silversummit healthplan

Progress Notes

A Progress Note is required for each day a service is delivered. The note must be legible and must include the following information

The name of the individual receiving the service(s).

• Correct patient demographic information must be included in all progress notes. A progress note is a legal document and in order for them to be effective, particularly when it comes to requesting and coordinating additional services, this information needs to be accurate.

• Specifying the type of service is essential when determining what other means of care may be necessary to support the patients care needs. This should include a distinction between services conducted in individual vs group treatment setting.

The place of service (POS).

• This is important, especially for codes that are specific to certain POS such as Telehealth, Community Settings, etc. The documentation should clearly indicate where the service is taking place.

• Medical necessity must be documented for in-home and community services.

The date of service (DOS).

• Every progress note must include the date and time of the session to be valid. This information is necessary not only for tracking patient progress but also used to correctly support the type of service billed. A progress note will not be accepted, and the claim denied without this information. Although a progress note doesn't have to be written immediately after an appointment, the clinician must ensure the right information is recorded.

The actual beginning and ending times the service was delivered (start/stop times).

- MSM Chapter 400 requires the actual start and stop times (for time-based services).
- Appointment times are not sufficient; time actually spent face to face with the member must be documented.
- Time should be changed accordingly from any approximate EHR or System generated times.

The name of the provider who delivered the service.

• Documentation should include the name and relevant descriptors for the provider issuing care. Progress notes should also specify coordination of care with other relevant providers when necessary, including supervising clinician, treating physician collaboration, as necessary.

The credentials of the person who delivered the service.

• Please be sure to verify your licensure status such as prescriber
(MD,DO) or non-prescriber (LCSW, CSW, MFT, CPC). Intern level clinicians should specify themselves as such.

• Credentials are required to validate covered services were delivered by the Qualified Provider Type.

The signature of the provider who delivered the service.

• Signing and/or finalizing a progress note signals that the documentation for the billed service is complete and ready for review. Progress notes with no provider signature may be flagged for additional information and delays in billing may occur.

The goals and objectives that were discussed and provided during the time the services were provided.

• Progress notes are used to develop a thorough understanding of a patient's health status. It should include the specific, measurable goals/intervention methods that the patient has set with the clinician.

A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the QMHP.

• A progress note is most helpful when it specifies the progress and challenges to completing the identified treatment goals. This highlights the clinician's impression of the patient and what circumstances may warrant additional treatment periods. It's always good practice to record as many pertinent details as deemed necessary.

• We acknowledge that every progress note will vary slightly depending on the patient and how far through a treatment program they are, but these are some of our top tips to help create effective progress notes.

Things to Remember:

• Progress notes should be completed and signed as soon as possible. Any delay should be reasonable and appropriate (such as for transcription).

• Billing of services should not occur prior to completion of the supporting documentation.

• Avoid using "cloned" notes – notes that appear identical for different visits; these may not reflect the uniqueness of the encounter.

• Documentation to support any service for which payment has been made must be available and provided upon valid request.

Resources:

CMS Toolkits for Providers, Documentation Matters Fact Sheet for Behavioral Health Practitioners

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resource-Library/documentation-matters-fact-sheet-behavioral-health-practitioners

Nevada Medicaid Services Manuals

https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

• Chapter 100 – Medicaid Program

• Chapter 400 – Mental Health and Alcohol and Substance Abuse Services

• Chapter 3300 – Program Integrity