RECORDKEEPING – How Much? What content?

written by Richard Leslie | March 1, 2024

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Note: This article was first published on the CPH website in January 2016. It appears below with minor changes. Last month (February 2024) I wrote about amending/ correcting treatment records. In this article, I address the recordkeeping issue more broadly. At a minimum, practitioners must comply with state laws or regulations that address recordkeeping issues (e.g., required content), to the extent that they may exist in a particular state.

RECORDKEEPING – How Much? What content?

How much detail, and what kind of content, should be in your treatment records? This is a question that many have asked over the decades, and the answer is neither simple nor singular – and that is probably a good thing. Records are kept for the benefit of the client/patient and for the benefit of the practitioner. It must be remembered that practitioners holding different licensures see a wide variety of people who appear with a wide array of problems and issues. A variety of services may be offered, ranging from the diagnosis and treatment of serious mental illness, to couples counseling, group counseling on a wide variety of issues, and non- medically based personal growth and development services. Some practitioners work within a health facility or other business entity that may require certain entries into the records or that established policies be followed.

As I have written here before (see archives), copious notes/treatment records may provide "fodder" for cross-examination of the practitioner in the event that there was litigation that reached the deposition or trial stage. Viewed differently, copious notes/treatment records might provide the treating practitioner with a good defense in the event of a complaint, claim, or lawsuit. Too little content might suggest or be argued as inadequate treatment and might hinder the defense of the practitioner in the event that there is litigation or an enforcement action. Of course, records that accurately reflect appropriate and competent treatment would likely be useful in one's defense. Practitioners must include in the records any information that is required by law, regulation, or by applicable ethical standards, and they may want to include information that is recommended or encouraged.

If insurance reimbursement is involved, thought must be given to what may be required by the insurer in order to justify continued payment or reimbursement for services rendered. A patient might be upset with a therapist whose inadequate records do not allow for continued reimbursement. In the unlikely event of a complaint from the patient against the treating practitioner, it should be understood that a licensing board will likely be obtaining and reviewing the records. Thought must also be given to the desires of the patient with regard to privacy. Although the patient does not dictate or determine what

the treatment records should look like, due regard for the patient's desires may be heeded in some circumstances. When major decisions or changes are made during the course of treatment, these junctures should be reflected in the records and should be well documented. Support (e.g., consultation obtained, research done, rationale used) for these changes or decisions should also be reflected in the records.

It is important to recognize that mental health practice is both an art and a science, and in my view, the importance of the art portion of psychotherapy should not be underestimated. It has long been my view that mental health practitioners should be given broad discretion with regard to the method and nature of treatment and how that treatment is reflected in their records. The regulatory board for LMFTs and LCSWs in California once considered proposing regulations that would have specified aspects of professional services rendered that had to be reflected in patient records. The proposal was met with strong opposition from the professions. Rather than go down the slippery slope of the government specifying the content of records, legislation was successfully pursued that gave practitioners wide latitude with respect to the content of treatment records. The standard enacted simply requires practitioners to keep that amount of records that is consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

For those practitioners who are "covered entities" under HIPAA, it is important to understand the differences under the Privacy Rule between the term "psychotherapy notes" and the more generalized notions of psychotherapy or mental health treatment records. Issues dealing with the practitioner's denial of patient access to psychotherapy or mental health treatment records, and to the denial of access to "psychotherapy notes," or the need for a signed authorization before release of "psychotherapy notes" to a health insurer, are affected by these terms. The Privacy Rule defines "psychotherapy notes" 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 **and** that are separated from the rest of the individual's medical (includes mental health) record.

The term "psychotherapy notes" excludes, for example, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. These exclusions from the term "psychotherapy notes" are an indication of what might be expected to be present or addressed in mental health treatment records. For those who are not covered entities under HIPAA, it may be useful to review the state law or regulation that allows a practitioner to provide a summary of the treatment records (to the requesting patient) in lieu of the actual records, and the circumstances when that may lawfully be done. In such situations, the applicable law or regulation may require, as it does in California, that specific content be covered in the summary provided to the patient.

The content specified for inclusion in the summary may help practitioners decide upon the content of their actual and perhaps more complete treatment records. For example, in California, the content of the summary must include, among other things, chief complaints including pertinent history, findings

from consultations and referrals to other health care practitioners, diagnosis (where determined), treatment plan, progress of the treatment, and prognosis (including significant continuing problems or conditions). While the above information (and more) must be included in the summary, the law also provides that this section of California law "… shall not be construed to require the medical records to be written or maintained in any manner not otherwise required by law."

There are various aspects of the law that relate to records or recordkeeping that I have written about in the past (e.g., responding to a subpoena for treatment records, inspection and obtaining copies of records by patients, the practitioner's right to provide a summary of the records or to issue a denial to the patient, destruction of records, the right of the patient to submit an addendum to the records), and for those who are interested, the CPH website may be a good place to start looking for one or more of the articles covering such subject matter.