Documentation of Psychotherapy by Psychiatrists
RESOURCE DOCUMENT

Approved by the Board of Trustees, March 2002

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I. Conflicting Principles and Priorities

The issues considered in the following paragraphs highlight potential conflicts between two important principles. On the one hand, medical-legal principles indicate that the medical record should be complete, factual, and accurate. On the other, the growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical record lest this expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in every individual clinical situation must be free to use their judgment in facing this dilemma. What follows is a consideration of the issues involved; it is not a standard of practice and is not binding on members of the APA.

Documentation of any medical procedure serves multiple purposes and is generally required by state statute, case law, and/or the bylaws of health care organizations. Documentation is a medical and legal record of assessment, decision-making, general management, and specific medical treatment. It should be factual, legible and accurate. The record traditionally serves to facilitate continuity in the care of the patient by the treating psychiatrist or successors. Secondarily, with the patient's specific written, informed consent, the medical record can also be referenced to verify that services actually took place or to evaluate "medical necessity" of services rendered for purposes of claiming third party payment. (Such usage of a detailed record of psychotherapy is, however, considered by many practitioners to be incompatible with the practice of psychotherapy.) Furthermore, the medical record may become evidence in litigation for a variety of forensic purposes, including professional liability, where documentation may make a significant difference in the exposure of the treating psychiatrist to liability (Psychiatrists' Purchasing Group, 1994).
Despite ethical standards and varying degrees of legal protection of confidentiality of the doctor-patient relationship, medical records may be open to disclosure in unanticipated ways that are beyond the control of the patient or the psychiatrist, as in the case of mandated reporting laws or other statutory exceptions to confidentiality. Such potential intrusions may present risks to the integrity of psychotherapeutic treatments. The psychiatrist should use all available legal means to protect the confidentiality of any record of psychotherapy.

Originally approved by the Board of Trustees, July 1999. Revised 2001 to integrate compliance with the HIPAA privacy rule promulgated in December, 2000, and effective in April, 2001, with enforcement date of April, 2003. Revision was done by the Commission on Psychotherapy by Psychiatrists in consultation with the Committee on Confidentiality, and submitted for comment by chairs of other components of the APA. Approved by the Council on Psychiatry and the Law.

Psychiatric treatment, especially psychotherapy, involves sensitive, personal information about the patient and other people in the patient's life. The patient reveals this information to the psychiatrist in the faith and trust that it will be used to advance the treatment and that no information from that treatment will be revealed to any other person without informed consent for disclosure. In a landmark ruling pertaining to the admissibility of evidence in Federal courts, the U.S. Supreme Court has explicitly acknowledged that psychotherapy requires an atmosphere of trust and confidence (*Jaffee v. Redmond* 116 S.Ct. 1923[1996]).

HHS protection of psychotherapy notes. This principle was further elaborated in the special protections for psychotherapy notes in the Privacy Rule promulgated by the U.S. Department of Health and Human Services (HHS) in December, 2000, in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Mandatory compliance with the rule will take effect in April, 2003. It establishes a special category of protection for psychotherapy notes, which are defined as "*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*." The definition 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." (The items excluded from psychotherapy notes are components of the general medical/psychiatric record.) Furthermore, "*to meet the definition of psychotherapy notes, the information must be separated from the rest of the individual's medical record*." Notably, psychotherapy notes are still a part of the identifiable record.

Access to these notes is forbidden except with the patient's specific authorization. Authorization may not be compelled as a condition of health insurance payment or provision of services. Narrow exceptions to this protection include reporting laws (e.g. child abuse), disclosures necessary to prevent harm to the patient or others, supervision for training purposes within the ambit of confidentiality, defense against litigation by the patient, investigation by a medical examiner to determine the cause of death of the patient, health care oversight (investigation of the therapist), and disclosures authorized by the patient. The patient does not have the right to read, amend, or have a copy of psychotherapy notes. The protection continues after the death of the patient, except as noted above.

The APA believes disclosure of psychotherapy notes to third-party payers is not necessary for determining payment or medical necessity; this is consistent with the HIPAA Privacy Rule's definition of psychotherapy notes. (The reader is referred to APA Resource Document, "Psychotherapy Notes Provision of HIPAA Privacy Rule (March 2002).

The rationale for special protection of psychotherapy notes is based on the deep trust needed for full disclosure of intimate personal material by a patient for the sole purpose of understanding and benefit within a psychotherapeutic relationship, delineated in *Jaffee v. Redmond*. It is keyed to the patient's expectations and the process of treatment, not to the procedure code of the service at hand. Therefore, sensitive material disclosed by a patient may be segregated in psychotherapy notes, whether the service is a specifically identified psychotherapy service (e.g., CPT 90805 to 90829, 90845, 90847) or another psychiatric service that the patient would view as establishing or including a "counseling relationship", such as psychiatric evaluation (CPT 90801) or pharmacological management defined as providing no more than a minimal amount of psychotherapy (CPT 90862). APA's resource document on Psychotherapy Notes Provision of HIPAA Privacy Rule (March 2002), developed by the Committee on Confidentiality and the Council on Psychiatry and the Law, presents a summary and clarification of the regulation insofar as it pertains to psychotherapy notes. The American Psychiatric Association is committed to seeking maximum protection of the confidentiality of psychiatric records.

The fact that it is now technically feasible to computerize medical records and transmit them electronically may present a greatly increased vulnerability to unauthorized access that may compromise confidentiality and could cause significant harm to the patient. No existing security

system absolutely protects electronic records in data banks from human error or malice. Although the same risks pertain to paper records, access to electronic records may be easier to accomplish and more difficult to detect unless audit trails are maintained, accessible, and monitored. Recording psychotherapy content or process in electronic systems beyond the direct control of the practitioner (and professionals in an organized setting who are collaborating in the patient's psychotherapeutic treatment) would place a patient's private thoughts and acts at such grave risk of unauthorized disclosure as to deter or limit treatment.

Psychotherapy is a crucial part of the training of psychiatric residents. As a part of this training, residents must learn how to document psychotherapy in the medical record while maintaining confidentiality. They need to understand those instances when documentation conflicts with and potentially jeopardizes the confidentiality upon which the effectiveness of the psychotherapy is based. The same emphasis on maintaining confidentiality in documentation should also be addressed in the continuing education of practicing psychiatrists.

What follows is a suggested format, not a standard of practice, for documentation of psychotherapy by psychiatrists. It does not address issues involved in the process of releasing information to third parties, but it considers how the possibility of such release may affect documentation procedures. This discussion does not necessarily reflect current practice of documentation of psychotherapy throughout the profession. Variations occur because of state law and the requirements of individual clinical situations. The extent of documentation may vary from session to session and depends on the treatment method and intensity. A patient and/or a psychotherapist may prefer that there be no documentation, although this can pose significant liability risks to the practitioner because of the absence of contemporaneous documentation that can serve as evidence to support the standard of care provided. It should also be noted that the absence of adequate documentation makes it difficult for another psychotherapist to take over the care of a patient in cases of psychotherapist disability or death. In some states documentation is explicitly required under law.

APA's ethical principles state "Because of the sensitive and private nature of the information with which the psychiatrist deals, he/she must be circumspect in the information that he/she chooses to disclose to others about a patient." And, "Ethically the psychiatrist may disclose only that information which is relevant to a given situation. He/she should avoid offering speculation as fact." The psychiatrist should be mindful of the cautions stated in these principles when writing medical records in general, considering how likely it is that others might view the records and thus become a vehicle for disclosure. Entering any notation of psychotherapy process or content requires even greater circumspection.

II. Suggested format for documentation of psychotherapy by psychiatrists

1. **Clinical judgment**. The growing vulnerability of medical records necessitates great circumspection on the part of the practitioner about what to write in an official medical/psychiatric record in order not to expose the patient to a breach of privacy and confidentiality that would undermine the psychotherapy and harm the patient. Practitioners in each individual clinical situation must be free to use their judgment in coming to terms with this dilemma.

2. **Variation in documentation procedures**. Variations in documentation procedures may necessarily occur because of state law or the requirements of individual clinical situations. The latter may include a patient's request or the clinician's judgment that there be no identifiable documentation. Possible legal ramifications of avoiding documentation may vary in different jurisdictions.

3. **Initial evaluation**. The record of the patient's initial evaluation should accord with generally accepted procedures for conducting and documenting an initial psychiatric evaluation, which are beyond the scope of these recommendations. It is important that the individual clinician use judgment in regard to what information is included in the evaluation report so as not to jeopardize the patient's privacy or confidentiality. An initial evaluation may be done and documented by another psychiatrist. While documentation of the initial clinical evaluation is a part of the general medical/psychiatric record, the first meeting with a psychiatrist is the introductory experience in establishing the psychotherapy portion of psychiatric treatment. Therefore, personal information revealed by the patient during evaluation for psychotherapy may be recorded in the psychotherapy notes, subject to the definitions and exceptions that are elaborated in the HHS privacy rule.

4. **Concise documentation of psychotherapy while respecting the privacy of the patient's mental life.** Characteristically, the general medical/psychiatric record should concisely record only administrative material regarding the psychotherapy itself, such as the date, duration of the session, procedure code, and/or category of psychotherapeutic intervention (e.g., psychodynamic therapy, supportive therapy, cognitive restructuring, relaxation or behavioral modification techniques, etc.). Depending on clinical judgment, the treatment setting and the security of the patient record in that particular treatment setting, some practitioners may also include a brief mention of major themes or topic(s) addressed, whereas others would consider this an unacceptable risk to the confidentiality of sensitive communications. While scheduled clock times of starting and ending the session or duration of a session may be recorded as an administrative matter if required by third parties, the Commission on Psychotherapy by Psychiatrists believes that actual times of the patient's arrival (e.g., lateness) and departure as determined by the patient (e.g., abrupt departure) are subject matter for the psychotherapy process and therefore should be recorded in the protected psychotherapy notes. If the psychiatrist were investigated for alleged fraud related to time issues, the information and the clinical explanation for the patient's deviation from the scheduled times would be available for defense in the psychotherapy notes. It is important to remember the principles of “minimum necessary” information (see following section.) Clinicians should use their judgment about the information that they plan to record in the general medical/psychiatric record, especially in the context of other persons having potential access to this information..

5. **Documentation of psychiatric management.** The general medical/psychiatric record may include other descriptive and historical information, not related to the process or content of psychotherapy, which may provide a record of responsible, diligent psychiatric management and be valuable both to patient care and to the psychiatrist in case of untoward developments. Examples of such information are:

- Clinically important objective events in the treatment setting or the patient's life (e.g., the therapist's unexpected absence, or a death in the family)
- Clinical observations of the patient's mental and physical status (e.g., noting the signs that a patient's depression has improved)
- Changes in diagnosis, DSM or ICD codes, functional status, or treatment plan (e.g., the appearance of new symptoms, return to work, new medication)
- Documentation of the psychiatrist's efforts to obtain relevant information from other sources
- Notation that a patient has been informed and indicated an understanding of the risks and benefits when medications or therapeutic procedures are changed in the course of treatment
- Collaboration with other clinicians
- Changes in the legal status of the patient -e.g. custody, guardianship, involuntary status
- Other pertinent administrative data.

Legal reporting requirements or the need to justify hospitalization or protective intervention may necessitate documentation of information indicating danger to the patient or others, such as suicidal ideation with intention to act, child abuse, or credible threats of harm to others. The record would generally include basic management information that could enable other clinicians to coordinate effective care by a psychiatric treatment team or to maintain continuity of care if necessary. However, a responsible professional approach in today's world is to consider and justify the necessity of recording each item.

The HIPAA privacy rule mandates that disclosure of medical records information be limited to the minimum necessary to accomplish the purpose of the disclosure. The reader is referred to the APA Position Statement, Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment (December, 2001) when anticipating possible disclosure to third party payers. The psychiatrist may wish to consider organizing the documentation of psychiatric management in such a way that notations of minimum necessary information can be easily extracted from the rest of the record.

6. **Psychotherapy Notes**. Intimate personal content, details of fantasies and dreams, process interactions, sensitive information about other individuals in the patient's life, or the psychiatrist's personal reactions, hypotheses, or speculations are not necessary in a formal medical/psychiatric record. Before charting such material the clinician should carefully consider the potential vulnerability of the record to disclosure and misinterpretation. In any case, such notations, if recorded at all in identifiable form, should be confined to the protected psychotherapy notes as defined and designated by the HHS privacy rule.

7. **Information systems considerations.** Information entered into a computerized system that goes beyond the direct and immediate control of the treating psychiatrist (and, in an organized treatment setting, of the professionals who are collaborating in the patients care) should be stringently restricted to protect patient privacy and confidentiality. It must be limited to the minimum requirements of the system for administrative and basic clinical data and not jeopardize the essential privacy of psychotherapy material. As with any disclosure of medical records, paper or electronic, transmission of detailed clinical information to information systems outside the treatment setting must not occur without the awareness and specific, voluntary, specifically defined, written consent of the patient. Psychiatrists, along with their patients, should have the right to decide together to keep information from psychotherapy out of any computerized system. If kept on a computer, psychotherapy notes should be in a separate and secure file that is inaccessible to other users or other computers, unless the patient specifically authorizes disclosure to others.

8. **Psychotherapy with Medical Evaluation and Management.** The APA and the Commission on Psychotherapy by Psychiatrists affirm that psychiatrists' medical training, experience, and assessment and management skills are integral to their ongoing psychotherapeutic work. However, certain CPT codes in the 908xx series specifying "Psychotherapy with Medical Evaluation and Management (E&M)" have been interpreted by APA's experts on coding to require specific documentation that in each session thus coded the physician 1) *assessed* the patient's condition through *history-taking and examination* and/or 2) carried out *medical decision-making* and/or 3) provided *management services*. The medical E&M service(s) may optionally be described under a separate heading from the psychotherapy service. Writing a prescription is only one of many possible actions fulfilling this requirement. Documentation may include mental status or physical observations or findings, laboratory test results, prescriptions written (dates, dosages, quantities, refills, phone number of pharmacy, etc.), side effects or rationale for changes of medication, notation that a patient has been fully informed and indicated an understanding of the risks and benefits of a new medication or therapeutic procedure, compliance with medication regimen and clinical response, etc. A minimal number of E&M activities may suffice. At this time, it appears that the medical evaluation and management service (as distinct from the psychotherapy service) rendered under the "Psychotherapy with Medical E&M" codes is comparable to a Level One service under the general E&M codes (992xx) available for use by all physicians. Level One assessment could consist of one element of the mental status examination, a vital sign, or an observation of musculoskeletal status.

Documentation requirements for the general E&M (992xx) codes are still in flux. Third parties, such as Medicare, insurance companies, and HMO's are still in the process of developing policies on the kind of documentation they may require in order to reimburse patients and/or pay practitioners for CPT codes for "Psychotherapy with Medical E&M" (908xx). The APA will work hard to ensure that these new standards conform to APA recommendations for documentation of psychotherapy by psychiatrists. The contents of the psychotherapy portion of a Psychotherapy with E&M service should be documented in the protected psychotherapy notes in accordance with the principles stated above. The medical E&M portion belongs in the general medical/psychiatric record.

9. **Consideration of patient access to records**. Psychiatrists should be cognizant of and sensitive to the fact that patients have access to their medical records in many jurisdictions. State law may require release of the record to another physician or health care professional caring for the patient or to the patient's attorney, pursuant to valid written authorization by the patient. The HIPAA rule mandates that patients may view and submit corrections to their general medical record, but psychotherapy notes are excluded from this mandated access by the patient unless the record is involved in litigation.

10. **Psychiatrist's personal working notes: an unresolved dilemma.** In keeping with the APA Guidelines on Confidentiality (1987) and some authorities on psychiatry and the law (Appelbaum and Gutheil, 1991), the psychiatrist may make personal working notes, unidentified and kept physically apart from the medical record, containing intimate details of the patients mental phenomena, observations of other people in the patient's life, the psychiatrist's reflections and self-observations, hypotheses, predictions, etc. Such personal working notes are often used as a memory aid, as a guide to future work, for training, supervision or consultation, or for scientific research that would not identify the patient. Many psychiatrists consider such uses to be crucial to the clinical care they provide. *If such notes are written, every effort should be made to exclude information that would reveal the identity of the patient to anyone but the treating psychiatrist.* If there is any risk of disclosure, patients should be informed in a general way about the use of notes for teaching and research and the ways in which identifiable disclosures will be avoided, and the patient's authorization should be obtained for such uses. As long as personal working notes are not identifiable and are not part of the patient's medical record, they are not covered by the HHS regulations.

Psychiatrists should be aware, however, that these notes might be subject to discovery during litigation, unless specifically protected by state statute. Even in protective jurisdictions the definition of personal working notes may be challenged and the notes could be subject to judicial review. It is likely that they would be considered privileged in federal judicial procedures covered by *Jaffee v. Redmond*, and in state courts that follow an approach similar to *Jaffee*. If the court does not quash the subpoena on the ground that the material is privileged, the judge would probably review it in camera and select what is relevant to the case at hand. *Destroying such notes after a subpoena arrives opens the psychiatrist to extreme legal risk and should never be done. Personal working notes should be destroyed as soon as their purpose has been served, and this should be done in a systematic, routine way for all cases that clearly is not designed to avoid discovery in a specific case*. Psychiatrists should acquaint themselves with prevailing law affecting personal working notes in their state. The presence or absence of notes is unrelated to the issue whether or not the psychiatrist will be required to testify.

11. **Final clinical note**. A final clinical note at the end of treatment may summarize the psychotherapy concisely in the general medical record from a technical standpoint without divulging intimate personal information, and document the patient's status and prognosis, reasons for termination, and any recommendations made to the patient regarding further treatment and/or follow-up. It is important that the individual clinician use judgment in regard to what information is included in the final report so as not to jeopardize the patient's privacy or confidentiality.

12. **Special situations**. Special documentation requirements established by reputable professional organizations for use by members of those organizations may apply to specified treatment methods or clinical situations. An example is The American Psychoanalytic Association's Practice Bulletin on "Charting Psychoanalysis" (American Psychoanalytic Association, 1997.)

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