

Treatment and Progress Notes

For Social Workers, Marriage & Family Therapists, and Psychologists
(including students of these disciplines)

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

Standard Course of Action

1. Assessing

- Complete a mental health assessment and establish medical necessity;
- Complete an initial medication 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

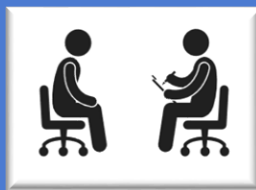
Treatment Services = services that address a client's mental health needs and are not primarily for the purpose of:

- 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



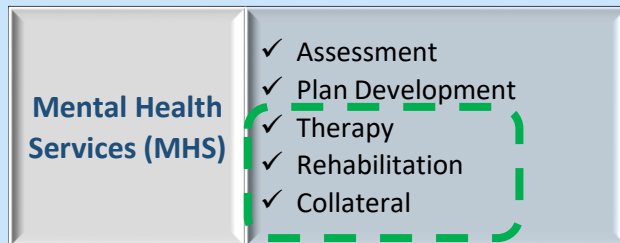
For more information, refer to the [Organizational Providers Manual](#)

Treatment Services

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



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



- ✓ 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



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

Mental Health Services (MHS)	<p>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</p>	<ul style="list-style-type: none"> ✓ Assessment ✓ Plan Development ✓ Therapy ✓ Rehabilitation ✓ Collateral
Intensive Home Based Services (IHBS)	<p>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.</p>	<ul style="list-style-type: none"> ✓ Rehabilitation ✓ Collateral
Targeted Case Management (TCM)	<p>Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)</p>	<ul style="list-style-type: none"> ✓ Assessment ✓ Plan Development ✓ Referral and Related Activities ✓ Monitoring & Follow-Up
Intensive Care Coordination (ICC)	<p>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</p>	<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)	<p>Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms</p>	<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)	<p>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.</p>	<ul style="list-style-type: none"> ✓ Assessment ✓ Therapy ✓ Collateral ✓ Referral

MHS Treatment Services

Service Component	Procedure Code(s)	What the Service Entails
<p>Therapy</p> 	<p>H0046 0-15 min FTF time</p> <p>90832 16-37 min FTF time</p> <p>90834 38-52 min FTF time</p> <p>90837 53+ min FTF time</p> <p>90847 Family Psychotherapy w/ 1 client</p>	<p>Also known as “talk therapy,” a service whereby psychological problems are treated through communication and relationship factors between the client and a trained mental health professional.</p> <p>Therapy focuses on symptom reduction and restoration of functioning as a means to improve coping and reduce impairments.</p>



Procedure Code Modifiers

- ✓ **SC** – for services provided over the telephone
- ✓ **GT** – for services provided via telehealth

Therapy over the phone is always **H0046SC**.





MHS Treatment Services

Service Component	Procedure Code(s)	What the Service Entails
<p>Collateral</p> 	<p>90887</p>	<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>
<p>Rehabilitation</p> 	<p>H2015</p>	<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
<p>Collateral</p> 	<p>H2015HK</p>	<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>
<p>Rehabilitation</p> 	<p>H2015HK</p>	<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	<p>A service that helps clients get access to needed ancillary services (e.g. medical, alcohol and drug treatment, social, educational providers, etc.) and includes</p> <ul style="list-style-type: none">• Making referrals and scheduling appointments• Coordinating service and mobilizing resources
Monitoring & Follow Up 	T1017	<p>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</p>

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	A service that includes referral, linkages, monitoring, and follow-up activities to ensure the child/youth's needs are being met.
Transition	T1017HK	A service where transition plan for a child/youth and family is developed 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:

- 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:

- 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

“Services” that are never billable

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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

Practitioner reviews the last few progress notes and medication notes in preparation for today's therapy 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...



- Review **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
- Claim 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

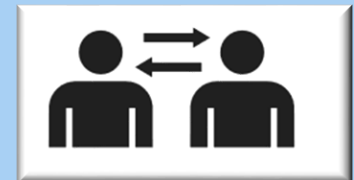


- Within the progress note:

- ✓ 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

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- 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*

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 including self-defeating beliefs of hopelessness and inferiority.

Per the treatment plan:

Objective: Reduce depressive symptoms from a PHQ-9 of 20 to less than 4

Intervention: Provide individual therapy to modify self-defeating beliefs...

On the progress note: "Met w/ client for individual therapy. Continued to address client's self-defeating beliefs. Client's current PHQ-9 score is a 14. Developed disputing techniques to help identify and modify client's negative global self-rating and overgeneralization. Practiced identifying the thoughts and beliefs that result in negative feelings. Modeled problem solving skills to address triggers..."

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

- ✓ “Due to client’s worsening symptoms, provided client with a referral for a medication evaluation...”
- ✓ “Mother reports improvements with client’s behaviors at home. Will continue to provide family therapy and collateral sessions...”

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

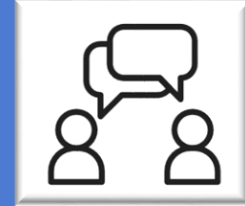
- ✓ “Processed client’s feelings...challenged client’s all-or-none thinking patterns”
- ✓ “Modeled appropriate ways of communicating feelings using I-statements...”
- ✓ “Provided psychoeducation regarding impacts of trauma on behavior...taught parenting skills around setting boundaries...”

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 group therapy sharing her story with others..."

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

“Writer and case manager 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.

Writer de-escalated client and modeled ways to better manage feelings of frustration. Writer and client attempted to practice deep breathing, and writer 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**

Progress Note Tips



Tip #1: Document risks

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- 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 feeling 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 monitor his anxious symptoms 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 for the purpose of individual therapy	Explored, identified, challenged, modified client’s self-defeating beliefs, addressed concerns/fears, directed/redirected, explained, redefined
• 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

Pause the video if you want to review these examples

- Consider the facts and keep in mind how information will affect the client's treatment plan
- Document client's specific behaviors rather than using non-specific psychotherapeutic jargon (technical-sounding clinical terms)
 - ✓ 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.

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 processed client’s feelings towards possibly sharing her diagnosis with her parents. Role-played how client can communicate her feelings...”

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 client 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
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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 - Psychotherapy

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

Intervention: Met with the client for the purpose of conducting an individual therapy session. **Reimbursement**

Administered the PHQ-9 – client’s current score 14 (moderate): endorsed feeling depressed, feeling like a failure, difficulties falling asleep, and fatigue. Reviewed client’s homework (mood diary) focusing on the triggers of his depressed mood and patterns of negative self-talk and self-defeating beliefs. Focused on challenging his underlying belief related to worthlessness, and modifying his tendency toward global self-rating. Assisted client in using statements to rate his behaviors not his entire self and using problem-solving skills to more effectively address his triggers. **Clinical**

Response: Client completed his mood diary in which he frequently described himself as loser, idiot, and failure. Willing to practice using statements to rate his behavior rather than his entire self and to continue practicing problem-solving skills.

Plan: To continue working on modifying self-defeating beliefs and strengthening problem-solving skills. **Legal**

Service Code: 90837 (*Individual Psychotherapy*)

Face to Face Time: 66 minutes (*time spent w/ client*)

Other Time: 12 minutes (*time spent documenting*)

Pause the video if you want to review this example

Progress Note Example 2 - Collateral

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

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

Reimbursement

Discussed challenges regarding parenting and explored different parenting strategies. Acknowledged mother's challenges and validated her experiences. Therapist explored different ways of de-escalating situations. Therapist and mother role played how to respond to client.

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: Therapist to provide weekly collateral session with mother aimed at helping client achieve treatment goals.

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 3 - 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 4 - 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 5 – 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 last individual therapy session. **Reimbursement**

Reviewed client's progress and skills learned from treatment. Processed client's feelings regarding termination. 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 session. 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 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 CBT sessions for 7 months. Client has been responsive to sessions and participated in all sessions including completing exercises and practicing skills at home. In addition to individual therapy 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 session. 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: 90832 (*Individual Psychotherapy*)

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

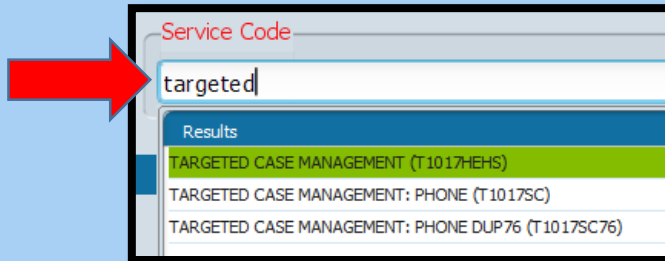
- **Individual Service Progress Note** – used for individual services (except MSS by prescribers)
 - ✓ Appointment must be entered in the **Scheduling Calendar**
- **Special Use Progress Note** – can be used for non-billable activities, unscheduled telephone contacts, and when writing a billable service 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**

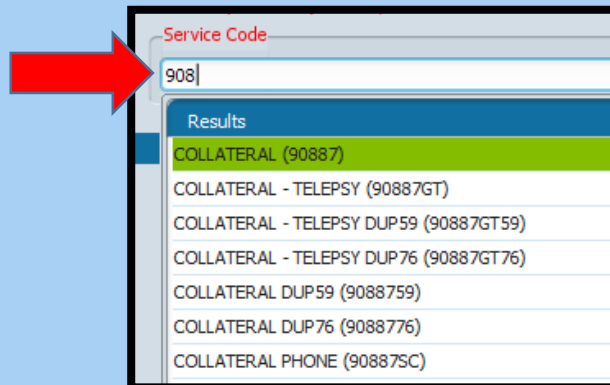
- ✓ Start typing in the name of the service (e.g. “therapy,” “group,” “assess”)



A screenshot of the 'Service Code' dropdown menu in the IBHIS system. The input field contains the text 'targeted'. A red arrow points to the input field. The dropdown menu is open, showing a list of results. The first result, 'TARGETED CASE MANAGEMENT (T1017HEHS)', is highlighted in green. Other results include 'TARGETED CASE MANAGEMENT: PHONE (T1017SC)' and 'TARGETED CASE MANAGEMENT: PHONE DUP76 (T1017SC76)'.

Service Code
targeted
Results
TARGETED CASE MANAGEMENT (T1017HEHS)
TARGETED CASE MANAGEMENT: PHONE (T1017SC)
TARGETED CASE MANAGEMENT: PHONE DUP76 (T1017SC76)

- ✓ 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 the IBHIS system. The input field contains the text '908'. A red arrow points to the input field. The dropdown menu is open, showing a list of results. The first result, 'COLLATERAL (90887)', is highlighted in green. Other results include 'COLLATERAL - TELEPSY (90887GT)', 'COLLATERAL - TELEPSY DUP59 (90887GT59)', 'COLLATERAL - TELEPSY DUP76 (90887GT76)', 'COLLATERAL DUP59 (9088759)', 'COLLATERAL DUP76 (9088776)', and 'COLLATERAL PHONE (90887SC)'.

Service Code
908
Results
COLLATERAL (90887)
COLLATERAL - TELEPSY (90887GT)
COLLATERAL - TELEPSY DUP59 (90887GT59)
COLLATERAL - TELEPSY DUP76 (90887GT76)
COLLATERAL DUP59 (9088759)
COLLATERAL DUP76 (9088776)
COLLATERAL PHONE (90887SC)

Progress Note Form in IBHIS

- Columbia Suicide Screener

COLUMBIA SUICIDE SCREENER

~Suicide Screening Questions~

Screening Completed
 Screening Not Completed

Since last visit (or past 30 days if never previously asked)

Have you wished you were dead or wished you could go to sleep and not wake up?
 Yes No

Have you actually had any thoughts of killing yourself?
 Yes No

Have you been thinking about how you might do this?
 Yes No

Have you had these thoughts and had some intention of acting on them?
 Yes No

Have you started to work out or worked out the details of how to kill yourself and do you intend to do this plan?
 Yes No

Since last visit (or lifetime if never previously asked)

Have you done anything, started to do anything, or prepared to do anything to end your life?
 Yes No

If the Columbia Suicide Screener was completed on another form (e.g. the assessment 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

▼ TREATMENT PLAN ELEMENT(S) ADDRESSED IN THIS PROGRESS NOTE

Select Treatment Plan Version

DMH Treatment Plan

SELECT TX PLAN ELEMENTS

CLEAR TX PLAN ELEMENTS

Treatment Plan Element(s) Addressed in This Progress Note

Problems-> Generalized anxiety disorder
Goals-> Reduce Anxiety
Objectives-> Client will reduce anxiety symptoms from a GAD-7 score of 18 (severe) to 6 (mild)
Interventions-> Practitioner will provide individual therapy to identify and modify client's anxiety provoking cognitive disorders and teach skills to better manage anxious thoughts

DMH Treatment Plan

DMH Treatment Plan - 6840, M.Young - Plan Date: 06/23/2020 (Plan Type: Annual Submitted: 06/23/2020 at 09:56 PM by Michelle Young-Sambajon):

- Problems: Generalized anxiety disorder
 - Goals
 - Reduce Anxiety
 - Objectives
 - Client will reduce anxiety symptoms from a GAD-7 score of 18 (severe) to 6 (mild)
 - Interventions
 - Practitioner will provide individual therapy to identify and modify client's anxiety provoking cognitive disorders and teach skills to better manage anxious thoughts
- Problems: Homeless
 - Goals
 - To get housed
 - Objectives
 - Client will obtain stable housing
 - Interventions
 - Practitioner will identify and evaluate available housing resources, assist with application process, and work with housing agency a

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**.

Append Progress Notes

Note Type: Progress Note

List of Notes: 3 - Service date: 06/24/2020 Service: TARGETED CASE MANAGEMENT...

Submit

Original and Appended Notes

Note Date (Original): 06/24/2020
Last Updated by: Michelle Young-Sambajon On: 06/24/2020 At: 10:19 AM

Goal: Client will obtain permanent housing

Intervention: Writer and client met for the purpose of facilitating linkage to Section 8 housing. Writer scheduled an appointment for client with the housing authority on 6/1/20 at 10am. Writer communicated the importance this appointment in order to obtain her Section 8 housing.

Response: Client brought all of the necessary documents to the appointment. Client appreciated writer's assistance. Client reported that she understood importance of the appointment.

Plan: Writer to review next steps. Writer and client to meet next week for rehab session.

Problems-> Homeless
Goals-> To get housed
Objectives-> Client will obtain stable housing
Interventions-> Practitioner will identify and evaluate available housing resources, assist with application process, and work with housing agency and monitor linkage

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
- Special Use Progress Note
- Append Progress Notes
- Viewing notes via the Chart View and Notes Widget

Progress Note Resources

1

PROVIDER CENTRAL

2

ADMINISTRATIVE TOOLS

CLINICAL TOOLS

ADMINISTRATIVE
INFORMATION FOR
CLINICIANS

PROVIDER MANUALS &
DIRECTORIES

POLICIES, PARAMETERS &
GUIDELINES

ADMINISTRATIVE FORMS

3

QUALITY ASSURANCE

QUALITY IMPROVEMENT

COPING WITH STRESS DURING
COVID-19

Resources

QUICK LINKS

[DMH Provider Directory](#)

[Geospatial Initiative](#)

FROM THE DIRECTOR



Quality Assurance

Quality Assurance

Manuals

Bulletins

Clinical Forms

Chart Review Requirements

Certification

QUALITY ASSURANCE - MANUALS

A A A

[Organizational Providers Manual](#)

[A Guide to Procedure Codes](#)

[IBHIS Addendum Guide to Procedure Codes](#)

[Community Outreach Services \(COS\) Manual](#)

Quality Assurance

Quality Assurance

Manuals

Bulletins

QUALITY ASSURANCE - BULLETINS

A A A

[QA Bulletins](#)

[Clinical Forms Bulletins](#)

[Medi-Cal Certification Bulletins](#)

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

Confirmation of Completion Instructions

Complete the online Quiz to receive your
Confirmation of Completion

To access the quiz either
scan the QR code or use the URL address

Scan the QR Code

- iPad/iPhone:
 - open the camera app
 - hold it over the QR Code
 - click Open "forms.office.com" in Safari
- Android:
 - Utilize a QR code reader app



Use the URL address

- Open a web browser and type the below URL into the address bar:

<https://tinyurl.com/TreatmentandProgressNotes>

Complete the quiz

Once submitted, a confirmation of completion will be emailed to you
Make sure to click View Results to see how you did