

Treatment and Progress Notes

For Case Managers, Community Workers, Recreational Therapists,
Occupational Therapists, and Mental Health/Health Advocates

- ✓ Treatment Services
- ✓ Purpose of Documentation
- ✓ Progress Note Requirements
- ✓ Examples
- ✓ How to use IBHIS

LACDMH Quality Assurance Unit – Policy and Technical Development Team – 7/6/20

Standard Course of Action

1. Assessing

- Complete a mental health assessment and establish medical necessity;
- Complete an initial medication evaluation (if needed)
- Complete a Community Functioning Evaluation (if needed)

2. Planning

- Develop a client treatment plan (and if applicable, obtain medication consent) with the client; then

3. Treating

- Provide treatment services to address the identified mental health condition and assist the client in reaching his/her objectives.

What are Treatment Services?



Treatment Services

Treatment Services = services that address a client's mental health needs and are not primarily for the purpose of:

- Assessment
- Plan Development
- Crisis Intervention
- Linkage and referral if a need of immediate concern exists

✓ Documented in the client's Treatment Plan



✓ Provided to the client or the significant support person



✓ Provided individually or in a group/family setting



✓ Provided in person, over the phone, or via telehealth



For more information, refer to the [Organizational Providers Manual](#)

Treatment Services

For treatment services to be reimbursable by Medi-Cal, the interventions described must:



- ✓ Represent a covered Specialty Mental Health Service (service component)

Mental Health Services (MHS)	✓ Assessment
	✓ Plan Development
	✓ Therapy
	✓ Rehabilitation
	✓ Collateral

- ✓ Reduce the client's impairment, restore his/her functioning, or prevent significant deterioration in the client's functioning



- ✓ Be individualized to the client's specific needs and relate to the client's diagnosis and impairments

- ✓ Be on the client's treatment plan





For more information, refer to the [Organizational Providers Manual](#) and [QA Bulletin 17-13](#)

Outpatient SMHS covered & provided by directly-operated (reimbursable services)



Mental Health Services (MHS)	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	<ul style="list-style-type: none"> ✓ Assessment ✓ Plan Development ✓ Therapy ✓ Rehabilitation ✓ Collateral
Intensive Home Based Services (IHBS)	An intensive form of MHS that is predominantly delivered in the home, school or community. IHBS is specifically intended for children/youth who are already receiving Intensive Care Coordination.	<ul style="list-style-type: none"> ✓ Rehabilitation ✓ Collateral
Targeted Case Management (TCM)	Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)	<ul style="list-style-type: none"> ✓ Assessment ✓ Plan Development ✓ Referral and Related Activities ✓ Monitoring & Follow-Up
Intensive Care Coordination (ICC)	An intensive form of TCM that facilitates the assessment, planning and coordination of services. ICC is specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a Child and Family Team	<ul style="list-style-type: none"> ✓ Planning & Assessment of Strengths & Needs ✓ Reassessment of Strengths & Needs ✓ Referral, Monitoring, and Follow-Up Activities ✓ Transition
Medication Support Services (MSS)	Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms	<ul style="list-style-type: none"> ✓ Evaluation of the Need for Meds ✓ Evaluation of Clinical Effectiveness & Side Effects of Meds ✓ Obtaining Information Consent ✓ Medication Education ✓ Collateral ✓ Plan Development
Crisis Intervention (CI)	Unplanned and expedited services to address a condition that requires more timely response than a regular appointment in order to assist a client to regain/remain functioning in the community.	<ul style="list-style-type: none"> ✓ Assessment ✓ Therapy ✓ Collateral ✓ Referral

MHS Treatment Services

Service Component	Procedure Code(s)	What the Service Entails
Collateral 	90887	<p>A service provided to a significant support person* which can include:</p> <ul style="list-style-type: none"> consultation and training of the mental health diagnosis and impairments teaching skills to better assist the client at home or in the community <p><i>*Examples of significant support persons include family members and close relatives, foster parents, friends, teachers, DCFS social workers, public guardian, etc.</i></p>
Rehabilitation 	H2015	<p>Restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation.</p> <p>Emotional, social, and intellectual skill-building to live and work in the community with the least amount of professional support.</p>

Procedure Code Modifiers
 ✓ **SC** – for services provided over the telephone
 ✓ **GT** – for services provided via telehealth



IHBS Treatment Services

Service Component	Procedure Code(s)	What the Service Entails
Collateral 	H2015HK	<p>A service provided to a significant support person* which can include:</p> <ul style="list-style-type: none"> consultation and training of the mental health diagnosis and impairments teaching skills to better assist the client at home or in the community <p><i>*Examples of significant support persons include family members and close relatives, foster parents, friends, teachers, DCFS social workers, public guardian, etc.</i></p>
Rehabilitation 	H2015HK	<p>Restoring, improving, and/or preserving a client's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation.</p> <p>Emotional, social, and intellectual skill-building to live and work in the community with the least amount of professional support.</p>

These services are more intensive and are predominantly delivered in the home, school or community. These services are also specifically intended for children/youth who are already receiving ICC.

Procedure Code Modifiers
 ✓ **SC** – for services provided over the telephone
 ✓ **GT** – for services provided via telehealth

TCM Treatment Services

Service Component	Procedure Code	What you did
Referral & Related Activities 	T1017	A service that helps clients get access to needed ancillary services (e.g. medical, alcohol and drug treatment, social, educational providers, etc.) and includes <ul style="list-style-type: none"> • Making referrals and scheduling appointments • Coordinating service and mobilizing resources
Monitoring & Follow Up 	T1017	A service that includes activities and contacts to ensure that the client's treatment plan is implemented and that services are adequate and being provided

Procedure Code Modifiers
 ✓ **SC** – for services provided over the telephone
 ✓ **GT** – for services provided via telehealth

ICC Treatment Services

Service Component	Procedure Code	What you did
Referral, Monitoring, and Follow-Up Activities	T1017HK	Evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. Activities that ensure that the child/youth's needs are met including ensuring that services are being furnished in accordance with the child/youth's plan.
Transition	T1017HK	Developing a transition plan for a child/youth and family to foster long term stability including the effective use of natural supports and community resources.

These services are specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a CFT.

Procedure Code Modifiers
 ✓ **SC** – for services provided over the telephone
 ✓ **GT** – for services provided via telehealth

Providing Treatment During a Medi-Cal Lockout

Medi-Cal Lockout = when Specialty Mental Health Services are not reimbursable by Medi-Cal (i.e. client is in an IMD, jail/prison setting, psychiatric inpatient/psychiatric health facility/crisis residential facility, excluding the dates of admission and discharge)

- Also used by CalWorks/GROW programs using the CalWorks/GROW funding plan

What it is	Procedure Code
MHS that are not billable to Medi-Cal due to reasons below but are billable to another payer source: <ul style="list-style-type: none"> • Medi-Cal Lockout • Lack of medical necessity 	MHS 00001
TCM services that are not billable to Medi-Cal due to reasons below but are billable to another payer source: <ul style="list-style-type: none"> • Medi-Cal Lockout • Lack of medical necessity 	TCM 00002







Procedure Code Modifiers

Services may be provided over the telephone or telehealth, however, no modifier is utilized with these codes

For more information, refer to [QA Bulletin 17-03](#)

“Services” that are never billable

Pause the video if you want to review this list

1. No shows and missed appointments 
2. Services solely for transportation 
3. Leaving the client a voicemail or text message 
4. “Linkage” to the program’s psychiatrist, NP, or other treatment team member
5. Supervisory type activities
6. Interpretation/translation (e.g. providing “cultural competent services”)
7. “Check-Ins” with no identified purpose 
8. Getting up to date when cases are transferred to you 
9. Reviewing the chart with no identified service (e.g. checked to make sure everything is up to date, to schedule an appointment)
10. Making copies of chart for release of records 
11. General activities that help the clinic (e.g. buy food/items for groups, develop forms for clients to complete)

Scenarios when a billable service can be provided to a no-show or missed appointment

Case Manager reviews the last few progress notes in preparation for today's rehab session with a client. Client does not show up.

90885
Record Review

Client calls to cancel today's scheduled session due to feeling "overwhelmed." Practitioner asks about this and prompts client to use coping skills learned in sessions. Practitioner and client continue to engage in a rehab session over the phone.

H2015SC
Rehab
(over the phone)

Father calls practitioner to reschedule today's family session. Father mentions feeling frustration as client recently had an incident at school. Practitioner and father discuss ways to address client's behavior and modeled ways father can respond to client's negative behaviors.

90887SC
Collateral
(over the phone)

In IBHIS – appointment will be marked as "no show" or "canceled by client," and the billable service will be documented using a **Special Use Progress Note**

**Refer to the Scheduling Calendar Module*

Treatment Process

Before the treatment session with the client...



- Reviews **Treatment Plan** to determine what interventions will be provided during the client's session
- May also review other documentation (e.g. last few progress notes or medication notes)

During the treatment session with the client... (this can be in-person, over the phone, via telehealth)



- Practitioner and client:
 - discuss any important updates since the last session
 - review client's progress or lack of progress
 - update the plan, if applicable
- Practitioner provides intervention as described in the treatment plan
- If collaborative documentation is used, practitioner and client may write the progress note together

After the treatment session






- May fine tune the progress note and finalize the form
- Claims for the time spent providing the treatment service via the appropriate progress note form

Documenting on Progress Notes



Progress Note

- Services provided to clients are documented using a progress note 
- Within the progress note:
 - ✓ Select the procedure code based on the service provided
 - ✓ Enter the duration of the service
 - ✓ **Face to Face Time** = time spent seeing the client 
 - ✓ **Other Time** =
 - time spent providing a service to a significant support person
 - time spent writing the progress note and completing other applicable forms
 - travel time, if this applies 

Purpose of Documentation

Clinical Care & Coordination of Care



Communicate the client's condition, your treatment, and facilitate continuum of care

Clinical Record is a Legal Document



To provide evidence of what occurred

Reimbursement



So payer knows what they are paying for

Progress Note Requirements

Pause the video if you want to review this list

- Date of service
- Procedure code
- Duration of service (face to face and other time)
- **Relevant aspects of client care including medical necessity**
- **Relevant clinical decisions**
- **Interventions applied**
- **Client's response to interventions**
- Location of interventions
- If appropriate, referrals to community resources, follow up care
- Signature of the person providing services



Frequency - a progress note is needed for every service contact for MHS, TCM*, IHBS, ICC, MSS, and Crisis Intervention

**TCM progress note may include multiple service activities (e.g. phone calls) performed w/in the same day and intended to accomplish the same specific objective*

Reference: [DMH Policy 401.03](#) and the [Organizational Provider's Manual](#)

What to Document

Relevant aspects of the client's care:

- ✓ What is going on in treatment
- ✓ Describe how services provided are helping to reduce the client's impairment, restore functioning, or prevented significant deterioration (Medical Necessity)

Example:

Per the assessment:

Client reports symptoms of depression. Due to these symptoms, client reports difficulty looking for housing. Client has difficulty communicating his needs and asserting himself.

Per the treatment plan:

Objective: Obtain permanent housing

Intervention: Provide individual rehab to teach and model communication skills to improve client's independence.

On the progress note: "Met w/ client to continue to practice more effective communication skills. Modeled how to ask for assistance and how to ask follow-up questions. Client practiced using a louder voice when asking for someone's attention. Role played how to communicate his needs to the housing authority in preparation for an upcoming appointment..."

What to Document

Relevant clinical decisions

- ✓ What needs to be done to help the client get better
- ✓ Do outside referrals need to be made?

Examples

- ✓ "Provided client with a referral for a substance use group to help address client's alcohol use..."
- ✓ "Mother reports improvements with client's behaviors at home. Will continue to provide collateral sessions with the mother..."

What to Document

Interventions

- ✓ What the practitioner did to address the client mental health needs and impairments
- ✓ The service(s) that was provided to the client or to a significant support person

Examples

- ✓ “Monitored linkage to section 8 housing”
- ✓ “Modeled appropriate ways of communicating feelings using I-statements...”
- ✓ “Taught parenting skills around setting boundaries...”



What to Document

Client's Response to Treatment

- ✓ How the client participated in treatment
- ✓ The client's reaction to the interventions
- ✓ Are the interventions working for the client?



Examples

- ✓ “Client was responsive to practicing problem solving skills and felt they were helping...”
- ✓ “Client expressed frustration and anger when prompted to use coping strategies...”
- ✓ “Client re-rated her guilt to 10 % instead of 90% and attributed the change to sharing her story with others during a support group...”

Co-Practitioners

- If more than one practitioner provided interventions, document each practitioner's involvement in the context of the mental health needs of the client

- ✓ Document the specific interventions of each person



"Case manager and therapist met with client and mother for the purpose of providing a family session. During the session, client became frustrated which led to a tantrum, and mother also became upset.

Therapist de-escalated client and modeled ways to better manage feelings of frustration. Therapist and client attempted to practice deep breathing, and helped client process frustration and anger...

Case manager de-escalated mother. Case manager and mother reviewed incident that led to client's tantrum. Case manager modeled ways mother can respond to client..."

- ✓ Duration – the specific amount of time of each person's involvement including documentation and travel time

Discharge Progress Note – for Ending Treatment

Clinical steps to complete documentation:

Required information to write in the note:

- Brief treatment summary
- Status update on client's progress toward their treatment plan objectives
- Referrals, if applicable
- Reason for termination of services
- Follow up plans, if applicable

If applicable, complete a Discharge CANS and Discharge PSC

Other administrative steps to complete in IBHIS:

- Removing **Primary Program of Service**
- Removing client from **Practitioner Caseload**

For more information, refer to the [Organizational Provider's Manual](#) and [Policy 312.01 Mutual and Unilateral Termination of Mental Health Services](#)

Progress Note Tips



Tip #1: Document risks

Pause the video if you want to review this example

- Documentation should clearly reflect that the practitioner assessed for and addressed any safety concerns (e.g. suicide risks, self-harming behaviors, homicidal ideation, etc.)
 - ✓ Include what the client said and how he/she said it
- Document all relevant interventions provided and clinical decisions made to address risks
 - ✓ What was done for the client to make sure he/she is safe

Insufficient

"Client reports no SI/HI"

Sufficient

"Given client's history of suicidal ideation, completed the Columbia Suicide Screener. Client answered 'no' to acting on any thoughts or having a plan. Per client, he is the sole supporter of his daughter and could never abandon her at this time. Client also confirmed that he has been feelings better..."

Tip #2: Keep the treatment plan in mind

- Review the treatment plan prior to meeting with or calling the client or significant support person
- Ask “How are you doing related to [treatment objective]?” instead of “How are you?”

Non-Billable

“Called client to check-in. Client said she was doing ok. Reminded of upcoming appointment with the psychiatrist on x/x/xx”

Reimbursable

“Called client to check on his constant worrying and racing thoughts and to practice the relaxation techniques as described on his treatment plan...Prompted client to use anxiety-reducing exercises that we’ve practiced in sessions...modeled challenging his thoughts and creating more realistic self statements...Also reminded client of his appointment with the psychiatrist on x/xx/xx.”

Pause the video if you want to review this example

Tip #3: Use a structured format

Pause the video if you want to review this list

- A structured format can help ensure progress notes are clear, concise, and the intervention is clearly stated

**DMH does not have a required format for writing progress notes.*

G = Goal(s)/objective being worked on from the client’s treatment plan

- Client’s current focus based on the treatment plan

I = Intervention(s) used in treatment

R = Response(s) of the client

P = Plan for next steps

- Plan for next session
- Any instructions for the client to do until the next session

P = Problem

- Focus of treatment based on the treatment plan

A = Assessment or interpretation of client’s progress

I = Intervention

P = Plan for next steps

- Plan for next session
- Any instructions for the client to do until the next session

S = Subjective Data

- Information from the client

O = Objective Data

A = Assessment

- Interpretation of the client’s condition or level of progress

P = Plan(s)

- Your intervention provided in session (what you did to address the client given the subjective and objective data)
- Client’s response to treatment
- Instructions to give to the client after the session

Tip #4: Document the intervention provided

- Focus on describing the active interventions you provided rather than passive activities
(e.g. provided a safe environment, provided a “culturally sensitive” environment, validated feelings, provided empathy, provided active listening)
- Start your notes with “Met with the client for the purpose of (enter service component)...”

Service Component	Interventions
Met with client for purpose of targeted case management	Facilitated linkage, researched appropriate referrals, submitting application materials, monitored linkage and progress, referred to [ancillary service]
Met with client for the purpose of individual rehabilitation	Taught, practiced, modeled, prompted, reinforced/role-played problem-solving skills/communication skills/relaxation skills/anger management skills
Met with client’s [significant support person] for the purpose of providing collateral	Taught, modeled, provided psychoeducation/consultation regarding [mental health topic], role-played/practiced how to communicate with client/manage client’s behaviors/set limits with client

Pause the video if you want to review these examples

Tip #5: Be objective

- Consider the facts and keep in mind how information will affect the client’s treatment plan
- Document client’s specific behaviors
 - ✓ Write what was witnessed, who caused it, and who initiated it
- Remember that other practitioners will view your notes and may need to make decisions about the client’s care

Jargon	Objective Behaviors
Impulsive	Acts without anticipating consequences as exhibited by blurting out hurtful remarks during group.
Hostile	He shouted, “Shut up! No one wants to hear what you have to say!” when his mother began talking during session.
Psychotic	Appears preoccupied with listening to internal voices and frequently shouts in response to what she hears.
Non compliant	Client has not taken her medications for the past week due to concerns regarding side effects.
Poor ADLs	Client is odorous and dirty. Client reports that she has not showered in a week.

Pause the video if you want to review these examples

Tip #6: Be clear and concise

- Document all necessary information but avoid extraneous details

Instead of...

"Client moved to Kansas at age 4. Her parents separated when she was 6, and they moved back to Chicago, then reunited and moved to Indiana, where father took a job as a shoe salesman. When he lost that job, they moved back to Chicago and divorced for good. Mother remarried a fireman, who was an alcoholic; they stayed together for 2 years until ..."

Simply write...

"Client's childhood was chaotic with many moves; her mother remarried 3 times. No physical or sexual abuse ..."

Pause the video if you want to review this example

Tip #7: Include adequate & relevant details

- Include information critical to explaining treatment decisions but get to the point quickly
- Describe the symptoms the client is reporting

Irrelevant Details

"During the session, client shared that her parents will be visiting her for the weekend. Client stated that she was happy about this and the news improved her week. Client said she has been looking forward to her parents visiting her and can't wait to show them around. Client said she wants to talk to her parents about some of the hardships she has had but doesn't know how. Client isn't sure if she should tell her parents that she is participating in mental health services since her parents do not understand..."

Relevant Details

"Client reported that her depressive symptoms have decreased since last week. Her current PHQ-9 score is a 6 today compared to an 11 last week. Client attributes her improved mood to seeing her parents this weekend. Client also reports being consistent with her medication. Practitioner and client role-played how client can communicate her feelings to her parents..."

Pause the video if you want to review this example

Tip #8: Be mindful of how you describe the client and other staff

- Do not use derogatory or pejorative statements to describe clients
- Do not include complaints about other staff members whether from the patient or other staff

Instead of...

"Client is obviously lying about his history..."

"Client stated that the doctor can't do his job and was rude..."

Write...

"Client's version of his history is at odds with what is written in previous hospital records."

"Client expressed frustration when her psychiatrist disagreed with her..."

Pause the video
if you want to
review these
examples

Tip #9: Use approved abbreviations and acronyms

- Only use abbreviations and acronyms approved by the department

Examples of Approved Abbreviations:

Dx – diagnosis	DTO – danger to others	T/C – telephone call
Sx – symptom	DD – developmental disability	V/M – voicemail
Hx – history	EBP – Evidenced Based Practice	L/M – left message
ADL – activities of daily living	FSP – Full Service Partnership	D/O – disorder
Bio – biological	IEP – Individualized Education Plan	F/V – field visit
CM – Case Manager	PCP – Primary Care Physician	F/U – follow-up
Thp – Therapist	PO – Probation Officer	R/O – rule out
Clt – Client		Y/O – years old

For more information, refer to the [LACDMH Approved Abbreviations](#)

Pause the video
if you want to
review these
examples

Progress Note Examples



Progress Note Example 1 - Collateral

Goal: Client will decrease depressive symptoms from a PHQ-9 score of 19 (moderately severe) to a 4 or less (minimal).

Intervention: CM called mother for the purpose of providing collateral service. Reimbursement

Discussed challenges regarding parenting and talked about different parenting strategies. Acknowledged mother's challenges and validated her experiences. CM modeled different ways of de-escalating situations with the client. CM and mother role played various scenarios. Clinical

Response: Mother reports having difficulty managing client's angry outbursts, especially when it happens in public. Mother practiced how to de-escalate and respond to client. Mother reports she is open and willing to try different approaches in order to develop a healthier relationship with client.

Plan: CM to continue to provide collateral session with mother. Next session schedule for next Tuesday, x/x/20. Legal

Service Code: 90887SC (Collateral – over the phone)

Face to Face Time: 0 (client is not present, and session is over the phone)

Other Time: 52 minutes (time spent providing the service and documentation)

Pause the video if you want to review this example

Progress Note Example 2 - TCM

Goal: Client will obtain permanent housing

Intervention: Writer called housing authority and client for the purpose of facilitating linkage to Section 8 housing. Reimbursement

Writer scheduled an appointment for client with the housing authority on 12/18/19 at 10am. Writer called client informing her of this appointment and reminded her to bring required documents. Communicated the importance of her attending this appointment in order to obtain her Section 8 housing. Confirmed with client that she has transportation to this appointment. Clinical

Response: Client stated that her sister will take her to the appointment. Appreciative of the reminders and reported that she has all required documents in an envelope in her purse.

Plan: Writer to follow up with client and housing authority on the outcome of her appointment. Legal

Service Code: T1017SC (*Targeted Case Management – over the phone*)

Face to Face Time: 0 (*session is over the phone*)

Other Time: 37 minutes (*time spent providing the service and documentation*)

Pause the
video if you
want to
review this
example

Progress Note Example 3 - Rehab

Goal: To decrease angry outbursts (e.g., yelling, breaking things, hitting walls) from 5x to 0x per week

Intervention: Met with the client for the purpose of teaching him productive ways of expressing his anger. Reimbursement

Identified common triggers to his anger, which included situations where he is treated unfairly, and where others don't do what they're supposed to do. Identified how he currently responds to these triggers and the consequences of his responses. Taught and modeled healthier ways of expressing his anger, including deep breathing exercises and coping self-statements to calm down, and developing "I" statements to communicate his frustration and anger. Using identified trigger scenarios, therapist role-played with client having him practice these skills. Clinical

Response: Client participated in developing coping self-statements which writer wrote down on index cards. Client agreed to carry cards in his pocket so he'll use them when he needs them. Reported that the role-playing was helpful in practicing the "I" statements.

Plan: To continue with role-playing and modeling healthier ways to communicate frustration and anger. Legal

Service Code: H2015 (*Individual Rehab*)

Face to Face Time: 42 (*time spent w/ client*)

Other Time: 11 minutes (*time spent documenting*)

Pause the
video if you
want to
review this
example

Progress Note Example 4 – Discharge Progress Note

Goal: Client will decrease depressive symptoms from a PHQ-9 score of 20 (severe) to less than 4 (minimal)

Intervention: Met with client for the final individual rehab session. Reimbursement

Reviewed client's progress and skills learned from treatment. Administered PHQ-9 – client's current score is 2 (minimal)

Response: Client agreed that her symptoms have greatly improved over the last 6 months. Client reports that she will continue to utilize skills learned in treatment. Client will also continue with medication management with her PCP instead of the psychiatrist.

Plan: Client to continue with medication management w/ PCP. Provided client with information for support groups in the community to foster social engagement. Clinical

Discharge Summary

Reason for Termination: Given client's progress with improving symptoms, individual rehab and therapy sessions will end as of today, 6/x/20. Client's last psychiatrist appointment was yesterday, 6/x/20. Client's PCP will continue her current medication regimen.

Treatment Summary: Client has participated in individual therapy sessions with Dr. Smith and individual rehab sessions with this writer for 7 months. Client has been responsive to treatment and participated in all sessions including completing exercises and practicing skills at home. In addition to individual therapy and rehab sessions, client was responsive to medication management with the psychiatrist and has been stable on her medications.

Status Update: Client has made progress towards reducing symptoms of depression to a PHQ-9 score of less than 4.

Follow Up Plans/Referrals: Client to continue to utilize skills learned in treatment. Client to continue with current medication through her PCP. Provided client with information for support groups in the community to foster social engagement. Legal

Service Code: H2015 (*Individual Rehab*)

Face to Face Time: 36 minutes (*time spent w/ client*)

Other Time: 19 minutes (*time spent documenting*)

Pause the video if you want to review this example

Forms in IBHIS



Progress Note Forms in IBHIS

Pause the video if you want to review this list

- **Individual Service Progress Note** – used for individual services (except MSS by prescribers)
 - ✓ Appointment must be entered in the **Scheduling Calendar**
- **Special Use Progress Note** – can be used for non-billable activities, unscheduled telephone contacts, and when writing a billable service to a missed appointment
 - ✓ No appointment entered in the Scheduling Calendar
- **Scheduled Group Progress Note** – used for group services
- **Crisis Evaluation Progress Note** – used for crisis intervention services
- **Medication Service Progress Note** – used by prescribers/furnishers
- **Crisis Stabilization Note** – used by crisis stabilization unit

Tip: Make sure to add these different progress note types in your **Chart View**

Progress Note Form in IBHIS

• Service code

- ✓ Start typing in the name of the service (e.g. “targeted...”)

A screenshot of the 'Service Code' dropdown menu in IBHIS. The search term 'targeted' is entered in the input field. The dropdown shows a list of results under the heading 'Results'. The first result is 'TARGETED CASE MANAGEMENT (T1012H610)' which is highlighted in green. Below it are two other results: 'TARGETED CASE MANAGEMENT: PHONE (T10175C)' and 'TARGETED CASE MANAGEMENT: PHONE DUP76 (T10175C76)'.

- ✓ Enter in the procedure code but recommend entering the first 3 digits so options with modifiers appear

A screenshot of the 'Service Code' dropdown menu in IBHIS. The search term '908' is entered in the input field. The dropdown shows a list of results under the heading 'Results'. The first result is 'COLLATERAL (90887)' which is highlighted in green. Below it are several other results: 'COLLATERAL - TELEPSY (90887GT)', 'COLLATERAL - TELEPSY DUP59 (90887GT59)', 'COLLATERAL - TELEPSY DUP76 (90887GT76)', 'COLLATERAL DUP59 (9088759)', 'COLLATERAL DUP76 (9088776)', and 'COLLATERAL PHONE (908875C)'.

Progress Note Form in IBHIS

• Columbia Suicide Screener

If the Columbia Suicide Screener was completed on another form, select "Screening Not Completed"

Must be completed at each visit for clients determined to be at moderate or high suicide risk.

View the **Summary Suicide Risk Screening History** widget prior to the session to determine if a screening must be completed

Summary Suicide Risk Screening History			
Days since suicidal ideation / behavior endorsement * 6 days *	Most recent endorsement - Suicidal ideation Jun 8, 2020-6 days ago (Progress Note)	Most recent endorsement - Suicide behavior Jun 1, 2020-13 days ago (Child Adolescent Full Assessment)	Most recent screening date Jun 8, 2020-6 days ago (Progress Note)

Progress Note Form in IBHIS

• Bring in the treatment plan elements

Select the intervention that you provided during your treatment session with the client.

Append Progress Note Form in IBHIS

- **Append Progress Note** – allows you to add information to the text of the progress note after that note has been finalized

In the Append Progress Note form, select the **Note Type** and the progress note to be appended in **List of Notes**.

Add the new content in the **New Comments to be Appended to the Original Note**.

New Comments to Be Appended to the Original Note

Client's sister also attended the appointment for Section 8 Housing. Per client, her sister has been integral in helping her find stable housing. Client's sister states that she can assist client with appointments in the future.

New information can be seen in the progress note in the **Chart View** and in the **Progress Notes Report (IBHIS)**

ADDITIONAL NOTE - 06/24/2020 at 10:23 AM by Michelle Young-Sambajon

New Comments to Be Appended to the Original Note:

Client's sister also attended the appointment for Section 8 Housing. Per client, her sister has been integral in helping her find stable housing.

Let's go into IBHIS...



- Scheduling Calendar
- Individual Service Progress Note
- Append Progress Notes
- Viewing notes via the Chart View and Notes Widget

Progress Note Resources

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

OUR SERVICES **1** FOR PROVIDERS ▾ ABOUT DMH ▾ CONTACT INFORMATION EVENT CALENDAR GET HELP NOW!

2 PROVIDER CENTRAL
ADMINISTRATIVE TOOLS ▾
CLINICAL TOOLS ▾

3 ADMINISTRATIVE FORMS
QUALITY ASSURANCE
QUALITY IMPROVEMENT

QUICK LINKS
[DMH Provider Directory](#)
[Geospatial Initiative](#)

FROM THE DIRECTOR

QUALITY ASSURANCE - MANUALS

- [Organizational Providers Manual](#)
- [A Guide to Procedure Codes](#)
- [JBHIS Addendum Guide to Procedure Codes](#)
- [Community Outreach Services \(COS\) Manual](#)

QUALITY ASSURANCE - BULLETINS

- [QA Bulletins](#)
- [Clinical Forms Bulletins](#)
- [Medi-Cal Certification Bulletins](#)

QUALITY ASSURANCE

- Quality Assurance
- Manuals**
- Bulletins
- Clinical Forms
- Chart Review Requirements
- Certification

Progress Note – Resources

- [Organizational Providers Manual](#)
 - ✓ What it is: Provides information about the Short-Doyle/Medi-Cal claiming and documentation system
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Manuals
- [A Guide to Procedure Codes](#)
 - ✓ What it is: lists and defines the compliant codes reflecting services throughout DMH system
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Manuals
- [LACDMH Policy 312.01 Mutual and Unilateral Termination of Mental Health Services](#)
 - ✓ What it is: Provides policy and procedures for clinical record documentation related to the delivery of SMHS within DMH
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Policies
- [QA Bulletin 17-13: Determining if a Treatment Service is Billable to Medi-Cal SMHS](#)
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins
- [QA Bulletin 17-08: Claiming for Travel Time](#)
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins
- [QA Bulletin 17-03: Non-Billable and Never Billable to Medi-Cal Procedure Codes](#)
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins
- [LACDMH Approved Abbreviations](#)
 - ✓ Where to go: DMH Website > For Providers > Administrative Tools > Quality Assurance > Clinical Forms