Psychotherapy Notes under HIPAA

Under the Health Insurance Portability and Accountability Act's (HIPAA's) Privacy Rule, *psychotherapy notes are held to a higher level of confidentiality than the rest of the patient's medical record*. While the rest of a patient's medical record may be released for review to the patient's insurer for payment audits or other insurance reviews, psychotherapy notes may not. In fact, the Centers for Medicare and Medicaid Services (CMS) issued a transmittal in February 2005, which clarified that under Medicare claims for psychotherapy cannot be denied because of a provider's failure to produce psychotherapy notes. This should be the case for all other insurers as well.

Under HIPAA, *psychotherapy notes are defined as notes that document or analyze the contents of a therapy session and are separated from the rest of the medical record*. The definition of psychotherapy notes *specifically excludes patient information that is considered to be part of the medical record*.

The following information is not considered to be part of the psychotherapy note:

- Medication prescription and monitoring;
- Session start and stop times;
- Modalities and frequencies of treatment;
- Results of clinical tests and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, progress, and progress to date.

The CMS transmittal states that should any of the above medical record information be physically integrated into the psychotherapy note, the psychiatrist is responsible for extracting it if the patient's information is requested by the insurer. This would be done by redacting, or blocking out, all other information in the note before submitting a copy of it for review.