10 THINGS ABOUT:
DOCUMENTATION

1. Your medical record has three essential purposes: 1) to support good clinical care; 2) to use in your defense in the event of a claim or lawsuit; and 3) to substantiate your billing and demonstrate adherence to payer guidelines.

2. There is no such thing as a perfect record. As with most aspects of psychiatric practice, documentation remains a lifelong learning process, a perpetual skill-in-progress that must continually be reassessed in order to respond to changing demands and considerations.

3. A good record accomplishes several things: it substantiates your clinical judgment and choices, demonstrates the knowledge and skill you exercised during treatment, provides a contemporaneous assessment of the patient's needs and behaviors, and documents significant events, revisions of the treatment plan, and explanations of your decisions.

4. State regulations and third party payers with whom you contract may have medical standard with which you must comply. Failure to follow state regulations may be a breach of the standard of care and failure to follow payer requirements may impact reimbursements.

5. Even if your records are less than desirable, an experienced defense attorney can work well with a cooperative clinician and a "good enough" record. But an altered/falsified record will be indefensible if discovered (and they almost always are).

6. Documenting what you didn't do and why may be just as important as documenting what you did do and why. This is particularly true if you are rejecting or deviating from a standard course of treatment.

7. Patients may at some point want to see their records (and you will likely be required to allow this). While still documenting to appropriately capture the situation clinically, consider whether you can use words that might be less upsetting to a patient who does read his or her chart.

8. It may at some point be necessary for your patient to allow the release of his or her records to someone with adverse interests (e.g., the opposing side in a lawsuit) thus you should document discreetly whenever possible. Consider whether the information you've been provided is clinically relevant and just how much detail is needed.

9. Notes taken in conjunction with psychotherapy sessions do not automatically qualify as "psychotherapy notes" as per HIPAA and thus entitled to special protection. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of

conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

10. Electronic health records present unique documentation concerns. Documentation short-cuts such as box checking, templates, autopopulation, and note cloning may actually increase a physician's liability exposure.

Compliments of:

PRMS®
Professional Risk Management Services

Call	(800) 245-3333
Email	TheProgram@prms.com
Visit	PRMS.com
Twitter	@PRMS
Facebook	Facebook.com/PRMSPrograms
LinkedIn	LinkedIn.com/company/PRMSPrograms