The Carlat Report

On Psychiatric Treatment

AN UNBIASED MONTHLY COVERING ALL THINGS PSYCHIATRIC

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The Humble Progress Note

By definition, a "progress note" should be a written record of the degree of our patients' progress. We can all agree on this much, and this is pretty much where the agreement ends.

TCR has recently made an effort to assess variability in progress notes for psychopharm visits, mainly by talking to colleagues. The variability is extreme.

Some psychiatrists subscribe to the Hemingway style of progress notes – functional, spare, but not without a certain kind of elegance: "Improved. No side effects. Continue meds."

Others favor Dostoevsky, in which each note is a fascinating and complete character study, replete with extended verbatim quotes. Most of us fall somewhere in between, and presumably we are all doing the right thing by our patients.

Some psychiatrists prefer Hemingway; others, Dostoevsky.

Unlike most articles in *TCR*, we can offer no empirical studies to guide us in figuring out the "answer." To our knowl-

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IN THIS ISSUE:

Focus of the Month:
Chart Documentation in Psychiatry

Using Psychiatric Rating Scales in Clinical Practice

Should we use rating scales in our clinical practices? And if so, which ones? Do the benefits of scales compensate for the extra time it takes to administer them?

As you may have surmised from reading journal articles, there are an awful lot of rating scales out there, making the process of choosing one a daunting task. According to one recent book, there are at least 30 different scales available to assess depression and suicidality alone, and there are at least as many focusing on anxiety problems.

In my own practice, I use scales primarily for my more "difficult" patients-that is, those whose symptoms are chronic and do not obviously respond to my usual treatments. For these patients, scales help me to detect subtle improvement with greater sensitivity.

The king of all scales is surely the Hamilton Depression Rating Scale (*Br J Soc Clin Psychol* 1967; 6:278-96, free download at http://healthnet.umassmed.edu/mhealth/HAMD.pdf). Widely used for over 40 years, it pops up in journal articles all over the world. However, if you've ever tried to use it, you've found that it overemphasizes somatic symptoms of depression (reflecting the fact that it was originally developed for more severely ill, hospitalized patients). The common 17-item version takes at least 15 minutes to administer and thus is not practical for most of us, but a more recent 7-item version is available and less unwieldy (*Primary Psychiatry* 2003; 10:39-42; free download from http://www.cfpc.ca/cfp/2004/Oct/vol50-oct-cme-1.asp).

Self-administered scales are much

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Learning objectives for this issue: 1. Describe the elements required for excellent progress notes. 2. Identify the requirements of HIPAA in psychiatric practice. 3. Compare different psychiatric symptom scales for use in clinical practice.

This CME activity is intended for psychiatrists, psychiatric nurses, and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

The Humble Progress Note

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edge, comparative studies of different progress note styles have yet to be conducted. Thus, we must resort to a common sense approach as we zero in on recommendations for your practice.

As our framework, we'll use the "SOAP" format – Subjective, Objective, Assessment, Plan. We all learned this in medical school, and it is a useful template for our notes, even though there may be little that is truly "objective" in the psychiatric exam.

The "subjective" part of SOAP refers to how the patient describes his issues, and is usually expressed as a verbatim quote. Pick and choose the quote that seems to best encapsulate your patient's issues of the visit, e.g., "My day was horrible. My boss chewed me out and I know he's about to fire me."

The "objective" portion refers to the major psychiatric symptoms over recent weeks, including issues with sleep, appetite, energy, anxiety, suicidality, and the like. If you use numerical scales in your clinical work (see accompanying article for recommendations on how to use these), this is the place to insert them.

"Assessment" should include your DSM diagnosis--all five bitterly tedious axes. Insurance companies and disability reviewers will eventually want to see this information for most of our patients, and as much as we may hate to admit it, the multi-axial system forces us to think through issues to which we should pay attention. So get into the habit of writing down the actual DSM numbers for all your Axis 1 and Axis 2 diagnoses. Torture? You bet, but it is a good defense against intellectual (and therefore therapeutic) laziness. Similarly, Axis 3 forces us to remind ourselves of our patient's medical issues at each visit, ensuring that we scrutinize our meds for possible interactions with other medications.

What about documentation of Axis 4 ("psychosocial stressors") and Axis 5 ("global assessment of functioning")? For Axis 4, simply writing "mild," "moderate," or "severe" is so vague as to be useless, but briefly noting the specific stressors can be a useful check on your patient's progress from visit to visit.

With regard to GAF, I once considered the assignment of a number to describe a patient's life functioning to be so reductionistic that I rebelled, randomly oscillating between 65 and 75 as the mood suited. A spate of coverage denials from insurance companies ensued – be advised that GAFs of 75 and greater may indicate too much health to qualify your patient for your care. Chastened, I still randomly oscillate, but now between 60 ("moderately poor functioning") and 70 ("mildly poor functioning"). Of course, those of you involved in inpatient care will often be dealing with GAFs well below 50.

"P" is for "Plan" and there's not much to add, other than to say that, medico-legally, adding a one-liner revealing the thinking that goes into your plan is a good idea. So it's not just "Add lithium," but "Add lithium in order to augment response to antidepressant." In this example, if the lithium causes toxicity, you have a documented rationale for having used the medication in a patient without bipolar disorder. And so on for innumerable other possible scenarios.

Thus, the trusty SOAP mnemonic is pretty useful, but it does leave out a few important items that deserve documentation: medication instructions, side effects and risks vs. benefits of treatment. Some clinicians resort of an alphabet soup to save their writer's hand--"I, S/E, R/B", indicating that all three were addressed during the visit. This may be fine in general, but you may need to be more prolific in some instances. The prescription of MAOIs comes to mind, when you should write out what you discussed: "Went over contraindicated foods and meds, gave handout, discussed potential symptoms of hypertension, and R/B of MAOIs."

A good way to remember to cover these is to add "SIR" to the SOAP mnemonic, as outlined in the box in the middle of this article. This will ensure that your progress notes are squeaky clean! ❖

TCR's Humble SOAP Revision: "SOAP, SIR"

S: Subjective
O: Objective
A: Assessment
P: Plan
S: Side Effects
I: Instructions
R: Risks/Benefits

TCR VERDICT: *Let's make it "SOAP, SIR."*

Using Psychiatric Rating Scales in Clinical Practice

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easier (at least for clinicians), and it turns out that the PHQ-9 (Patient Health Questionnaire 9), available as a free download at, http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/, has excellent sensitivity and specificity for picking up depression and for tracking response. It takes only a couple of minutes to score (*J Gen Intern Med* 2001 Sep; 16(9):606-13).

In terms of anxiety, the field is very crowded, but the Beck Anxiety Inventory (BAI) has been a popular self-report form and is especially good for monitoring panic symptoms. While free copies of the BAI seem to find their way to generations of psych residents (and can be downloaded at http://blue.butler.edu/%7Edluechau/questionnaires/beckanxietyinventory.doc) it is actually under copyright, and you can purchase it at https://harcourtassessment.com/hai/International.aspx.

For OCD, the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is famous, but also famously time-consuming to administer. However, a self-administered form is available as a free download (http://healthnet.umassmed.edu/mhealth/YBOCRatingScale.pdf) and can be completed and scored quickly--very handy for assessing response in this chronic condition.

Tracking the progression of dementia is a difficult clinical problem, and there are scales aplenty to help. The ADAS-cog (Alzheimer's Disease Assessment Scale-Cognitive component) is the one most commonly used in research, but don't try it in the office, as it will set you back about a half-hour. Many clinicians use the good old MMSE to track response to cognition-enhancing medications, on the theory that in untreated Alzheimer's Disease, MMSE scores decrease by 2-4 points per year (see Agronin, *Dementia*, Lippincott Williams & Wilkins 2004), and that medication slows this deterioration a bit.

Because there are innumerable possible side effects from our medications, we sometimes forget to ask about them. Unfortunately, there is no brief side effect questionnaire to screen for everything. There is, however, a nice scale that covers sexual side effects of psychotropics, the ASEX (Arizona Sexual Experiences Scale). While I could not find a downloadable version on the web, many drug reps are happy to pass it along. It is a 5-item self-report scale with separate versions for men and women, and it may allow your patients to be more honest than they would be in conversation.

We've covered scales for specific symptoms, but there are several "all-purpose" rating scales available. The CGI (Clinical Global Impression) is widely used and is almost ludicrously easy, being at its most basic form a rating of the overall severity of your patient's illness, in relation to your "total clinical experience with this particular population."

Aside from all the formal and well-validated scales we've covered, many clinicians use a simple and intuitive "1 to 10" scale, adaptable for many different symptoms. For example, "On a scale of 1 to 10, 1 being not at all depressed and 10 being the most depressed you can imagine, how have you been feeling over the past month?" This poor man's (or poor woman's) scale works quite well for tracking various other discrete symptoms as well, such as anxiety, mania, anger, and fatigue. The more you use this, the more confident you will become in interpreting the responses.

We've only scratched the surface of this topic, of course. Two highly recommended books with more information, including scales that you can photocopy, are *Assessment Scales in Depression, Mania, and Anxiety*, Lam, Michalak and Swinson (Eds.), Taylor & Francis, 2005; and *Rating Scales in Mental Health*, 2nd Ed., Sajatovic and Ramirez (Eds.), Lexi-Comp, 2003. ❖

TCR VERDICT: *Pick a scale or two, and use it!*

Q&A With the Expert

This Month's Expert:

Rebecca W. Brendel, M.D., J.D.

HIPAA and Psychiatric Practice

Clinical Fellow in Psychiatry, Harvard Medical School
Fellow in Forensic Psychiatry, Massachusetts General Hospital

Dr. Brendel has disclosed that she has no significant relationships with or financial interests in any commercial companies pertaining to this educational activity.

TCR: Dr. Brendel, thanks for agreeing to educate us about HIPAA, which remains a pretty mysterious and intimidating entity for most psychiatrists! How did you get to be such a HIPAA expert?

Dr. Brendel: Well, I've been interested in the interplay between law and psychiatry for a long time. I received my medical degree as part of a joint M.D./J.D. program at University of Chicago, and then I came to the psychiatry department at Mass General, where I'm now doing a fellowship in forensic psychiatry. Back in April of 2003, when HIPAA privacy regulations went into effect, there was a lot of concern about what these would mean for physicians, and since I was a lawyer, my colleagues would frequently ask me questions about HIPAA. So I sat down and collaborated with Eileen Bryan, CHP (the MGH HIPAA Compliance Specialist) and we put together a number of talks and also an article answering the practical kinds of questions that psychiatrists had about what HIPAA would mean for their practice.

TCR: What is the reference for that article?.

Dr. Brendel: It is in the *Harvard Review of Psychiatry* in the June 2004 issue.

TCR: I look forward to reading it. But please give us a quick version!

Dr. Brendel: HIPAA stands for Health Insurance Portability and Accountability Act, and it was passed by Congress in 1996 with the goal of improving health insurance coverage and portability. The act is huge, and it covers a lot of legislative territory, but the parts that most concern practicing psychiatrists are elements designed to improve efficiency of the health care system, to detect fraud and abuse, and to facilitate access to medical information.

TCR: Facilitate access? HIPAA has the opposite reputation!

Dr. Brendel: It's true that most people, because of the privacy policies, believe that HIPAA is privacy legislation. But if there is one thing to remember about HIPAA, it's that the "P" in HIPAA is not for privacy; it actually *facilitates* circumstances in which medical information can be shared without consent.

TCR: How does it do that?

Dr. Brendel: Before HIPAA, the rule was that information patients gave to you would be held confidential unless you had their consent to release it. Under HIPAA, patients initially sign a privacy policy, but that privacy policy says that consent is not required for disclosure of information for treatment, payment and health care operations. So that means that if a patient's primary care physician calls a psychiatrist whose practice is covered by HIPAA, that psychiatrist can release information to the primary care physician without the patient's consent, as long as the patient already signed your global privacy policy.

> **"If there is one thing to remember about HIPAA, it's that the 'P' in HIPAA is not for 'privacy;' it actually *facilitates* circumstances in which medical information can be shared without consent."**
>
> **– Rebecca W. Brendel, M.D., J.D.**

TCR: And whose practices are covered by HIPAA? All psychiatrists?

Dr. Brendel: No, only those psychiatrists who perform certain electronic transactions, including electronic billing.

TCR: On a practical level, what does the typical office-based psychiatrist need to put into place to become HIPAA-compliant?

Dr. Brendel: The first requirement is to have a privacy policy informing patients that there are certain circumstances when their health care information might be released without their consent. (Ed. Note: see accompanying article for information about how and where to obtain free templates of all the documentation discussed in this interview.)

TCR: So under HIPAA, we no longer have to ask our patients to sign a special consent form each time we want to discuss their case with another health care practitioner or with an insurance company?

Dr. Brendel: Correct. HIPAA allows disclosure of health information for treatment, payment and health care operation purposes. So if it falls under the rubric of any of these, it could be released.

TCR: Now, what about releasing information to a patient's family member?

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Q & A With the Expert

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Dr. Brendel: That would depend on the circumstances, but HIPAA applies mainly to the coordination of treatment between providers, and so usually giving out information to family members requires specific consent from the patient. And this example brings up another point, which is that even under HIPAA, physicians still have their usual responsibility to their patients to do no harm. And so there may be circumstances where it would be harmful to release information and there may also be circumstances where individual practitioners would choose to adopt standards of practice that are more in line with the old days of specific consent rather than just adopting HIPAA's practices. Also, some state laws may impose a higher standard of protection than HIPAA, so it's critical to be aware of the laws in your state.

TCR: What about sharing the medical record with patients?

Dr. Brendel: Patients under HIPAA are actually entitled to a copy of their record and also have an explicit right under the law to request that incorrect or incomplete information in the record be changed. That being said, HIPAA does acknowledge that sometimes release of this information to the patient could be harmful. And so under a very narrow set of circumstances such as danger to the life or physical safety of the patient or another person, physicians do have the right to deny patients access to their records, including either the psychotherapy notes or the medical record.

TCR: Aside from having patients sign a privacy policy, are there any other things we psychiatrists need to do under HIPAA?

Dr. Brendel: Yes, HIPAA requires that you take measures to ensure that medical information not be seen by people outside the "circle of knowing." So, for example, you should not keep patient information sitting on your desk where somebody else could see it, and you should not allow free access to your computer if it has patient information on it. And probably it makes sense to put a password, for example, on a palm pilot if you keep clinical information in that, in case it got lost or stolen.

TCR: Now what about all that legalistic language that everyone adds at the bottom of faxes and emails? Is that triggered by HIPAA as well?

Dr. Brendel: Yes it is. It is meant to protect the patient information contained in the faxes from going to the wrong place or being read by the wrong person. Faxes must have a cover sheet containing a confidentiality notice and emails must contain such a notice as well.

TCR: And exactly what type of information does this notice have to contain?

Dr. Brendel: It has to say that the information is confidential, that is intended for a particular recipient, that the information should be destroyed if it went to the wrong recipient, and it must include some way to contact the sender if privacy was breached.

TCR: What else do psychiatrists need to know?

Dr. Brendel: There's a special provision about psychotherapy notes. In the past, there has often been confusion about whether patients have rights to their psychotherapy notes because those notes might contain process notes or other information that perhaps the therapist would not want the patient to see. And HIPAA does recognize that some information in the course of psychiatric treatment, like psychotherapy notes, should always be private.

TCR: So if there are notes that are very personal notations about therapy, these are not necessarily something that we would have to give to patients?

Dr. Brendel: That is right. But the thing to be aware of is that the psychotherapy note exception under HIPAA is extremely narrow. Psychotherapy notes are defined as clinician notes that 1) document or analyze contents of conversation; 2) are about something that happened during a private counseling session or during group or family counseling sessions; and 3) must be kept separate from the rest of the individual's records.

TCR: Can we just create a separate section for them in our chart or do these notes actually have to be in a different chart?

Dr. Brendel: They actually have to be in a different chart, but simply keeping them in a separate chart doesn't necessarily make them psychotherapy notes. So even if it is called a "psychotherapy" note, if it includes information that under HIPAA is properly considered part of the general medical record, what you have titled the psychotherapy note will not be protected. That information includes things such as the medications prescribed, test results, treatment plans, diagnosis, prognosis, and progress to date. So really, psychotherapy notes under HIPAA are traditional process notes.

TCR: So process notes are absolutely private?

Dr. Brendel: No, not absolutely. They can still be released to an outside party with the patient's specific consent, and they still could be subpoenaed if there were a lawsuit.

TCR: What about deadlines? Have the deadlines passed us already, we members of Procrastinators Club?

Dr. Brendel: The deadline for implementation of HIPAA privacy regulations was April of 2003.

TCR: What might happen to those of us who don't get our HIPAA act together?

Dr. Brendel: Not only are there potential fines, but there is actually the possibility of jail time for willful violations of HIPAA.

TCR: Now you're really sounding like an attorney! But your point is well taken, and I'm sure many our readers will use this opportunity to get quickly up-to-date on their HIPAA responsibilities. I know I will. Thanks very much for your help.

Dr. Brendel: My pleasure. And if any of your readers have any further questions, they can feel free to contact me personally at rbrendel@partners.org.

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HIPAA Compliance for Psychiatrists: A One-Stop Shop

In this month's interview, Dr. Brendel does a wonderful job explaining what psychiatrists need to know in order to become HIPAA-compliant. In this article, *TCR* really gets down and dirty with HIPAA, taking you by the hand to tell you exactly what to do, what forms to use, and where to get them. The only thing we won't do is to actually come to your office to post notices – but we can give you the number of Staples if you need to order some scotch tape!

Are you a "covered entity"?

Many psychiatrists do not have to comply with HIPAA guidelines because they are not HIPAA-defined "covered entities." If you file any insurance claims electronically, you are a HIPAA provider; otherwise, you're not.

The following psychiatrists are *not* HIPAA providers:

- Psychiatrists who don't accept any insurance.
- Psychiatrists who accept insurance but file all their claims by old-fashioned paper mail.
- Psychiatrists who use their computer or Palm pilots for various aspects of their practice (like storing patient info, writing notes, or doing medline searches) but who never use their computer to communicate with insurance companies about anything.
- Psychiatrists in solo practice who see Medicare patents and file paper claims rather than electronic claims by special arrangement with Medicare.

There's a fairly understandable flowchart from the government to help you decide if you're a covered entity at http://www.hipaanews.org/Flowcharts.pdf.

What do you absolutely have to do under HIPAA?

Assuming that you are a covered entity, there's a relatively short list of things you are absolutely required to do by law:

1. Create and post a **Privacy Notice** in your office.
2. Make a good faith effort to have your patients sign an **acknowledgment** that they have read it.
3. Obtain and sign a special HIPAA **Business Associates Agreement** with any company you do business with who must see patient information as part of their business (e.g., billing companies).
4. You should add a **confidentiality statement** to all faxes and emails.
5. You were supposed to have done all these things by April of 2003!

The Privacy Notice

How do you go about creating a privacy notice? Most of us will simply copy a colleague's notice or download a copy from innumerable samples available for free on the internet. You should be aware, however, that the Government requires that notices be written in "plain language," and that most of the samples you see (including the APA's sample at http://www.psych.org in the "member's area") fail miserably in this regard.

In fact, in a study conducted by the Privacy Rights Clearinghouse, a nonprofit consumer group, six HIPAA privacy notice samples and 31 actual HIPAA privacy notices were downloaded and analyzed using readability software. They were all scored at the "difficult" reading level, with complicated vocabulary and grammar (http://www.privacyrights.org/ar/HIPAA-Readability.htm), and they were judged to be non-compliant with HIPAA based on failing the plain language standard.

The other problem with most samples is that they include a lot of stuff that is not applicable to the typical small psychiatric practice, like statements that patient information might be used for marketing, fundraising, research, patient directories, etc., all of which is relevant mostly to hospitals and other large organizations. It's overkill for solo practitioners, and you don't have to include it in your own notice.

Because *TCR* was not able to find anything appropriate for most psychiatrists on the web, we wrote up our own sample, which you can access and download for free from our website (www.TheCarlatReport.com). Feel free to alter it as you see fit.

The Acknowledgment

This is an easy one, being simply a one-pager saying something like, "I acknowledge that I have read Dr. X's Privacy Notice," with a place for a signature. You can download a sample at *TCR's* website.

The Business Associates Agreement

If you contract with an outside company or individual to help you with your practice in such a way that they must see some patient information (for example, someone who does your billing), you both have to sign an official Business Associates Agreement. This just says that your billing company, or transcriptionist, or whoever, promises to keep patient information confidential. These contracts don't have to be written in plain language (unlike the Privacy Notice) and a suitably legalistic sample is available for free at a continuing legal education site: http://contracts.onecle.com/exult/prudential.svc4.2003.04.14.shtml.

Regular employees, like your secretary or other regular office staff, *don't* have to sign this form, but you do have to document in their employment files that you've given them formal training in privacy practices.

Faxes and Emails

You can easily cut and paste a standard confidentiality disclaimer from a colleague's email or download this language from TCR's website. Again, this can be as legalistic-sounding as you can stomach.

The Deadline

You're very late, but don't worry, you won't get arrested – just get it done! ❖

CME Post-Test

To earn CME credit, you must read the articles and complete the quiz below, answering at least four of the questions correctly. Mail a photocopy or fax the completed page to **Wolters Kluwer Health, Office of Continuing Education, 530 Walnut Street, 8th Floor East, Philadelphia, PA 19106**; **fax: (215) 521-8637**. **For customer service, please call (215) 521-8635.** Only the first entry will be considered for credit and must be received by WKH by June 30, 2006. Acknowledgment will be sent to you within 6 to 8 weeks of participation.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Wolters Kluwer Health and Clearview Publishing, LLC. Wolters Kluwer Health is accredited by the ACCME to provide continuing medical education for physicians.

Wolters Kluwer Health designates this educational activity for a maximum of one (1) category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim credit only for the time that he/she actually spent in the activity.

Please identify your answer by placing a check or "X" mark in the box accompanying the appropriate letter.

1. *TCR*'s recommended addition to the standard SOAP progress note is:
- [ ] a. Add a numerical assessment of mood.
- [ ] b. Add "SIR": side effects, instructions, risks/benefits.
- [ ] c. Add the results of a physical exam.
- [ ] d. Add a full psychiatric review of symptoms.

2. Regarding rating scales for psychiatric symptoms:
- [ ] a. The ADAS is practical for assessing dementia in the office.
- [ ] b. The Ham-17 is a brief self-report scale.
- [ ] c. The self-report version of the Y-BOCS is practical for OCD assessment.
- [ ] d. The Beck Anxiety Inventory is primarily a research tool.

3. The deadline for implementing HIPAA privacy regulations is April 2006.
- [ ] a. True [ ] b. False

4. Required elements of HIPAA for practitioners include:
- [ ] a. All billing must be conducted electronically.
- [ ] b. Specific patient consent is required each time you share clinical information.
- [ ] c. A signed HIPAA acknowledgement form must be faxed to all insurance companies.
- [ ] d. All offices must post a Privacy Practices Notice written in plain English.

5. According to Dr. Brendel, HIPAA was enacted in order to facilitate access to patient information.
- [ ] a. True [ ] b. False

Get Your HIPAA Forms!

We've created and posted the basic HIPAA forms you'll need to become HIPAA-compliant. Go to www.TheCarlatReport.com in order to download and print them for free.

PLEASE NOTE: WE CAN AWARD CME CREDIT ONLY TO SUBSCRIBERS

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Your evaluation of this CME activity (i.e., this issue) will help guide future planning. Please respond to the following questions:

1. Did the content of this activity meet the stated learning objectives? [ ] Yes [ ] No
2. On a scale of 1 to 5, with 5 being the highest, how do you rank the overall quality of this educational activity?
   [ ] 5 [ ] 4 [ ] 3 [ ] 2 [ ] 1
3. As a result of meeting the learning objectives of this educational activity, will you be changing your practice behavior in a manner that improves your patient care? Please explain.
   [ ] Yes _____
   [ ] No _____
4. Did you perceive any evidence of bias for or against any commercial products? Please explain.
   [ ] Yes _____
   [ ] No _____
5. How long did it take you to complete this CME activity? ___ hour(s) ___ minutes
6. Please state one or two topics that you would like to see addressed in future issues. _____

Tales from the History of Psychiatry:
Talking Back to Managed Care

Oxford Health Plans (a subsidiary of UnitedHealthcare) recently shocked the psychiatric community by doing a retroactive audit of psychiatric services, and demanding repayment of up to tens of thousands of dollars of reimbursements from some physicians based on insufficient documentation. When clinicians protested, Oxford convened meetings with several professional organizations to agree on documentation standards. They developed a policy that required seven elements for documentation of psychotherapy: (1) Patient name; (2) Clinician name; (3) Date of service; (4) Diagnosis; (5) CPT code or description of service; (6) Other session participants; and, (7) Focus of psychotherapy session. The choices for "Focus of psychotherapy" do not represent content; they are: Assessed family, work, marital, and/or social issues; Assessed symptoms of patient's illness or condition; and Assessed patient's functional status (home, work, daily living, social activities, family, etc.). Providers and payers found this an appropriate resolution, and were pleased with the process; it may serve as a model for the UnitedHealthcare system.

Source: Storman, L; The American Psychoanalyst; May 2005 (http://www.apsa.org/tap/Stormon-Oxford05-05.pdf)

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This Month's Focus:
Chart Documentation in Psychiatry

Next Month in *The Carlat Report*: Geriatric Psychiatry Update, including reviews of the cholinesterase inhibiters and Memantine, and an article on whether atypical antipsychotics are truly unsafe for the elderly.