A Brush Up on Clinical Documentation: A Clinician's Considerations

By Elizabeth Irias, LMFT

We therapists and social workers are told time and time again that our notes are legal documents, yet we often receive very little training about what actually needs to be in them. Further, there are a number of myths that float around the therapist community that can get providers into serious legal trouble (for example: "Notes need to be short and vague to protect client confidentiality," or, "Clinicians in private practice don't really need to keep notes"). Many therapist do not realize that inadequate documentation can have grave consequences, including threats such as loss of licensure and even time behind bars, not to mention the potential negative impact on our clients. With all of the responsibilities facing busy clinicians, clinical documentation often becomes an afterthought, though it behooves us to stay on top of our records, as a service to ourselves, our practices, and our clients. Let's take a few minutes to review some California laws and standards, and their impact on our clinical documentation.

According to California Business & Professions Code §4982.05, licensed clinicians can have their licenses suspended or revoked due to unprofessional conduct, including, "…failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered." Our records, therefore, need to adequately record the care we provide to our clients. When we boil it down, our charts ought to tell the story of the Five W's: The who, what, where, why, and when of a client's treatment, and this standard applies to all California clinicians, regardless of their workplace (private practice, agency, etc.) or payment type (insurance, Medicare, private pay, etc.). David Jensen, a former staff attorney for the California Association of Marriage & Family Therapists, calls clinical documentation a 'persuasive tool' and stresses that it really ought to persuade a reader why we did what we did. This persuasive tool can be used for multiple purposes, including in matters like insurance authorizations, custody cases, short-term and long-term disability cases, or investigations conducted by licensing boards, not to mention in legal investigations should there be a significant client incident. When it comes to an investigation of any kind, it may (and often will) depend on whether our documentation can prove that our treatment was appropriate. Did we do what other prudent, well-trained, and ethical clinicians would have done in our shoes? If a client were to have a significant incident, like a suicide attempt, would our records back up our choices and illustrate our appropriate clinical decision-making and competence? Quality documentation reduces our liability risks, and helps us sleep a little better at night, knowing that we have both done what is required of us by law, and also made steps to protect our licenses.

Though unpleasant to consider, our profession includes legal risks, and our charts are effectively legal documents. We clinicians never want to find ourselves in a legal "he said, she said" scenario, and sound clinical records protect us… how awful to consider a clinician needing to question the competence of a past client in order to protect him/her/themself because the record itself did not sufficiently capture the relevant details. Relating to audits across the board, the old adage remains true: "If it's not in the chart, then it didn't happen." We may tell ourselves that our memories are good and we will be able to recall important details, but let's be honest: Who among us has been immune to the occasional oversight like putting our fresh milk in the pantry and our laundry detergent in the fridge? Our attention to detail simply is not that good, nor are our memories; and timely, sound charting is like an insurance policy for our hard-earned licenses. California Business & Professions Code §4993 states that clinicians should retain records for seven years, or for minors, seven years after age of majority (18 years of age). It is important to keep in mind that a CA Board of Behavioral Sciences complaint can be filed for up to ten years after the service occurred, which implies a tip for providers: If we really want to be careful, we should keep our records for a decade after treatment concludes, at a minimum, and longer if the client is a minor. If there is a board complaint, the BBS may go into the chart looking for one thing and find other inadequacies. Additionally, if you are found medically negligent, you could lose more than your license, including thousands upon thousands of dollars in legal bills, and you could even potentially do jail time if the situation were very extreme… the importance of sound clinical documentation can rarely be overstated.

In terms of the impact of clinical documentation on our clients, what stories do our records tell, and how could this affect our clients? There have been many cases where individuals have lost significant and critical behavioral health benefits like insurance authorizations or short-term disability payments as a result of a clinician's failure to appropriate document the client's symptoms and prognosis. Even in cases that do not involve financial benefits or authorizations, our charts support collaborative and ethical care, potentially allowing future clinicians to be able to pick up where we picked off. Though macabre, we clinicians need to consider what would happen if we need to abruptly leave our practices, become disabled, or pass away… our documentation needs to tell the next person who sees it what happened, and it must be clear, specific, and legible. Our charts are held to the same standard as medical charts, and need to reflect the same caliber. I have occasionally been asked this question: "In order to protect client privacy, shouldn't we leave certain things out of the record?" The answer there is something worth consideration: The standard of care dictates that we

accurately record what happened in session… essentially, what influenced our clinical decision-making. If we jump into the world of the medical model, imagine a doctor choosing not to document a symptom, procedure, or consideration due to concerns about the patient's privacy: The chart is simply there to record what happened, to tell the story of an encounter. When clinicians leave out critical details (ie- details that have influenced the provider's clinical decision-making, like symptoms that support a diagnosis, etc.) to protect a client's privacy, the clinician has made a subtle choice that the client's privacy is higher ranking than the clinician's license… it is ultimately the clinician who the record may protect (or fail to protect).

One of the complicated considerations for counseling and therapy is the concept of 'medical necessity'… what does this nebulous term really mean, and how do we illustrate it? Simply put, medical necessity requires that there is a legitimate clinical need for behavioral health treatment, and our charts must record the factors that indicate medical necessity. Per California Welfare And Institutions Code §14059.5, "[A] service is 'medically necessary' or a 'medical necessity' when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." As such, our records need to illustrate why we believe treatment is necessary to prevent significant illness, disability or alleviate severe pain… they need to pass the smell test, so to speak. Even in cases where clinicians are providing long-term therapy to clients who are generally stable, there still must be medical necessity… why do you think this person needs this service? Do you believe that attending weekly therapy helps them maintain their treatment gains, or stave off another depressive episode? If yes, document it.

It's also important to note that this concept of medical necessity is as relevant for self-paying clients as it is for insurance clients. Again, jumping back into the medical model: Imagine a surgeon not documenting a service he/she/they had performed because of how the patient was paying for it. To do so would be incredibly risky for the doctor, and automatically treads into delicate ethical territory. Regardless of the pay source, the record need to tell the story of what happened. Moreover, imagine that a large-scale audit of your charts is being performed, and the charts for insurance clients are much detailed than the charts for your private-pay clients. It could appear, then, that the insurance-paying clients were actually receiving better care, since the records are better and more thoroughly explain what treatment the client received. Once again, this discrepancy could be interpreted in a way that is damaging to the clinician: The provider offered better care to those who used their insurance to pay for treatment, even though this may not be the case.

To sum it up, when it comes to our clinical documentation, there are many factors to consider: We need to remember that medical necessity is the backbone of the care we provide, and that the quality of the charts we maintain is critical to the security of our practices. Truthfully, none of us entered this field because we love to document (at least, I haven't met this person yet!). We went into the field because of a love of people and a commitment to healing. In order for us to continue to do what we do, and provide the artful dance of therapy and social work, our records give us a jumping-off point that either give us more security or more risk, and the choice really comes down to us, via our pens or our keyboards.

Elizabeth Irias, LMFT, is the founder and president of Clearly Clinical, a national, affordable, podcast-based behavioral health Continuing Education program approved by CCAPP, CAMFT, the APA, CPA, NBCC, and NAADAC. She has specializations in Utilization Review, Clinical Documentation, and Quality Assurance, and works closely with clinical teams across the country to reduce documentation-related liability risks and improve their quality of care, documentation practices, and Utilization Review outcomes. An adjunct graduate professor at Pepperdine University, Beth provides dynamic, targeted presentations for national conferences, seminars, universities, and mental health providers. She also operates a private practice in Westlake Village, CA, where she provides therapy to adolescent/young adult clients, members of the LGBT population, and those with addictive disorders. To learn more about her work and to take one of her free CE courses, please visit Clearly-Clinical.com.

Back to top

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By Kim Roser-Kedward, LCSW

"…Sleep that knits up the ravell'd sleave of care,

The death of each day's life, sore labour's bath,

Balm of hurt minds, great nature's second course,

Chief nourisher in life's feast." ~ Macbeth (2.2.46-51)