Group Psychotherapy Progress Note

The Group Psychotherapy Progress Note is used for billable outpatient psychotherapy groups. Use the Intensive Services Progress Note form to document other groups offered as part of programs such as Partial Hospitalization (PHP), Community Based Adolescent Treatment (CBAT) and Transitional Support Services (TSS).

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
Group Name	Give the name of the specific group. Example: Anger Management.
Number of Attendees	Enter the number of persons attending the group on this date.
Person Served Did Not Attend	Indicate the reason the person served did not attend the group session.
Data Field	**Documentation of Person's Served Participation and Response to Group Treatment**
Behavior in Group	Check box(es) to document the person's observed behavior during the group session.
Person's Served Mood	Check box(es) to document the person's observed or reported mood during the group session.
Stressots/Extraordinary Events/New Issues Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions section and indicate the resolution in the Response section of the progress note. If services are provided during the session that have not been previously ordered in the Individualized Action plan, then an explanation of the rationale for those services should be provided. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. **Example: Person became uncharacteristically angry with another group member during the group session and the two began arguing loudly. Group therapist intervened and assisted person with identifying what had triggered excessive anger today. Person was able to recognize that the other group member reminded her of her abusive uncle and apologized to the other member.** **Example of New Issue needing CA Update:** **The person reported new symptoms of nightmares, intrusive memories, and**

	feeling unsafe, triggered by an event that reminded her of an incident when she was a victim of abuse at age 12, as recorded on the CA Update of this date. See individual note manual for suggestion. See quote from State Medicaid Manual on this type of encounter: **For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC should be submitted with bills. Similarly, a detailed explanation should accompany bills for a medical or remedial therapy, session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.** **This same is applicable to individual note.** **If a new issue were already documented in the Assessment, and resolved in the session, no CA update would be needed.**

Data Field	Goals, Interventions and Progress Information
Goals/Objectives Addressed as Per Individualized Action Plan	Identify the specific goal(s) and objectives(s) in the Individualized Action Plan being addressed during this group.
Therapeutic Intervention(s) Delivered in Session	Describe the specific therapeutic interventions used in this particular group session to assist the person in realizing the goals and objectives listed above. All interventions must be targeted toward specific goals/objectives in the Individualized Action Plan. The intervention documented in this section would be the same for all persons served in the group. **Examples:** • **Clinician taught group members relaxation breathing techniques.** • **Using the example of one person's stressful experience, the clinician asked group members to verbalize positive ways to resolve the situation.**
Person's Response to Intervention and/or Progress Toward Goals and Objectives Today	Describe how the session has helped move the person closer to, further away from, or had no discernible impact on meeting his/her goals/objectives. If no progress is made over time, this section should address how the group leader intends to change his/her strategy. **Example: Jack listened to feedback from the group about how he could handle the conflict with his wife differently, which is an improvement for him, but he seemed hesitant to try the suggestions made.**
Plan/Additional Information	The clinician should document future steps or actions planned with the person such as homework, plans for the next session, etc. ***OR*** *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. Example: Nancy reported she will miss next week's session due to planned vacation with family. During her trip she will use stress management techniques learned today and journal outcomes to share during session upon her return.

Data Field	Signatures Information Instructions
Provider	Print provider name.
Provider Signature/Credentials	Legible signature and degree/license of provider.
Date	Record the date of each signature, including the month, day and year.
Supervisor (if needed)	Print the supervisor's name, if needed.
Supervisor Signature/Credentials	Legible signature and degree/license of supervisor, if needed.
Next Appointment	Record the date, including the month, day and year of the next appointment, and the time of day.
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and credentials of Supervising Professional on Site	Enter the name and credentials of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriately licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare carrier's local medical review policies.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM**
Total Time	Indicate the total time of the session. **Example: 34 minutes**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.