County of Sacramento **Department of Health and Human Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-30**
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Title: **Progress Notes (Mental Health)**	Functional Area: **Chart Review – Non-Hospital Services**

Approved By: (Signature on File) **Signed version available upon request**

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BACKGROUND/CONTEXT:

The Sacramento County Division of Behavioral Health Services and Mental Health Plan (MHP) requires that Progress Notes accurately record all service contacts. Progress Notes are a description of direct and indirect service activities including billable and non-billable contacts. Progress Notes also convey information from collateral resources, consultation contacts, and coordination with other system providers and agencies.

PURPOSE:

The purpose of this policy is to establish guidelines, requirements, and timelines for the completion and submission of Mental Health progress notes.

In the Avatar Clinician Workstation (CWS) system and other electronic health record systems, the submission of a progress note is also the mechanism for service billing.

DETAILS:

It is the policy of Sacramento County MHP that Progress Notes are completed for all service contacts.

1. Progress Notes must support the applicable service but should be brief and succinct. Long narratives and lengthy descriptors should be avoided.

2. County approved abbreviations may be used in Progress Notes (see *BHS Abbreviations and Acronyms*).

3. The Clincal Introductory Progress Note is written at the first face to face contact, or very soon thereafter, providing an overview of the client and his/her mental health condition. A complete note includes, but is not limited to: the identity of the client, including age, ethnicity, and other significant demographic information, the referral source, presenting condition, including symptoms, behaviors, and level of functioning, need for services/medical necessity justification, client strengths, supports, and a plan for subsequent services. If a client indicates a primary language other than English, or a physical disability, the provider will offer an accommodation to provide culturally and linguistically competent services and note this in the clinical introductory progress note. If a client refuses such accommodation, this refusal will be documented in the clinical introductory progress note.

4. Cultural and linguistic accommodations must be offered to the client and on behalf of the family/caregiver. This must be documented in every note when a language other than English is indicated. If the provider is trained and proficient in English and the target language then the

progress note must specify the language spoken during the session. When an interpreter is necessary the progress note shall include the following: the language the session was conducted in, language services offered, the name of the interpreter, how interpretation was conducted. If a provider is using a client's family member for interpretation document the emergency situation and circumstances where no other means of interpretation or communication was available. Should the client elect a family member as the interpreter there must be documentation of the clinical decision making informing that decision and documentation demonstrating efforts to offer an independent interpreter. Sacramento County prohibits the use of children as interpreters under all circumstances. *See Cultural Competence & Ethnic Services Policy and Procedure "Procedure for Access to Interpreter Services" for more information.*

5. Progress notes should document relevant clinical decisions, when decisions are made, alternative approaches for future interventions.

6. A description of the interventions used, client's response to the interventions and progress made toward treatment goals/ objectives by the client and family (when applicable) must be reflected in the notes. Each progress note claimed must demonstrate how services provided reduced impairment, restored functioning or prevented significant deterioration in an important area of life functioning, allowed a child to progress developmentally as individually appropriate or for client's under the age of 21, corrected or ameliorated the condition. Each progress note claim must relate to the qualifying diagnosis and identified functional impairments as well as should be medically necessary.

7. The Discharge Summary should include information summarizing the course of treatment, the reason for discharge, and recommendations for follow-up care and referral.

8. Progress Notes must be completed in a timely manner according to the following guidelines:

    a. Progress notes should be completed on the same day a service was provided but will be considered "on time" if completed within 3 business days of the service. (Example: If a service was provided on Tuesday, the note could be completed no later than Friday and still be considered "on time").

    b. Progress notes will be considered late but accepted if completed within 4 and not more than 5 business days from the date of service. (Example: If a service was provided on Tuesday, the note would be considered late if it was completed the following Monday or Tuesday). Supervisors may be notified of this late entry.

    c. A progress note later than 2 weeks from the date of service may be subject to non-reimbursement for the service provided.

9. When services are being provided to, or on behalf of, a client by two or more persons at one point in time then one of the following must occur:

    a. Each provider documents his/her own individual progress note including service code, service time, documentation and travel time. There must be documentation of each perons' involvement in the context of the client's mental health needs and describe how each role was separate, distinct and medically necessary.

10. Progress Notes are considered final once submitted into Avatar CWS and electronic health record systems. If critical content or information is left out, notes may be "appended" (Append Note function in Avatar CWS) in order to justify the service code or time claimed.

11. Corrections for open or closedcharge services that has not claimed must be submitted to QM on the Open Charge Deletion Request (OCDR) form. Corrections for services already claimed must be submitted to DBHS Fiscal on the Claims Correction Spreadsheet. Refer to the Instructions on

How to Edit or Delete a Service Claim Document. In some cases services may need to be re-entered as a non-billable activity so that documentation exists for completed service activities.

12. Any Progress Notes that are hand written and not entered through an Electronic Health Record must be legible, including legible printed name, signature and professional classification, as well as include the date of service, amount of time taken to provide services and location that the service took place in order to be considered a complete progress note. The hand written progress note would be scanned in the Scanned Document Folder labeled, "Non Medication Progress Notes" or "Medication Progress Notes" depending on the type of service.

Procedure:

Progress Notes shall contain the following elements:

1. **Date of Service**
   Enter the date the service occurred. Note that "entry date" is recorded in Avatar and electronic health record systems. Entry date is used to confirm timely submission of progress notes.

2. **Service Charge Code**
   Enter or select the applicable Service Charge Code. See *Sacramento County Service Code Definitions/Training Guide* for updated list of Service codes, code definitions, and training information. A separate progress note must be written for each service billing (i.e. multiple notes may be needed for different service activities occurring during one client contact or session).

3. **Service Location**
   Enter or select the applicable Service Location. Location options are predefined through Department of Health Care Services (DHCS) Client Services Information (CSI) data requirements.

4. **Practitioner Name and Signature**
   Practitioner name and professional classification (i.e. MHA-I, MHRS, LPHA) are automatically entered in Avatar CWS and electronic health record systems. The practitioner's signature or electronic signature is required on all notes and are automatically entered upon finalizing the progress note

5. **Duration**
   Enter total duration of service time in minutes. Direct service time, Documentation time, and Travel time must be entered separately, if applicable. Documentation time includes the time it took to complete the progress note for the service. Travel time is the round-trip travel time from agency office to service location. Travel time can only be counted for services where a billable activity occurs.

6. **Service was Face to Face**
   Select "yes" or "no" as appropriate. Select "yes" if a service was provided to the client face to face.

7. **Evidence-Based Practices/Service Strategies (CSI) and Additional SS/EBP**
   Evidence-Based practices (EBP) are effective clinical practices supported by extensive literature and data. Coding of EBPs must be pre-approved by the Sacramento County MHP. See Policy and Procedure *Review Process for Implementation of New Clinical Practices* for more information. The listing of EBPs is defined by the MHP and the State DHCS.

   Service Strategies (SS) are general service descriptions for specific interventions. Service Strategies do not require pre-approval and should be coded for all applicable services. The listing of Service Strategies is defined by the State DHCS. See Policy and Procedure QM-14-01 *Review Process for Implementation of New Clinical Practices for more information regarding service strategies* for more information.

8. **Note Type (Avatar CWS users)**
   Select the applicable Note Type (i.e. Standard, Intake, Discharge, Injection). Note Type should be "Standard" unless a specialized service that fits another category is provided. Note Type is independent of Service Code claimedand does not affect billing.

9. **Language in Which Service Was Provided**
   Select the language the service was provided in. If multiple languages are spoken during a service please clarify in the progress note narrative.

10. **Was Interpreter Used**
    Select "yes" or "no" as appropriate. If the staff providing the direct service is providing interpretation "yes" should be selected.

11. **Group Services**
    Group services must indicate the number of clients participating in the group. In Avatar CWS, "Number of Clients in Group" must be used to identify the number of participants so that duration can be accurately apportioned to each client.

    If a group is co-facilitated, the second facilitator can only bill and be identified as "Co-Practitioner" if his or her non-duplicative role is defined in the narrative of the note.

    Note: "Preparation time" is not accepted as billable time for group services.

12. **Discharge Notes**
    The Discharge Note Type should be selected and the applicable Service Charge Code used for the service is selected. Discharge notes are billable only if a billable service is provided in that final contact (i.e. case closed with final Individual Therapy service). If no contact has been made with the client for an extended period then the Discharge note is considered "administrative" and the Non-billable Service code (11111) should be selected. See Policy and Procedure **QM-10-28** *Discharge Process* for more information.

REFERENCE(S)/ATTACHMENTS:

- Mental Health Plan Contract

RELATED POLICIES:

- QM 00-08 Deletion of Open and Closed Charges
- QM 10-28 Discharge Process
- CC 01-02 Procedure for Access to Interpreter Services
- QM 14-01 Review Process for Implementation of New Clinical Practices

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