PROGRESS NOTE GUIDELINES

Instructions

Clinicians should attempt to complete therapy notes during the session whenever possible. Time away from the session to complete the note may not be included as part of the session time. This form is used for psychotherapy with individual and family members

DATE: "**dd/mm/yy"** This should reflect the date the session was actually performed.

PRIMARY DIAGNOSIS: Record both the DSM IV TR code number and the name of the disorder. Technically, CMS uses ICD-9 codes, but they cross over closely. Use the Diagnostic Code taken from the initial Psychological Assessment. If Diagnosis needs to be changed it should be reflected on a Change in Diagnosis form. List the psychological disorder diagnoses first, followed by cognitive disorders. The existing diagnosis can be found in several locations; 1) the last Progress Note, 2) the Psychological Assessment, or 3) Change in Diagnosis form (if one exists).

NAME: This needs to be the patient's **LEGAL name** (NO nicknames). Standard convention should always be **last name first, then first name** on all official documents. This avoids the inevitable confusion with those individuals with "two first names" or "two last names". This will reduce errors in the billing process and assure better communication.

AGE: The present age of the patient is entered here.

GENDER: Check the appropriate box.

LENGTH OF SESSION (minutes): Record the total length of the face to face contact with the patient in the psychotherapy session in minutes. Do not put ideal minutes, or minutes defining a CPT code, but ACTUAL minutes.

> This should reflect a single encounter.
>
> No Session: This box is to report when a session was attempted but not conducted due to the patient's refusal, medical or mental status, or lack of availability, etc. This of course is not billable, but is still clinically relevant information.

TYPE OF SERVICE BILLED: Check the box that most accurately reflects the time for individual sessions, or others for different procedures.

- 90832 is a 30 minute session. The session length must be 16 minutes minimum to bill this code.
- 90834 represents a 45 minute session. The session length must be 38 minutes minimum to bill this code.
- 90837 reflects a 60 minute session, which is reserved for those acute and unique situations where extra time is necessary, requiring accompanying clinical explanation in the progress note. The session length must be 53 minutes minimum to bill this code.
- 90785 is an add-on code for clinical complexity. An example of this is the presence of a difficult family member, abuse requiring report, or other clinical obstacle to implementing the treatment plan. This code is checked in addition to the primary service rendered. The note must identify the specific complexity which justifies the add-on.

OUTCOME MEASUREMENT: Our standard outcome measurement is the Periodic Treatment Review. This section must always be checked, as per Medicare guidelines. If “other”, then specify. An example may be a Behavioral Frequency Chart.

SYMPTOMS/BEHAVIORS FROM TX PLAN TARGETED ***DURING THIS SESSION***: Note that this is to be directly from the current treatment plan on file, and is the symptom and/or behavior that the current therapy session was focused on. Be specific but descriptive, but use targets DIRECTLY from the treatment plan

CURRENT PROBLEMS/SYMPTOMS:
This area should relate to the diagnosis and treatment plan. If not, plan may need revision. Refer to the list of definitions below for these symptoms/behaviors. It is critical that you take some time during the session to closely observe the resident for symptoms/behaviors and gently probe for those symptoms you know are associated with their diagnosis. Refer to DSM-IV-TR and make a list of common symptoms of the disorders troubling your client. Medicare standards and their guidelines for reimbursement clearly state that a “medical necessity” must be demonstrated to ensure reimbursement for the service billed. This list of symptoms is a comprehensive list of symptoms found in the vast majority of psychological disorders found in our client. In addition to providing essential, up-to-date information for nursing, attending physicians and psychiatry providers this clearly establishes the distress and need for intervention. Take the time to familiarize yourself with the meanings of, and techniques used to assess/detect these symptoms.

SYMPTOM DEFINITIONS

aggression (verbal): verbal hostility, threats, cursing at someone

aggression (physical): combativeness- biting, hitting, pinching. Raising a hand as if to hit is not considered physical aggression

agitation: inappropriate verbal, vocal, or motor activity not judged by an outside observer to result directly from the needs or confusion of the individual (but NOT limited to isolated periods OR when discussing something upsetting

anhedonia: absence of pleasure or inability to experience pleasure

anger: strong feeling elicited by real or supposed injury that is often accompanied by desire to take vengeance

anxiety/fear: feeling of fear, apprehension, or excessive concern about present or future events (without actual real danger) often accompanied by somatic symptoms of dry mouth, pupil dilation, sweating, shortness of breath

appetite disturbance: loss of appetite can result from several sources, from major depression to grief reactions or may be the result of poor physical health in the aging population.

delusions: unfounded, unrealistic belief held without supporting evidence

depressed: discouraged, pessimistic, loss of interest in activities previously enjoyed, low energy or fatigue, low self-esteem, feelings of hopelessness, possible sleep disturbance, possible appetite disturbance, possible sleep disturbance.

distractibility: able to have one's attention drawn too frequently and/or easily to unimportant or irrelevant external stimuli

danger to self: risk of inflicting harm to self

danger to others: risk of inflicting physical harm to others. Poorest predictors among mentally ill are diagnosis, severity of mental disorder, and personality traits

decreased energy/fatigue: abnormal tiring during mental or physical activity making it difficult to sustain normal activity level

emotional lability: pattern of abrupt mood shifts from normal to depressed, irritability, anger, anxiety, or mania

feelings of worthlessness: lack of purpose and value to family, friends and/or society; feeling as though they are a burden on others and that others would be better off if they were to die.

hallucinations-auditory: hearing sounds, voices, clicks, rushing noises without stimulus

hallucinations-visual: seeing formed images (people, objects) or unformed images (flashes of light) without observable sensory stimulus NOTE: illusions are a misperception of "observable" stimuli

hopelessness/helplessness: having no expectation of good or success, passivity, withdrawal, and hypoactivity or belief that they have no capability to accomplish goals

hypersomnia/insomnia:
hypersomnia- excessive sleep, beyond that needed to achieve needed rest insomnia difficulty initiating or maintaining sleep (can be at beginning, middle, or end of typical sleeping time)

impulsivity: behavior characterized by lack of deliberation and failure to consider consequences before acting

irritability: a tendency toward oversensitivity to stimuli, easily annoyed and provoked to anger.

negative statements: verbalizations that oppose a positive point-of-view.

noncompliance (medical care): lack of cooperation with physician and nurses in prescribed medical care

restlessness: unable to relax, uneasy, discontented

sad/pained/worried expression: self explanatory

self deprecation: expresses disapproval of self, low self esteem

socially inappropriate: exhibits behaviors that are considered inappropriate by societal standards

social withdrawal: diminished social involvement, increase in avoidance of interaction with others and reduced participation in facility activities. It is particularly noteworthy if this withdrawal represents a significant change in the resident's social interests.

suicidal ideation or plan: thoughts, ideas, or rumination about one's suicide, or overt threats to kill oneself (THIS MUST BE IMMEDIATELY REPORTED TO THE SUPERVISING PSYCHOLOGIST). The symptom of suicidal ideation must have a component of suicidal intent and not simply thoughts about death.

thought disorder: a thought process, judgement, opinion, idea, or belief that is not based on reality or reality based stimuli. Delusions, hallucinations (both need to be noted elsewhere in the list), loose associations, ideas of reference, etc., of which all, or some are features of thought disorder.

other observed symptoms: any other recognized symptoms of mental illness or behavioral disorder. Please be as specific as possible.

NOTE: ***Always consult with the supervising Psychologist regarding definitions, signs, symptoms and assessment criteria for any of the above listed behaviors and symptoms. Be sure to note in the body of the Progress Note any newly emerge symptoms.***

COMORBID MEDICAL CONDITION IMPACTING PSYCHOLOGICAL STATUS:

Some of the medical conditions identified in the literature to complicate treatment:

- High Blood pressure/ Low blood pressure
- Stroke
- Multiple strokes (TIA's)
- Hemiparesis (weakness on one side of body)
- Parkinson's Disease
- Huntington's Disease
- History of head injury
- Seizure Disorder
- Syphilis
- Diabetes
- History of alcohol/drug abuse
- Down's Syndrome

- Mental retardation
- Delirium
- Sensory deficits (hearing, vision)

THERAPEUTIC TECHNIQUES:
Check one of the boxes provided of the treatment models/theories/approaches that most closely matches your intervention approach. It's a good idea to consult with your supervising psychologist if you have questions about the technique you are using, and if it's appropriate given the level of resident's capability

INTERVENTION STRATEGIES **USED DURING SESSION**: These are the specific strategies you employed during the session. Use clinical terminology and rationale for the strategy. For example modeling and reinforcement (Behavior Modification), or empathic listening, reflection (Supportive). Suggestion: Consult with team for varied descriptors of strategies so progress notes are not repetitive (it's also good clinical practice to broaden your skill set). "*Focus of session was* …" is a good way to start this section, i.e. *identifying recent positive events, continuing to support interest (in plants, movies, cars, music etc.), pt. participation in activity, goal to make light conversation with another res.*, etc. More examples are: "*Provided reflective listening for patient's concerns about health." "Verbal praise to positively reinforce patient's pro-social behavior." "Focus of session was renewal of past interest areas, i.e. fishing."*

PATIENT RESPONSE: Some suggestions for interpreting the choices in this area.

MARKED IMPROVEMENT: Represents a significant shift from prior response to sessions. Some might refer to this as a breakthrough, new insight, significantly better response to prompts, much better able to be redirected without negative reaction. This will depend on the level of functioning of the resident to begin with

SOME IMPROVEMENT: Better able to attend throughout, or greater portion, session, perhaps evidenced by better eye contact, more spontaneous conversation, recognition of therapist, remembered prior conversation, subjective report of feeling better at end of session, engaged in area of interest with more energy, affect more responsive to environment or topic.

MAINTAINANCE OF FUNCTIONING: Used more frequently for residents with chronic, long-term psychiatric and/or cognitive problems. This indicates that the resident has shown no decline in function and therefore meets the Medicare accepted guideline of slowing decline. In this context, staying the same is a good thing!

SYMPTOMS WORSE: Noticeable increase in previously noted symptoms, or newly observed symptoms (NOTE: should be checked in symptom section above)

EVIDENCE OF PATIENT RESPONSE:
After checking one of the "patient response" boxes, a brief description of patient reactions, resident reports that led you to assess their response as you did. This needs to relate to the session and not be a global assessment of the patient. Suggestion: Look closely for the small things that many of our residents do to indicate change. For example, record incremental changes in recognition, eye contact, and affect that confirm their engagement in the process. Other examples, (in reference to intervention strategies section mentioned above,) could be that the patient was able to identify two positive events, engage in attention to area of interest subject, continues to resist actually participating in an activity, reports (not) meeting a potential friend. As you know, with many the process is slow, but it's important to document how the patient engages with the process.

FUTURE TREATMENT/FOLLOW-UP ISSUES:
This section is a note to remind of current plans. This may be to continue with the current plan, add a treatment goal, explore cause of a new symptom, check med changes, follow a strategy, i.e. "patient requests a family session," or "family to bring in pictures of patients old car, bring DVD player" etc. Here is where to record in a brief narrative any topics, key points, or other clinical matters that need to be brought up in subsequent sessions.

CHECK WHEN APPLICABLE: Check when necessary the need to change either (or both) the treatment plan or patient's diagnosis. Proceed with completing a Diagnosis Change Form or Revised Treatment Plan Form, as applicable. The completed form should be:

1. Faxed to the Senior Connections Billing office at 360-253-5170.
2. Original to patient's Medical Record.
3. Copy to patient's Senior Connection's File.

Signature and Title Required:

The signature of the Psychologist with the signature of the Therapist verifies direct supervision within the designated "office" area or presence in same room.

Signatures should be legible and included title, i.e. MA, MS, MSW, LICSW, PsyD, or PhD.