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~~Progress Note New Therapy~~
~~Progress Note Medicare~~
**Progress Note Requirements
for Physical Therapy,
Occupational Therapy
#MedicareBilling Therapy**

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**Interventions Cheat Sheet
for Case Notes How Long
Should it Take to Complete
Progress Notes? DPT Student
- CI Discuss Medicare
Documentation in 2020**

How to Write Clinical
Patient Notes: The Basics
*Psychotherapy Notes vs
Progress Notes* ~~Notes and
Documents in Therapy~~ Notes™
How to Write a Physical
Therapy Progress Note SOAP
NOTES

Psychotherapy Case Notes: My
Favorite Template
~~Productivity Hack for
Writing Case Notes (Best
Secret Revealed!)~~ HOW TO
WRITE A NURSING NOTE
**Requested* Quick and Easy
Nursing Documentation How To*

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*Catch Up On Requirements Notes
(Part 1) Five Tips For
Writing Case notes (Example
of a case note) | SOCIAL
WORK SOAP NOTES | PHYSICAL
THERAPIST ASSISTANT* **How to
Turn a Session Into a Note
Soap Note Made Easy (Pt, OT,
Speech, and Nurses-
documentation)**

Writing Good Case Notes

*How to Write SOAP Format for
Mental Health Counselors*

*Clinical Note Taking for
Therapists*

*Clinician's Corner: Writing
a good progress note***Intake
Diagnosis, Psychotherapy
Notes \u0026amp; Insurance
(Avoid FRAUD!) Tips For
Writing Better Mental Health
SOAP Notes** *How to Write a*

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~~Notes Requirements~~
*Progress Note for Physical
Therapy* NURSING

DOCUMENTATION TIPS (2018)

Coding and Documentation for
Behavioral Health Providers-
Part 1 Charting for Nurses |
How to Understand a
Patient's Chart as a Nursing
Student or New Nurse

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Checklist: Psychotherapy
Services Documentation. This
checklist is intended to
provide Healthcare providers
with a reference for use
when responding to Medical
Documentation Requests for
Psychotherapy services.
Healthcare Providers retain
responsibility to submit
complete and accurate

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~~Checklist: Psychotherapy
Services Documentation~~
Overview of Documentation
for Medicare Outpatient
Therapy ... A progress note
for each group or family
therapy session is required.

Each note must include: •

Date of the session and
start and stop times •

Statement summarizing the
clinical intervention used
in the therapy session

DOCUMENTATION REQUIREMENTS
MEDICARE PART A VS MEDICARE
PART B

~~Medicare Psychotherapy
Progress Note Requirements~~
psychotherapy notes progress

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~~Note Requirements~~
notes content can be kept to
minimum The following kinds
of information go in a
progress note further
guidelines and examples
appear below counseling 1 /
4

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as needed from a referring
physician's office (for
example, physician order,
notes to support medical .
necessity) or from an
inpatient facility (for
example, progress note). The
Medicare Program Integrity
Manual, Chapter 3, Section
3.2.3.3, "Third-Party
Additional Documentation
Request" states:

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~~Complying With Medical
Record Documentation
Requirements~~

PT/OT/SLP - Initial
evaluation, plan of care,
progress reports, treatment
encounter notes, discharge
summary, therapy PT/OT/SLP -
Progress reports, encounter
notes and therapy minute
logs and discharge summary :
Progress reports written by
the clinician-services
related to progress reports
are to be furnished on or
before every 10th treatment
day

~~Outpatient Therapy
Documentation Requirements—
Medicare~~

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~~Missing or incomplete~~
progress reports. Progress reports must include certain information, be done with frequency (at least once each 10 treatment days), and . contain your signature, professional identification, and date. The CERT program does not include progress reports. Refer to documentation requirements of progress reports in the

~~Outpatient Rehabilitation
Therapy Services: Complying
with ...~~

Progress toward achievement of treatment goals (This means, of course, that the patient record must include a treatment plan, although

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~~Note Requirements~~
you do not need to refer to it in the documentation for each session.) For psychotherapy lasting more than 52 minutes (90837, 90838), the reason the session required this length of time

~~How to Document~~

~~Psychotherapy Sessions~~

~~Psychiatric News~~

Psychotherapy 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

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~~Note Requirements~~
the rest of the individual's
medical record.

~~Federal rules mandate open
notes starting April 5, 2021~~

- Progress Notes must be filed in clinical records. Psychotherapy notes (process notes) should be kept separately. (CalOHI1)
- All entries must be legible(including signatures). (See "Clinical Documentation Standards" section, "Signature Requirements.") (CCR30 (DMHcontract3))
- Use only ink (black or blue recommended). (BHCSQA09)

~~Clinical Documentation
Standards~~

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~~Note Requirements~~

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~~Medicare Psychotherapy Progress Note Requirements~~

At minimum, a licensed therapist must complete a progress note—a.k.a. progress report—for every patient by his or her tenth visit. In it, the therapist must: Include an evaluation of the patient's progress

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Notes Requirements. Make a professional judgment about continued care.

~~Medicare Part B Documentation Requirements For Physical ...~~

Physical therapists must be mindful of the following documentation requirements for Medicare Part B. The following summarizes the documentation requirements required under Medicare Part B. Please refer to CMS' Medicare Benefit Policy Manual Chapter 15 Section 220.3 for detailed guidance on Medicare's documentation requirements.

~~Medicare Part B~~

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~~Documentation Requirements~~ APTA

Progress notes should contain: An assessment of improvement, extent of progress (or lack thereof) toward each goal; Plans for continuing treatment, reference to additional evaluation results, and/or treatment plan revisions should be documented in the clinician's progress report; and

~~Overview of Documentation for Medicare Outpatient Therapy ...~~

Progress notes for hospital and custodial care facility patients must have all entries dated and signed by

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~~Healthcare providers~~ who actually examined the patient; Provide sufficient detail to support necessity for diagnostic tests that were furnished and level of care billed; Not use statements such as "same as above" or ditto marks ("").

~~Documentation Guidelines for Medicare Services — JE Part B...~~

Progress Reports need to be written by a PT/OT at least once every 10 treatment visits. PTA/OTA's cannot write progress notes. It's also important to remember the time involved in writing a progress report cannot be billed separately. Like all

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documentation, Medicare considers it included in the payment for the treatment time charge.

~~Medicare Progress Note
Requirements for Physical
Therapy ...~~

REQUIRED AS A PROGRESS REPORT: "The Discharge Note (or Discharge Summary) is required for each episode of outpatient treatment. In provider settings where the physician/NPP writes a discharge summary and the discharge documentation meets the requirements of the provider setting, a separate discharge note written by a therapist is not required.

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~~DOCUMENTATION REQUIREMENTS
MEDICARE PART A VS MEDICARE
PART B~~

status, treatment plan, symptoms, prognosis, progress, and progress to date. Physically integrating this information into protected psychotherapy notes does not automatically transform it into protected information. B. Policy: This policy instructs contractors not to request that a provider submit psychotherapy notes. It

~~CMS Manual System — Centers
for Medicare & Medicaid
Services~~

To be clear, unlike

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Notes Requirements
psychotherapy notes – which are intended as a treating professional's separate personal notes and protected under HIPAA privacy rules – progress notes form a legal record of a patient's assessment, diagnosis, treatment and progress while under a provider's care.

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