

# General Documentation and Claiming: Progress Notes

Last Revised 7/9/20

Los Angeles County Department of  
Mental Health (LACDMH)  
Quality, Outcomes & Training Division  
**Quality Assurance Unit**

## About this Presentation

### Disclaimer

- This video series presentation highlights the basic minimum documentation and claiming standards for the provision of Medi-Cal Specialty Mental Health Services in Los Angeles County and incorporates interim guidance to assist practitioners in meeting the mental health needs of the County while minimizing the community spread of COVID-19.
- For a comprehensive list of documentation and claiming rules please refer to the Organizational Provider's Manual, the A Guide to Procedure Codes, and LACDMH Policy 401.03, which can all be accessed through the DMH website at <https://dmh.lacounty.gov/> and for the latest COVID-19 related QA information, click on the COVID-19 link from the Quality Assurance page.
- For contract staff, please check with your agencies regarding higher standards than the ones discussed in this presentation that may have been set and how your agency is setting standards around COVID-19.

## Purpose of Progress Notes

- Documents what is going on with the client
- Identifies what you and any other participating staff did (i.e. what intervention was provided)
- Identifies progress and response to treatment
- Documents interventions for reimbursement
- Provides the basis for benefits establishment
- Establishes an audit trail
- Reduces risk and liability



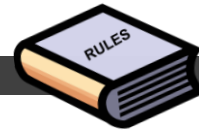
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## Progress Notes - ✓ Required Elements

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| <ul style="list-style-type: none"> <li>✓ Date of service and date written (if different than date of service)</li> <li>✓ Procedure code (e.g. TCM – T1017, Rehab – H2015)</li> <li>✓ Duration of service (Face-to-Face Time + Other Time)</li> <li>✓ For group, the total number of clients present or represented</li> <li>✓ Location of interventions</li> <li>✓ Relevant aspects of client care</li> <li>✓ Relevant clinical decisions</li> </ul> | <ul style="list-style-type: none"> <li>✓ Interventions applied</li> <li>✓ Client's response to interventions</li> <li>✓ Referrals to community resources and other agencies (when appropriate)</li> <li>✓ Follow-up care and discharge summary (if applicable)</li> <li>✓ Signature of the person providing the service (or electronic equivalent); discipline/job title, relevant identification number (if applicable) and date documented</li> </ul> |
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## Progress Notes – Documentation Rules



- **Progress Notes must:**
  - Be completed prior to the end of the next scheduled workday
    - If next scheduled workday exceeds 5 calendar days then must be completed before the end of the day on the date of service.
  - Be done prior to submission of a claim
- **One note per service contact**
  - Don't combine service components/types of services in the same progress note (e.g. TCM and Rehab services provided during the same meeting with the client should be documented in separate notes)
    - **Exceptions:**
      - **Plan Development** may be combined into a single progress note with another service
      - **Record Review** can be conducted in conjunction with another service (e.g. prep for a session that day) and would be claimed as Other Time under the code for that service (See QA Bulletin 17-19)
      - For **Targeted Case Management**, a single service contact may include multiple service activities (e.g. telephone calls) performed within the same calendar day and intended to accomplish the same specific objective

**Note:** A Progress Note must be written to document ALL activities – even those that are not billable.

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## Progress Notes

### Questions to Guide Documenting in the Progress Note

#### Purpose of the Service:

- What was the goal or reason for service?
  - The service should be tied to a treatment plan objective in the CTP.
  - The service should address the client's functional impairment and qualifying diagnosis.

**EXAMPLE:** ...met with client in client's home for the purpose of addressing use of self regulation techniques to manage symptoms of PTSD and improve functioning and to provide client with additional support and interventions to assist in meeting her mental health objective.

#### Progress of Client:

- What are the client's current symptoms and functional impairments?
  - Use direct quotes from the client.
  - Document objective observations of client behaviors and impairments. What did you see?

**EXAMPLE:** Client reports re-experiencing her childhood sexual abuse trauma daily this week after seeing her abuser at the store. Client shared that she has been experiencing intrusive images most of the day after seeing her abuser. Client reported that she's not been sleeping well and feeling very irritable. Client stated, "Seeing him again, brought up so much stuff. The images I see in my head make me feel like it's happening all over again." Client reported that she had 5 months and 10 days sober until a few days ago. She stated that alcohol seemed to be the only thing that helped to stop the images from coming at least for a little while. She reports she has been drinking a fifth of vodka daily for the past 2 days. Client observed to be slightly disheveled and 2 empty bottles of vodka were laying around the room.

- If significant changes in the client's condition are presented, ensure the information is documented in the Assessment Addendum and updates to the Client Treatment Plan are completed before providing related treatment services.

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## Progress Notes

### Questions to Guide Documenting in the Progress Note

#### Actual Intervention:

- What did you do to support the client in working towards the identified goal or reason for service?
  - Illustrate what you did on behalf of the client's mental health goals.
  - Describe the intervention in concrete **active** language.

**EXAMPLE:** Acknowledged client's situation, **reviewed** client's treatment goals, and with the **use of Motivational Interviewing** **asked** if client would like to change how she manages her stress. **Reviewed** safety plan and who client is able to contact for support. **Reviewed** coping skills toolbox and **encouraged** client to select coping skills she can use this week instead of drinking. **Educated** client on the impact of stress to the body and **assisted** client **in identifying** how stress affects her physical response and a sense of re-experiencing the traumatic experience. **Reviewed** with client the deep breathing techniques taught to her in previous sessions and **engaged** client to practice the techniques. **Educated** client on mindfulness and **taught** client grounding exercises as an additional technique to manage her PTSD symptoms.

#### Client Response:

- How did the client respond to the intervention?
  - Use direct quotes from the client.
  - Document objective observations of client's response(s) to the intervention.

**EXAMPLE:** Client reported that she wants to be able to manage her emotions better and not let her past get to her. She reviewed and updated safety plan to include more contact information of support system. She reviewed her coping skills tool box and identified deep breathing has usually been helpful. Client participated in the deep breathing techniques, agreed to learn about mindfulness and asked questions for clarification, and engaged in grounding exercises. Client reported, "I feel more relaxed and present after this session and am grateful to feel like I can have more control over this. I know I have people supporting me and I just need to reach out." Client appeared more relaxed and started cleaning out the alcohol bottles from her home.

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## Progress Notes

### Questions to Guide Documenting in the Progress Note

#### Plan:

- What are the next steps in treatment?
  - Document if there was homework assigned and/or what the client plans to do to address treatment goals.
  - Document if there was an update/adjustment in the treatment plan and/or what practitioner will do if applicable.
  - Document next session schedule.

**EXAMPLE:** Client plans to practice deep breathing techniques at least twice daily and more if she is triggered. Client plans to incorporate grounding techniques during deep breathing. Client agreed to attend her therapy session tomorrow to address the thoughts she has when she gets the triggering images and discuss with therapist if more frequent sessions are needed for now. She also agreed to reach out to her AA sponsor today since the urge to drink is stronger. Next session schedule for xx/xx/xx.

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## Progress Notes

### General Tips:

- **Be accurate:** Specify where information came from.
    - e.g. “client reports,” “significant support person informed,” “written reports from DCFS stated,” etc.
  - **Be objective:** Do not use negative, biased, and prejudicial language. Base things on facts, not interpretation.
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- **Be concise:** Document all necessary information to support treatment and avoid unnecessary details.
  - **Include adequate detail:** Do not exclude information critical to explaining treatment decisions/interventions or significant information regarding the client.

## Progress Notes

### General Tips:

- **Individualize notes:** Be specific to the client and to the session. Do not cut and paste.
  - **Be specific:** Do not use jargon or vague terms.
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- **Be reader friendly:** In keeping the necessary terminology, also document your objective observations in a simple and understandable manner. Thus, when others review the chart, a clear picture of the client will be presented and treatment decisions will be supported.
    - e.g. Client behaved impulsively as evidenced by blurting out remarks during group session. Reviewed group rule (i.e. raise hand when ready to speak) and redirected client 2x during 90 minute group session.
  - **Respect confidentiality:** Do not name or quote anyone who is not essential to the record.

## Procedure Code Selection in the Progress Note

When deciding whether an activity or service provided is reimbursable/claimable, here are a few important questions to ask yourself:

- ❖ What was the specific purpose of the activity/service provided?
- ❖ What Service Component and Type of Service were provided?
- ❖ Does the service match an Objective on the Client Treatment Plan (CTP) that relates back to the Assessment? How will this activity directly improve or preserve the client's functioning or prevent deterioration of their mental health condition?
- ❖ Is there an apparent Medi-Cal Lockout\* rule that applies here?

\*Medi-Cal Lockouts: Specific situations when reimbursement for specific Medi-Cal services is not available.

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## Procedure Code Selection in the Progress Note - Example

### Activity/Service:

Case Manager (CM) spoke with a coordinator at the VA by phone and referred client to a Veteran's Support Group.

1. What was the specific purpose of the activity/service provided?
  - **To link client to services (a support group)**
2. What Service Component and Type of Service were provided?
  - **Referral and Related Activities under Targeted Case Management (TCM)**
3. Does the service match an objective on the Client Treatment Plan (CTP)?
  - **Yes, if client is a veteran and diagnosed with PTSD and has a related CTP objective**
4. How will this activity improve/prevent deterioration of client's mental health condition or preserve their functioning?
  - **It will assist with the treatment of the PTSD**
5. Is there an apparent Medi-Cal Lockout that applies here?
  - **No**
6. What procedure code should be selected?
  - **TCM – T1017SC**

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## Documentation & Procedure Code Selection for Group and Family Services Provided Over the Telephone or Telehealth

- The use of telephone and telehealth methods of delivery were expanded for group and family services due to the COVID-19 public health emergency.
  - Add telephone modifier SC or telehealth modifier GT to the following procedure codes, when applicable:
    - Group sessions - 90853, 90847HEHQ, H2015HEHQ, and 90887HEHQ
    - Family sessions - 90847 and 90849
- These services **should be provided with caution** and all clients involved in such services must be advised of the privacy risks inherent in conducting group/family sessions over the telephone or through telehealth.

❖ For more guidance on Telephone and Telehealth for group/family sessions, please visit: [http://file.lacounty.gov/SDSInter/dmh/1070261\\_TelephoneandTelehealthGuidanceforGroupFamilyServices3-23-2020.pdf](http://file.lacounty.gov/SDSInter/dmh/1070261_TelephoneandTelehealthGuidanceforGroupFamilyServices3-23-2020.pdf)

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## Documentation of Services Provided in a Non-Standard Manner

- Documentation of services provided in a non-standard manner should include the following within the progress note:
  - Reason for the nonstandard provision of services (e.g. due to the COVID-19 public health emergency)
  - The method in which it was provided (e.g. telephone or telehealth)
  - Client's understanding and verbal agreement with the method
- This guidance applies to any other nonstandard procedures used in response to the COVID-19 crisis.

❖ Sample progress note language:



This session was provided via [HIPAA-compliant video conferencing or telephone] due to recommendations from public health agencies regarding face-to-face contact related to COVID-19. This client agreed to be treated via [telehealth or telephone] and provided verbal consent. The plan for dealing with an emergency during the session is that the clinician will [call 911 or contact an identified emergency contact], depending on the nature of the situation. The client is aware of this plan.

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## Some Examples of Delivering SMHS

What you did	Type of Service	Service Component(s)	Procedure Code	If delivered by telephone	If delivered by telehealth
Session with client for individual therapy. Reviewed client's triggers for depression and patterns of negative self-talk. Worked on modifying patterns of negative self-talk by using statements to rate his behaviors rather than his entire self. <b>FTF: 45</b> Other Time: 17	MHS	Therapy	90834 (based on FTF time)  90834: 38-52 min	H0046SC (there is no face to face time in a phone session, thus time claimed will be in other time)	90834GT (based on FTF time)  90834GT: 38-52 min
Spoke with client's teacher about behavioral observations made in the classroom and the progress in treatment. Provided teacher with psychoeducation and modeled a strategy for the teacher to use to assist client in managing anxiety symptoms.	MHS	Collateral	90887	90887SC	90887GT

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## Some Examples of Delivering SMHS

What you did	Type	Service Component(s)	Procedure Code	If delivered by telephone	If delivered by telehealth
Provided a regularly scheduled session with client. Client was more agitated and angry than usual. Client was yelling, cursing and became physically aggressive (i.e. throwing objects, punching the wall, etc.). Provided emergency intervention to de-escalate and stabilize the client. Further assessed for dangerousness and suicidality.	CI	Assessment  Therapy	H2011	H2011SC	H2011GT
Client is currently hospitalized for being a danger to himself. Completed housing application and submitted to the housing authority.	TCM	Referral & Related Activities	00002 (non-billable to Medi-Cal TCM)  T1017HX (for contractors)	NA	NA

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