HIPAA regulations regarding documentation: Psychotherapy vs. Progress Notes

“Psychotherapy Notes” are defined as:

1) notes recorded 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,
2) maintained separate from the medical record, and
3) that exclude:
   a. Medication prescription and monitoring
   b. Counseling session start and stop times
   c. The modalities and frequencies of treatment furnished
   d. Results of clinical tests
   e. Any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

"Psychotherapy Notes" are granted special protection under HIPAA due to the likelihood they contain particularly sensitive information, and also because they are the personal notes of the treating therapist—intended to help him or her recall the therapy discussion or session content, and are of little or no use to others not involved in the therapy.

Information in these psychotherapy notes is not intended to communicate to, or even be seen by, persons other than the therapist.

This information is kept separate by the provider for his or her own purposes/use.

A covered entity generally must obtain an authorization for disclosure of psychotherapy notes, or for use by a person other than the person who created the psychotherapy notes. This authorization is specific to psychotherapy notes and is in addition to any consent an individual may have given for the use or disclosure of other protected health information to carry out treatment, payment and health care operation. This additional level of individual control provides greater protection than a general application of the "minimum necessary" rule.

The purposes for which psychotherapy notes may be disclosed without authorization for purposes other than TPO (treatment, payment, operations of one's practice) are limited.

An authorization is not required for use or disclosure of psychotherapy notes when the use or disclosure is required for enforcement of this rule, when required by law, for oversight of provider who created psychotherapy notes, for a coroner or medical examiner, or when needed to avert serious & imminent threat to health or safety

Cannot be compelled for payment, underwriting, or plan enrollment

Psychotherapy notes are granted more protection with regards to disclosures and subpoenas but a) there are currently no state statutes about whether or not psychotherapy
notes should be included in disclosed records, and b) no record is ever completely immune from disclosure. Current status is yet to be determined by case law.

Because of this, it is recommended that Behavioral Health Providers not keep psychotherapy notes.

“Progress Notes” are defined as:

a) notes that are kept as part of the medical record

b) that include:
   • Session start & stop times
   • Medication info (unless noted elsewhere in the record)
   • Modalities & frequencies of tx
   • Summary of diagnosis, functional status, symptoms, prognosis, and progress to date

Progress notes are considered part of the medical record.