time further assess ct. alcohol use. *(your name)*

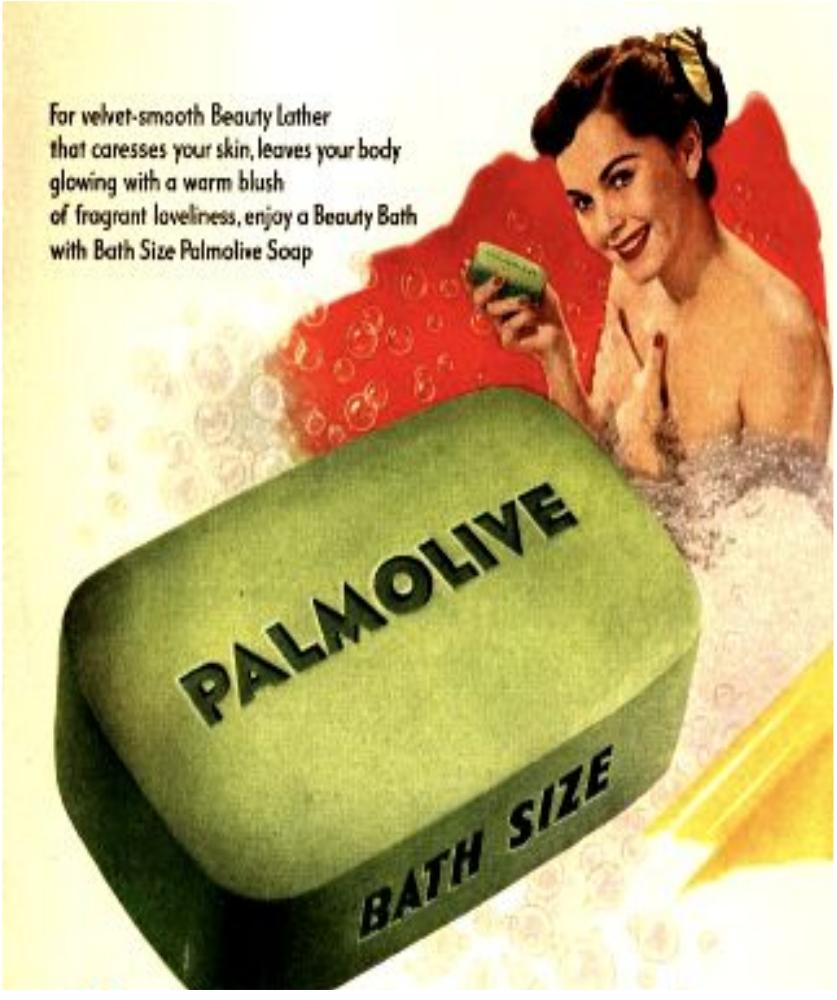
SOAP Notes

Subjective: What client says

Objective: Your observations of client in session (sometimes also test results)

Assessment: Your assessment of the diagnosis, medical necessity for therapy, and progress (or lack of)

Plan: Referrals, in-session interventions, homework, changes to treatment plan



SOAP Note: Case Example

Your Client, Belle

2:05 -2:55 pm, video. Telehealth consent obtained.
Subjective: Ct stated, "I always dreamed of leaving my village. Now I've been gone 4 weeks, I miss my friends and father." Reports the Beast plays many hours of video games daily, she is alone in castle with no one to talk to, "he just grunts." Reports weight gain of 10 lbs this month; "I feel fat and ugly."
Objective: Cried quietly as spoke, looked sad, picked nervously at ballgown.
Assessment (Progress): Ct. is having trouble adjusting to move, new life in castle, loss of support system. While ct reports therapy is helpful in combating loneliness, needs help to build support system and address compulsive overeating.
Plan/Interventions: Helped ct. identify trigger emotion for overeating (boredom). Together created list of alternative ways to deal with loneliness. Referred to Disney Princess online support group. Added treatment plan goal: Reduce emotional overeating. Next appt. (date), *(your name)*

Get Your Templates and Other Free Stuff

- SOAP, DAP, GRISWOLD Templates
- Sample Interventions List
- Article links:
  - Documenting Impairment
  - Billing for Longer Sessions
- Slide handouts
- Links to recorded webinars/resources

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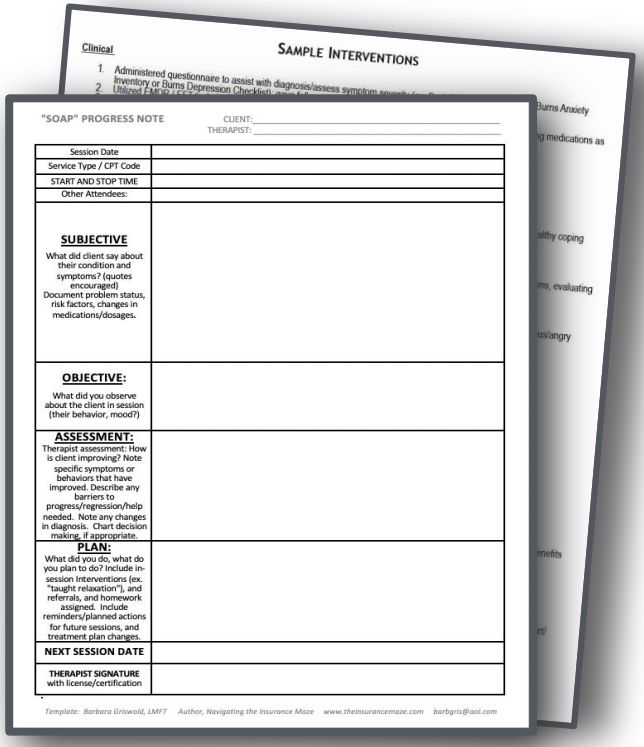
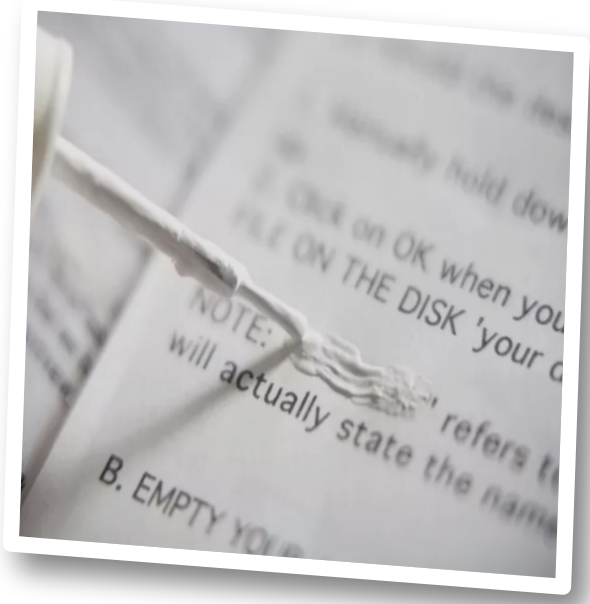


Tips for Better Notes

- Must be readable by others
- Avoid abbreviations
- Write as if reviewer will be reading
- Write as if client might read it
- Write like a journalist
- Avoid cloning, cutting and pasting

Altering Records



It's natural to want to "clean up" notes, but

- It may be illegal, unethical, or fraud to alter a record once written, to make it appear that you wrote something at the time of a session when you didn't
- Make it a habit to write notes within 48 hours
- If add information, the record should indicate when it was added (and any sources)
  - ➢ For example, for a note written one month after the session: *"Session 1/1/23, 9:01 - 9:55 am, video session, ct home. Continued to work on ct. anxiety and insomnia related to work demands. CBT and mindfulness therapy interventions utilized. Ct. shows progress: less severe and less frequent anxiety. Next appt 1/9/23. [Note was created/entered into EHR 2/4/23 from handwritten notes taken in session. Signed, Thelma Therapist, LCSW"]*

Reasons a Health Plan Might Call You

1 Treatment Reviews

Review care to see if they want to pay for future care, and at what frequency

- Usually by phone
- Usually don't ask for records / notes
- Usually reviewing for Medical Necessity
- Attitude here...

2 Administrative Audits

Required by federal regulations or plan's oversight agencies -- not claims-related

- Treatment Record Audit: Is everything in your chart?
- Risk Adjustment Audit: A can't-fail, not-to-worry audit

3 Claims Audits

These are the only ones related to payment, and will require notes

- Pre-Payment Audits
- Post-Payment ("Retrospective") Audits

7 Tips: Responding To Records Requests

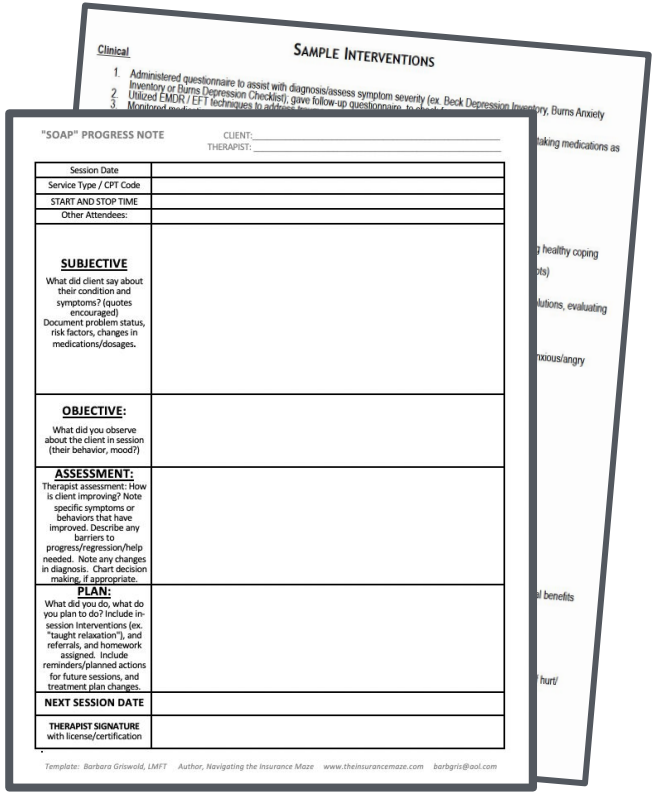
1. Don't panic! Most audits are "gnats, not bees"
2. Contact me or your professional association
3. Read it carefully. Look for "Risk Adjustment"
4. Contact the requesting agency. Ask purpose of request, ask if treatment summary enough, and what should be in summary. Can ask for extension
5. Don't just guess what to send!
    - Don't just send treatment summary unless told it is OK
6. Think twice before you rewrite notes
7. Don't release HIPAA psychotherapy (process) notes

➢ See webinar "*Audits and Records Requests: What EVERY Therapist Should Know;* link at: theinsurancemaze.com/ZM

Get Your Free Stuff at

theinsurancemaze.com/ZM

- GRISWOLD, SOAP, DAP Templates
- Sample Interventions List
- Article links:
  - Documenting Impairment
  - Billing for extended sessions
- Slide handouts
- Links to webinars and other resources



Clinical

SAMPLE INTERVENTIONS

1. Administered questionnaire to assist with diagnosis/assess symptom severity (ex. Beck Depression Inventory, Burns Anxiety Inventory or Burns Depression Checklist), gave follow-up questionnaire, to check
2. Utilized EMDR / EFT techniques to address
3. Monitored medic

"SOAP" PROGRESS NOTE

CLIENT:

THERAPIST:

Session Date	
Service Type / CPT Code	
START AND STOP TIME	
Other Attendees:	
SUBJECTIVE What did client say about their condition and symptoms? (quotes encouraged) Document problem status, risk factors, changes in medications/dosages.	
OBJECTIVE: What did you observe about the client in session (their behavior, mood?)	
ASSESSMENT: Therapist assessment: How is client improving? Note specific symptoms or behaviors that have improved. Describe any barriers to progress/regression/help needed. Note any changes in diagnosis. Chart decision making, if appropriate.	
PLAN: What did you do, what do you plan to do? Include in-session Interventions (ex. "taught relaxation"), and referrals, and homework assigned. Include reminders/planned actions for future sessions, and treatment plan changes.	
NEXT SESSION DATE	
THERAPIST SIGNATURE with license/certification	

Template: Barbara Griswold, LMFT Author, Navigating the Insurance Maze www.theinsurancemaze.com barbgris@aol.com

taking medications as

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Barbara Griswold, LMFT

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Bonus Slides (if time)

Common Claim-Related Audit Triggers

Many plans use technology which reviews claims for atypical patterns

1. Higher-than-average number of sessions for client (or all clients)
2. Higher use of longer session codes 90837 (or Prolonged Service codes 99354 / 99355, discontinued as of 1/1/2023)
   - ➢ For more on this topic, see “Billing for Longer Sessions” article link at theinsurancemaze.com/ZM)
3. Routinely billing more than 1 session per week
4. High number of sessions for diagnosis

LET'S TALK ABOUT THE 90837 ISSUE

- *Remember: CPT code 90837 (60 minute individual therapy) time range is 53 min+*
- *CPT 90834 (45 min therapy) is 38-52 min.*
- Insurance plans look closely at 90837 as they suspect upcoding
- UBH/UHC/OPTUM's view on 90837
  - May not feel it should be used routinely
  - Exceptions may include complex cases, EMDR, specialized trauma treatments, Systematic Desensitization
  - Just know you increase your likelihood of getting treatment review or audit if use 90837 regularly with that plan, Medicare, and possibly Blue Cross
  - May want to throw in some 90834

Other plans (including Blue Cross and MHN) may send "educational" letters saying you use 90837 more than your peers.

But this doesn't mean you have to stop using this code. Just be sure to:

- Document ACTUAL start and stop times of sessions, not scheduled (is session duration enough?)
- Times should vary for each session
- Use only when THERAPY time is 53+ minutes
- Downcode occasionally, especially for shorter sessions
- Do not use for ongoing couples/family therapy; Use only for individual work, or when a family member joins for part or all of the individual session (identified client must be present for all or majority of session)

You may want to document your reasons for longer sessions...

Examples: "60 min. session medically necessary due to..."

- "... use of technique that takes longer to implement (e.g. EMDR, Systematic Desensitization / DBT Protocol)"
- "... severity of client anxiety/depression symptoms"
- "... more session time needed to process trauma-related emotions"
- "... need to create and monitor relapse prevention protocols"
- "... dual diagnosis -- requires extra time to address both diagnoses"
- "... client's high emotionality; need to stabilize before session ends"
- "... need to manage high-conflict interactions of couple/family"
- "... extra time needed to monitor crisis issues and safety planning"
- "... client has extreme difficulty identifying [emotions/motivations], requires more session time to process and gain insights"

Proper Use of Common CPT codes

90791: diagnostic evaluation (first session), *no time specified*

90832: individual therapy 30 min *(16 – 37 mins)*
90834: individual therapy 45 min *(38 – 52 mins)*
90837: individual therapy, 60 min *(53+ mins)*

- *These can include informants, but identified client must be present for most of session. Don't use for ongoing couples/family therapy*

90847: couples/family therapy, 50 min *(26 min+)*
90846: couples/family without client, 50 min *(26 min+)*

Billing for longer sessions: See article link at theinsurancemaze.com/ZM

Telehealth: Add modifier (usually 95 or GT) and use telehealth Place of Service Code (usually 10 if client at home, 02 if elsewhere, except Medicare until end of 2023 – use 11). New phone modifier 93, check with the plan if they are using