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Psychiatry Coding & Reimbursement Alert

Documentation: Ensure HIPAA Compliance While Preparing Your Psychotherapy Notes

Plan your note making so that you do not land in trouble.

While HIPAA doesn't require providers who offer mental health services to disclose psychotherapy notes to their patients, that won't stop many of your patients from demanding them anyway. Advance planning can help providers respond to patients who cry, "Show me the notes!"

Keep Symptoms Out Of Notes

So, what exactly are "psychotherapy notes?" HIPAA's privacy regulations (45 CFR 164.501) define them as notes, recorded in any medium by a health care provider who is a mental health professional for purposes of documenting or analyzing "the contents of conversation during a private counseling session or a group, joint, or family counseling session that are separated from the rest of the individual's medical record."

Psychotherapy notes are the idiosyncratic jottings of the individual therapist. One way to define "psychotherapy notes" is in terms of what they're not. According to the same regulatory definition, they exclude 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
- Treatment plan
- Symptoms
- Prognosis
- Progress to date.

Thus, any information that's commonly shared in training or consultation with other clinicians or that's a summary of symptoms, diagnosis, treatment plan, or process of treatment, is probably not considered psychotherapy notes.

Of course, none of this is likely to impress a patient who wants to see their notes. "Telling a patient you don't have any notes because you wrote only 'psychotherapy notes' is not going to satisfy them and would probably provoke them," warns **Edward Zuckerman**, clinical psychologist in Armbrust, PA and author of HIPAA Help: A Guide to Record Privacy and Security Under HIPAA.

Take 3 Steps Toward Compliance

Instead, psychotherapists should follow a three-step plan to ensure they're prepared when a patient asks to see their notes.

1. Don't write down anything you wouldn't want the patient to see. In most cases, your notes won't provide the patient with much new information. Your patient already has a right to view his own chart and your notes probably won't tell him more than the chart already does. But by writing down only things you'd be comfortable showing the patient, you avoid a confrontation before one even exists.

2. Find out what the patient really wants. In most cases, Zuckerman, who is also the author of The Clinician's Thesaurus, says that the patient doesn't even really want the notes he wants information. "He wants to know if there was some secret he told you that he's forgotten. He wants to know if you have some insight you didn't share with him"

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but instead wrote in your notes.

Talk with him, Zuckerman counsels. If you're too high-handed and refuse to discuss the matter, he cautions, the patient might become so frustrated he goes to a lawyer.

Don't forget, he adds, that psychotherapy notes are discoverable in litigation. So even if you refuse the patient's request, you won't be able to refuse the court's request and the patient will ultimately get his way. "It's probably better to head it off with a discussion before that," Zuckerman concludes.

3. Offer the patient a summary of your notes. Are your notes even intelligible? "Most people's notes aren't readable and even if they are, they might be misunderstood," Zuckerman says.

After all, the personal, idiosyncratic nature of psychotherapy notes is precisely what distinguishes them from the rest of the medical record. For that reason, a valid initial response to the inquiring patient would be, "Sometimes, I scribble for my own memory, and it wouldn't make sense to anyone but me."

If that doesn't mollify the patient and you think your discussions with the patient have clued you in to what he wants, you should consider summarizing your notes and offering the summary instead, Zuckerman suggests.

Write a summary and ask the patient to agree to accept it in lieu of the original notes. This approach satisfies HIPAA and should do the same for the patient, Zuckerman says.

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