

**STATE OF MA DOCUMENTATION PROJECT  
COMPLIANCE REVIEW TEAM  
5-14-07**

**Consultant:** Mary Thornton, MTA, Inc.

**Facilitator:** Kathy Janssen, Riverside

**Present:** Jim Haughey, BHN, Madeline Becker, Vinfen, Michael Wagner, North Suffolk, Judith Boardman, HES, Fran Markle, High Point  
Carol Kress, MBHP, Marcy Morgenbesser Network Health  
Doug Thompson, Beacon Health Strategies, Christine Paschal, Wayside, Craig Gaudette, Advocates, Inc., Grace Beason, DMH, Michele Savage, BayCove Human Service

**AGENDA**

1. Review of the role of the CRT
2. Introduction of the “grid” template
3. Begin the development of the Compliance Grid
4. Homework assignments

**MINUTES**

1. Review of the role of the CRT
  - The task of the committee is to identify minimum fields for each of three forms – Progress Notes, Assessment and Treatment Plan
  - By the end of June the committee will forward to the SDT the basic data elements that need to be in the forms
  - The committee will make sure each field is required by some regulation/accreditation standard
  - The committee will determine if the field demonstrates one or more of the following:
    - medical necessity
    - client participation
    - client benefit
  - The committee will participate in the development of a manual identifying the documentation expectations for each field on all forms
2. The committee developed a list of potential progress note documents grouped by outpatient and inpatient (see attachment “Types of Notes”)
3. The committee began to list possible fields to be included in progress notes (see attachment “Progress Note List of Contents”)

#### 4. Homework assignments

- Group assignments:
  - review SOQIC progress note
  - review SOQIC grid for progress note
  - review own progress note(s)
  - review own agency diagnostic assessment grouping fields that can be combined, and crossing out fields not needed
- Individual assignments:
  - Judith will see if she can send the electronic copies of the regs she has on the HES web site to Mary Thornton so she can post them on the **MTM** web site.
  - Jim and Mike will send their agency's documents that have the requirements for the CPT codes they use.
  - Fran will check the JCAHO standards for documentation of progress notes by doctors
  - Christine will check the COA regs for documentation of progress notes by doctors
  - Craig will check to see if the MAP form is dictated by regulations
  - Madeline will check the CARF standards for progress notes
  - Kathy will talk with Vic regarding getting a DMA and Inpt Child reps to participate on the committee. And about a Legal Reviewer
  - Kathy will send the current Team List to the group (including email addresses)

## TYPES OF NOTES

### Outpatient

Individual Therapy

Group Therapy

Family Therapy

Medication Management

- Medications ordered
- Side effects
- Tests ordered or discussed
- Risks and benefits
- Off label uses
- Relevant medical issues
- E&M forms different
- Separate order form – MAP
- Med + E&M
- MAP information – must be included

Nursing Notes

- Non-billable – log type of thing
- Billable: injections/99211
- Verbal orders

Collateral Contact:

- Billable: same as IT
- Non-billable

Case Management: same as IT

Day Program: separate notes and documentation

Day Rehab: separate note

Club Houses: separate note

SEE Services: separate note

Partial Hospitalization: separate note

Residential Notes: ? separate note

- Congregate
- Supported Housing: same as IT

Community Outreach: same IT

Early Intervention Notes: same IT

- PT
- OT
- Speech
- Other

### Inpatient: continuous progress notes except consults

Nursing: continuous note

Group Notes: separate note same as IT

Psychiatry: continuous note

Consultations: separate note

- Nutrition
- Spiritual
- Psychiatric
- Other Medical

Internal Medicine: consult note

Activity/Rehabilitative Therapies: group notes

- Music
- Art
- Lectures

Case Management/ Primary

Clinicians: continuous notes

Aftercare: continuous note

Crisis Stabilization: need to add these notes

## PROGRESS NOTE LIST OF CONTENTS

1. the specific services rendered;
  - TRIS Audit, Abraxas Audit, and Iowa residential audits
  - Naming the service provided
  - Who is present – family and other notes – group notes don't name other participants just note they are there
  - Specific interventions that provide evidence that service listed was provided
    - a. Provided these interventions in order to .....
  - Medical necessity
2. the date and actual time the services were rendered;
  - a. Monthly notes: date range
  - b. Weekly notes: date range
3. who rendered the services: signature, credential, date of signature, supervisor's signature if necessary. Legibility – MAP regulations. Electronic and paper signatures.
  - a. What does credential mean? What about non-credentialed individuals?
    - i. Highest level license, then degree, then.....
  - b. What about team approaches? ACT, etc.
4. the setting in which the services were rendered;
  - a. need list of locations – should follow established codes
  - b. for community based services additional detail may be needed
5. the amount of time it took to deliver the services;
  - time out or total time
6. the relationship of the services to the treatment regimen described in the PoC and
  - a. reference to treatment goal
  - b. restate goal
  - c. specific to issue listed on plan
  - d. Medical necessity statement – continuing need for service
  - e. Client participation
7. updates describing the patient's progress
  - a. In relation to the goals and objectives of the client – in specific notes describe progress in relationship to goal/objective listed.
  - b. Client benefit
8. Risk assessment if client presents in a crisis – crisis plan if necessary
9. Specific testing done – e.g. AIMS
10. Plan for Next Visit – including any homework for client
  - a. Any anticipated adjustments to treatment plan and rationale
11. Referrals for other services
12. Date of next appointment