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Owner	Danielle Dobija: Quality Administrator
Policy Area	Quality Improvement
Applicability	Detroit Wayne Integrated Health Network

Progress Notes Procedure

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PURPOSE

This policy establishes standardized requirements for the documentation of behavioral health progress notes to ensure accurate, complete, and clinically defensible records of services provided. It defines the essential components that must be present in every progress note to support continuity of care, demonstrate medical necessity, and meet regulatory and payer requirements. Consistent progress note documentation protects both the patient and the clinician by creating a clear, chronological record of treatment progress and clinical decision-making.

SCOPE

This policy applies to all licensed and credentialed behavioral health clinicians, including licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), psychologists, psychiatrists, psychiatric nurse practitioners, and supervised pre-licensed clinicians providing services under an approved supervision agreement. It covers all behavioral health services delivered across outpatient, intensive outpatient (IOP), partial hospitalization (PHP), telehealth, and community-based settings. This policy applies to documentation for individual therapy, group therapy, family therapy, psychiatric evaluation and medication management, and case management services.

POLICY STATEMENT

All behavioral health clinicians shall complete a progress note for every clinical encounter at which a billable or documented service is rendered. Progress notes must be completed and finalized in the electronic health record (EHR) or approved documentation system within 24 hours of service delivery for outpatient encounters and within the same business day for crisis, inpatient, or PHP/IOP encounters. Late documentation must be clearly identified with the actual date and time of entry and the date and time of service, in compliance with Centers for Medicare and Medicaid Services (CMS) documentation standards and applicable state licensing board requirements.

Progress notes must demonstrate medical necessity for each service provided. Medical necessity documentation requires the clinician to establish a clear clinical rationale connecting the patient's presenting symptoms, functional impairments, and treatment plan goals to the specific intervention delivered during the encounter. Documentation that fails to establish medical necessity may result in claim denial, audit findings, or recoupment of reimbursement by payers including Medicaid, Medicare, and commercial insurers.

All progress notes must comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR Parts 160 and 164). Clinicians shall document only information that is clinically relevant and necessary for treatment, billing, or coordination of care. Progress notes containing psychotherapy content are afforded additional protections under HIPAA's psychotherapy notes provisions and must be stored separately from the general medical record when applicable. Clinicians shall not include third-party identifying information in progress notes unless directly relevant to the patient's treatment.

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Documentation must reflect the clinician's independent clinical judgment and must not be copied verbatim from a previous note without reflecting the current encounter's unique clinical content. The practice of cloning or copy-forwarding progress notes without individualized clinical content is prohibited and constitutes a compliance violation subject to corrective action. Each note must accurately represent the services rendered on the date of service.

Progress notes for services billed under Current Procedural Terminology (CPT) codes must contain documentation sufficient to support the specific code billed, including time-based documentation where required. Clinicians shall adhere to the American Medical Association (AMA) CPT code definitions and payer-specific documentation requirements when selecting and supporting procedure codes. Supervisors of pre-licensed clinicians must co-sign progress notes in accordance with applicable state licensing board supervision requirements and organizational policy.

IMPLEMENTATION GUIDELINES

Required Components of Every Behavioral Health Progress Note

Every progress note, regardless of service type, must contain the following core elements. The absence of any required element constitutes an incomplete note that must be corrected prior to claim

submission.

- Patient name and date of birth (or unique patient identifier per organizational policy)
- Date of service
- Start time and end time of the session (required for all time-based CPT codes)
- Service location or modality (e.g., office, telehealth, community-based)
- Type of service rendered (e.g., individual psychotherapy, family therapy, psychiatric medication management)
- CPT code and diagnosis code(s) (ICD-10-CM) supported by the note content
- Clinician name, credentials, and signature with date and time of entry
- Co-signature of supervising clinician with credentials, where required

Clinical Content Requirements

In addition to the administrative elements above, each progress note must contain substantive clinical content organized to reflect the patient's status, the intervention provided, and the clinical response. The following framework shall be used as the standard documentation structure:

Subjective Information

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The clinician shall document the patient's self-reported status at the time of the encounter. This section must include:

- The patient's presenting concerns or chief complaint for the session, using the patient's own words where clinically relevant
- Current symptom status, including changes in symptom severity, frequency, or functional impact since the last encounter
- Relevant interval history, including significant events, stressors, or changes in the patient's life since the previous session
- Current medications and any reported side effects or adherence concerns, when applicable to the service type
- Substance use status when clinically relevant to the treatment plan

Objective Information

The clinician shall document observable, measurable, and verifiable clinical findings. This section must include:

- Mental status examination (MSE) findings, including appearance, behavior, speech, mood (as reported by patient), affect (as observed by clinician), thought process, thought content, perceptual disturbances, cognition, insight, and judgment
- Results of any standardized assessment tools administered during the session (e.g., PHQ-9, GAD-7, Columbia Suicide Severity Rating Scale [C-SSRS]), including the instrument name, score, and clinical interpretation
- Behavioral observations relevant to treatment progress

- Vital signs or physical findings when documented by a prescribing clinician

Assessment

The clinician shall provide a clinical interpretation of the subjective and objective information gathered during the encounter. This section must include:

- A clinical summary of the patient's current functional status and symptom presentation in relation to the active diagnoses
- An explicit statement of the patient's progress toward identified treatment plan goals, using language such as "progressing," "not progressing," "goal met," or "goal modified," with clinical rationale
- Documentation of any change in diagnostic formulation, including the clinical basis for any new or modified diagnosis
- Risk assessment findings, including the clinician's evaluation of suicidal ideation, homicidal ideation, self-harm, and any other identified safety concerns. The risk assessment must document the presence or absence of ideation, intent, plan, means, and protective factors. When risk is identified, the level of risk (low, moderate, high) and the clinical basis for that determination must be stated explicitly
- Medical necessity statement connecting the patient's current clinical presentation to the continued need for the service provided

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Plan

The clinician shall document the clinical plan resulting from the encounter. This section must include:

- Specific therapeutic interventions used during the session, identified by name and theoretical orientation where applicable (e.g., cognitive restructuring using Cognitive Behavioral Therapy [CBT], behavioral activation, motivational interviewing, trauma processing using EMDR)
- The patient's response to the intervention during the session (e.g., engaged, resistant, distressed, demonstrated skill acquisition)
- Any modifications to the treatment plan, including new goals, discontinued goals, or changes in treatment frequency or modality, with clinical rationale
- Homework assignments, skills practice, or between-session tasks assigned to the patient
- Referrals made or coordination of care activities completed, including the name of the receiving provider or agency and the purpose of the referral
- Medication changes, including drug name, dose, frequency, and clinical rationale, when documented by a prescribing clinician
- Safety plan updates or crisis interventions implemented, with documentation of the patient's agreement and understanding
- Date, time, and type of next scheduled appointment

Group Therapy Documentation

Progress notes for group therapy services must meet all core requirements above and must additionally

include:

- The group topic or curriculum content addressed during the session
- The patient's level of participation and engagement within the group (e.g., actively participated, observed, required redirection)
- The patient's individual response to group content, including any disclosures, behavioral observations, or skill demonstrations specific to that patient
- Any individualized clinical concerns that arose during the group session

Group notes must be individualized for each patient. A single generic note applied to all group members does not meet documentation standards and is prohibited.

Telehealth Documentation Requirements

Progress notes for services delivered via telehealth must include, in addition to all standard required elements:

- Documentation that the service was delivered via telehealth (e.g., video, telephone)
- The patient's physical location at the time of service (city and state at minimum)
- The clinician's physical location at the time of service
- Confirmation that the patient provided verbal or written consent for telehealth services
- Documentation of the patient's ability to participate in the session (e.g., private location, adequate technology)

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Crisis and Safety Documentation

When a patient presents with active suicidal ideation, homicidal ideation, or a psychiatric emergency during any encounter, the clinician shall document the following in addition to all standard note requirements:

- A structured risk assessment using a validated tool (e.g., Columbia Suicide Severity Rating Scale [C-SSRS]) with the score and clinical interpretation recorded
- The specific risk and protective factors identified and their clinical weight in the risk determination
- The level of care determination and the clinical rationale supporting that determination
- All interventions implemented, including safety planning, means restriction counseling, collateral contacts, and emergency services involvement
- The patient's response to crisis intervention and their stated agreement with the safety plan
- Disposition and follow-up plan with specific timeframes (e.g., "patient will return for follow-up appointment within 48 hours" or "patient transported to emergency department via EMS at [time]")

Correction of Documentation Errors

Errors in a finalized progress note must be corrected using the organization's approved amendment or

addendum process within the EHR. Clinicians shall never delete, overwrite, or obscure original documentation. All amendments must include the date and time of the correction and the clinician's identification. A brief explanation of the reason for the amendment must be included in the addendum.

RESPONSIBILITIES

Licensed Behavioral Health Clinicians

- Complete a progress note for every clinical encounter within the timeframes specified in this policy
- Ensure all required documentation components are present and clinically accurate before finalizing each note
- Select CPT and ICD-10-CM codes that are supported by the documented clinical content
- Conduct and document a risk assessment at every encounter in accordance with this policy
- Individualize all progress notes to reflect the specific content of each encounter
- Correct documentation errors using the approved amendment process and never alter finalized records improperly
- Maintain compliance with HIPAA privacy requirements in all documentation

Pre-Licensed Clinicians and Supervised Staff

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- Complete progress notes in accordance with all requirements of this policy
- Submit notes for supervisory co-signature within the timeframe required by the applicable state licensing board and organizational policy
- Notify the supervising clinician of any crisis presentations or high-risk clinical situations documented during an encounter
- Participate in documentation training and competency review as directed by the supervisor

Clinical Supervisors

- Review and co-sign progress notes completed by supervised pre-licensed clinicians within the timeframe required by state licensing board regulations
- Provide documented feedback to supervisees regarding documentation quality, completeness, and compliance
- Identify and address documentation deficiencies through the supervisory process
- Escalate patterns of non-compliance to the Clinical Director or Compliance Officer

Clinical Director or Behavioral Health Program Manager

- Oversee implementation of this policy across all behavioral health programs and service lines
- Ensure all clinical staff receive initial and ongoing training on progress note documentation requirements
- Conduct or delegate periodic documentation audits to assess compliance with this policy

- Review audit findings and implement corrective action plans when documentation deficiencies are identified
- Update this policy in response to changes in regulatory requirements, payer standards, or clinical best practices

Compliance Officer or Health Information Management (HIM) Staff

- Monitor progress note documentation for compliance with HIPAA, CMS, and payer-specific requirements
- Conduct pre-billing and post-payment audits of behavioral health documentation to identify risk areas
- Report documentation compliance findings to organizational leadership on a scheduled basis
- Provide guidance to clinical staff on documentation requirements related to billing compliance and regulatory standards
- Manage the amendment and correction process for finalized documentation in accordance with applicable regulations

REFERENCES

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- Centers for Medicare and Medicaid Services. (2023). *Medicare Benefit Policy Manual, Chapter 4: Psychiatric and Other Mental Health Services.* U.S. Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration. (2020). *Behavioral Health Documentation: A Guide for Clinicians.* SAMHSA Publication No. PEP20-02-01-012. U.S. Department of Health and Human Services.
- American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct* (2010 Amendments). American Psychological Association.
- The Joint Commission. (2024). *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC).* The Joint Commission.
- U.S. Department of Health and Human Services, Office for Civil Rights. (2022). *HIPAA Privacy Rule: Psychotherapy Notes.* 45 CFR § 164.524. U.S. Department of Health and Human Services.
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., Currier, G. W., Melvin, G. A., Greenhill, L., Shen, S., & Mann, J. J. (2011). The Columbia Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *JAMA Psychiatry, 68*(12), 1266–1276.**Procedure Purpose**

To provide guidelines for…

EXPECTED OUTCOME

For example, Call Center Procedure: answering a call in a timely manner and addressing the caller's needs.

PROCEDURE

MONITORING STEPS

Who monitors this procedure:	Name/Title of person
Department:	
Frequency of monitoring:	
Reporting provided to:	
Comments:Include hyperlink or reference to the overarching policy	

Approval Signatures

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Step Description	Approver	Date
Unit Review and Approval	Danielle Dobija: Quality Administrator	Pending
Unit Review and Approval	April Siebert: Director of Quality Improvement	08/2026

Applicability

Detroit Wayne Integrated Health Network

Standards

No standards are associated with this document