Welcome, your facilitator will be: Samson Teklemariam, LPC, CPTM
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The Progress Note: Where Law & Ethics Meet Efficiency

Presented by
Elizabeth "Beth" Irias, MS, LMFT

www.naadac.org/webinars

Using GoToWebinar (Live Participants Only)

- Control Panel
- Asking Questions
- Audio (phone preferred)
- Polling Questions

Elizabeth’ Beth’ Irias, LMFT

- Utilization Review & Clinical Documentation Consultant
- Private Practice Therapist
- Adjunct Graduate Psychology professor at Pepperdine University

President & Founder of Clearly Clinical, a low-cost national podcast Continuing Education Company approved by NAADAC Webinar Presenter
Webinar Learning Objectives

- List three legal and ethical implications of inadequate clinical documentation practices
- Identify five important components of quality clinical documentation as they relate to Best Practice
- Provide a general definition of the term 'Medical Necessity' as related to Clinical Documentation

Polling Question

Have you been told by someone (a professor, a supervisor, a boss, a colleague) to keep your progress notes short and vague?

A. Yes, I've been told that!
B. Nope, I've never been told that.

The Way I See It

- My 'why'
- Care access issues
- The 'Medical Model'
- Making it stick
Underlying Clinical Records

WHO
WHAT
WHERE
WHY
WHEN

Records: Who Are They For?

A misnomer: “Client chart”

Note: Make sure to know your state’s requirements relating to the documentation of sensitive information

Big Picture Thinking

Quality Clinical Documentation

More Financial Stability, Including Liability Reduction

Increased Clinical Reflection and Responsiveness

Improved Utilization Review Outcomes (if care is managed by third parties)

Improved Client Care

Improved Quality Clinical Documentation

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Improved Client Care

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American Counseling Association Code of Ethics, Section A.1.b. “Counselors include sufficient and timely documentation to facilitate the delivery and continuity of services. Counselors take reasonable steps to ensure that documentation accurately reflects client progress and services provided.”

American Association for Marriage and Family Therapy Code of Ethics, Section 3.5 “Marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.”

National Association of Social Workers Code of Ethics, Section 3.04 “(a) Social workers should take reasonable steps to ensure that documentation in electronic and paper records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future…”
State Laws and State Ethical Codes

Inquire with your professional association for guidance about your state’s specific ethical codes and laws relating to clinical documentation.

An Example of a Documentation-Related State Law

California Health & Safety Code §123130

“… [A] summary must contain the following information if applicable:

- Chief complaint(s) including pertinent history
- Findings from consultations and referrals to other health care providers
- Diagnosis
- Treatment plan
- Progress of the treatment
- Prognosis including significant continuing problems or conditions
- Pertinent reports of diagnostic tests
- Discharge summaries...

The Joint Commission’s Take

“Today, the quality and content of the client record may well determine whether treatment is deemed appropriate and level of care are justified and reimbursable.”
Consequences of Inadequate Documentation

Auditing Impact

“If it’s not in the chart, then it didn’t happen.”
Our records can impact a client’s ability to receive things like insurance authorizations and disability coverage.

What does your current documentation say about the quality of your work?

“Health care fraud is a type of white-collar crime that involves the filing of dishonest health care claims in order to turn a profit.”

NOTE: Fraud does not have to be intentional to be a crime.
Fraud Red Flags

Copied-and-pasted phrases or sections
Missing entries
Frequent revisions to entries
Inaccurate charting
Service overlap

Unforeseen Circumstances

What happens if you abruptly leave your practice and your records are disorganized?

Unforeseen Circumstances

How Good Is Your Memory?

Record Retention in California, for example: “The Seven-Year Rule”

BUT: A complaint can be filed with the CA Board of Behavioral Sciences for 10 years after the service occurred
A Board Complaint

A board complaint can sometimes start with one thing, and end someplace else.

Polling Question

Can behavioral health and addiction providers go to jail relating to clinical documentation oversights?

A. Yes, in some cases.
B. No, that pretty much can't happen.

Legal Liability

FEAR NOT!
There’s a lot you can do to get your records in tip-top shape!

The Term ‘Medical Necessity’

The Term Itself
From Treatment Planning for Person Centered Care by Adams and Grieder (2014):

“Simply stated, the demonstration of Medical Necessity requires that there is a legitimate clinical need and that services provided are an appropriate response.”
Imagine a doctor performing a procedure that wasn’t medically-necessary.

Most third-party payers will only pay for services if they are the following:
- Indicated
- Appropriate
- Efficacious
- Effective
- Efficient
From The Joint Commission's 2018 Documentation Guide

“If it’s done effectively, documentation support and guides, justifies and confirms: It communicates.”


California Welfare And Institutions Code §14059.5

“[A] service is ‘medically necessary’ or a ‘medical necessity’ when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”


Polling Question

Do you work with insurance companies? (I.e.: Do you or your company receive reimbursement from insurance providers for sessions?)

A. Yes, I do.
B. No, I don’t.
Insurance Company Definitions
If you accept insurance, you need to know the Medical Necessity Criteria and Level of Care guidelines.

Where Medical Necessity Needs To Be...
In your:
- Assessment
- Treatment Plan
- Progress Notes
- Discharge Plan
- Case Notes
- Medical/Nursing Notes

Medical Necessity Recap
There is a legitimate clinical need
Services provided are an appropriate response
Writing Progress Notes

The Safety F.I.R.S.T. Mnemonic®

What really needs to be in your notes

Safety

F = Functional Impairment
I = Interventions
R = Response
S = Symptoms
T = Therapeutic Interpretation

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SAFETY
Have I documented the critical safety/risk factors? (If there are any… maybe there aren’t!)

F= Functional Impairment
How does the individual’s condition or situation impact his/her/their ability to function in important domains, like work, school, home, etc.?

An Example: Chuck
An Example: Chuck

An Example: Me

And Again: Chuck

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I= Interventions

What treatment intervention did you use, and what was the clinical reasoning behind it?

Example

“Therapist encouraged the client to identify the pros and cons of switching majors in college.”

Why?

“In order to…” (insert reason)”
How did the client respond to you and your interventions?

Document both the symptoms you observe and the reported symptoms.
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Therapeutic Interpretation

- Treatment compliance/lack of compliance
- Clinical impressions
- Progress
- Relapse potential
- Prognosis
- Exercise of clinical judgment
- Plan

The Clinical “Fancy Hat”

Safety

- Functional Impairment
- Interventions
- Response
- Symptoms
- Therapeutic Interpretation
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The 'So What' Challenge

... So what does all this data mean, doctor? So what is my condition? So what are my problems? So what should I do to resolve the problems I have, and where do I start? So what can you or others do to help me? So what can I do to help myself? So what should I look for and watch to see that I am progressing?


TJC Gets It!

"It is not that clinicians fail to complete evaluations or to identify the 'so what' questions; they merely do not write them proficiently and sometimes do not write them at all."

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"Client reports that her boss is becoming increasingly more frustrated with her absences, and she was written up yesterday."

So what?

- More stress, worse insomnia.
- More alcohol use.
- More work absences.
- She may lose her job.
- She may lose her housing.

"Client reports that her boss is becoming increasingly more frustrated with her absences, and she was written up yesterday; this stress appears to have been contributing to her increase in alcohol use, in a circular manner. Client’s job appears to be at risk (as well as her housing should she lose her job), due to her mental health symptoms and substance use."
Polling Question
How long do you spend writing an average progress note (not a crisis session note)?

A. Fewer than three minutes
B. Three to 10 minutes
C. 10 to 20 minutes
D. Longer than 20 minutes

How Long It Should Take
With some practice and patience, writing a sound progress note should take a few minutes, and no more than 10 minutes.

What To Expect
How Much To Write

Rule of Thumb:
"Write at least one intervention AND one response for every 10 or 15 minutes of session

*Not including crisis sessions*

A Hotly-Contested Topic

Duplicate Content = Audit Red Flag
Not inherently and always bad, but copy/paste must be used carefully, only when appropriate, and only when specifically applicable.

Other Best Practice Points to Remember
• Complete a note with each service
• Complete all note fields
• Scope of practice
• Use clinical and neutral language when describing clients and their behaviors
How To Avoid Novel-Writing: Six Questions To Ask Yourself © Elizabeth Irias, 2018

Question One
Have I documented the critical safety/risk factors? ©
(If there are any... maybe there aren’t?)

Question Two
If I had 30 seconds in a case conference to present this session, what would I say?
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**Question Three**

Why do I think the client needs this treatment?

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**Question Four**

Is this a summary of the session, or is it a play-by-play?

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**Question Five**

Is this sentence generally relevant to the gist of the note?
Question Six

Does the client’s actual quote explain this better than my clinical interpretation (i.e. ‘psychobabble’)?

Wrap Up

You Did It!

We discussed:
- Medical Necessity
- Common ways clinicians put themselves at risk with documentation practices
- Best Practice in clinical documentation
- Strategies for effective and efficient documentation
Now, put theory into practice, and go get 'em!

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