Intensive Services Progress Note

This form is to be completed for all group and individual therapy sessions offered as part of comprehensive treatment for Intensive Service Programs such as Partial Hospitalization Program (PHP), Transitional Support Services (TSS). Community Based Adolescent Treatment and for Inpatient Detox Services.

Page one provides space to document two interventions and page two provides space for one more intervention and summary information for the day. If the person participated in more than three interventions for the day, add an additional page one to the day's note packet. At the bottom of the page, number each page according to the total number of pages used for documenting the interventions for the day.

Data Field	Identifying Information, Type of Service, Attendance and Time of Session Instruction
Person's Name	Record the first, last name and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Service	Enter date of service.
Person's DOB	Record the person's date of birth to serve as another identifier.
Organization Name:	Record the organization for whom you are delivering the service.
Type of Service: **Group Name** **Individual Intervention**	If the service is a group, write the name the group in the first section and record the number of persons who attended. **Example: Anger Management Group No in Group: 6** If Medicare billing for PHP only, check appropriate group type. 915 = Group Therapy 942 = Education Training 904 = Activity Therapy If the service is an individual intervention, check the Individual Intervention box. If Medicare billing, check the Medicare only box 914. (PHP Only, not Medicare outpatient services)
Start Time/Stop Time	Record the time the session started and the time the session ended. If applicable only.
Person Served Did Not Attend	If the person did not attend this activity, please check the appropriate box: "Removed", "Refused Service", "No Show", or "Cancelled" with an explanation. If reason person did not attend is not known, write "unknown".
Data Field	**Goal(s) Information Instruction**
Goals/Objectives addressed from Individualized Action Plan	Identify specific goal(s) and objective(s) in the Individualized Action Plan addressed during this intervention. When using this form as a paper document, write only the number of the Goal(s) and Objective(s) and the description of those Goals and Objectives that are being addressed in this specific session.

Data Field	Interventions and Response Information Instruction
Therapeutic Interventions Delivered in Session	Document how the intervention is linked or targeted towards specific goal/objectives in the Individualized Action Plan. This section should describe the specific therapeutic interventions used in the group session to assist the person in realizing the goals and objectives listed above as the focus of this particular session. This intervention documented in this section would be the same for all persons served in the group. **Group Example: Provider facilitated a discussion on relapse prevention skills. Group was asked to list precursors to current relapse and hospitalization or step-up to partial. Then group asked to assist each other in determining how to recognize early signs, ask for help, and accept help.** If this section is being used to document an individual psychotherapy contact during the course of the day, then describe the specific therapeutic interventions used in the session to assist the person in realizing the goals and objectives addressed as the focus of this particular session. **Individual Example: The person came late to the program today. Therapist met individually to review with the person his individual goals and objectives and the progress the person has made over the weekend in implementing relapse preventions skills. Discussed the person's tardiness and reviewed with the person whether this level of care is still necessary.** **If there is other pertinent content from the session that should be recorded in the record and it is not a new issue, then record that information here. If the content is a new issue, then it should be recorded below in the Daily Clinical Summary Section under "New Issue(s) Presented Today/Plan/Additional Information"**
Person's Served Response to Intervention and Progress Towards Goals and Objectives OR Plan to Overcome Lack of Progress:	This section should address **BOTH**: • The **person's response** to the intervention, including evidence of how the person participated in the session and how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • **Progress towards goals and objectives**. This should include an assessment of how the session has moved the person closer, further away or had no discernable impact on meeting the identified goal and objectives. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. **Group Example: Person was able to participate in the role play without much anxiety. He listened to the group's feedback about how he could handle the conflict with his wife differently without getting angry, which is an improvement for him. Person agreed to practice recommended calming techniques during the next two weeks. He is very anxious about this, but agreed that the new strategy might help and he will report back to the group next week.** **Individual Example: Person was able to engage in the discussion about his tardiness and talked about how he had dreaded coming to group this morning and reporting to the group that he had avoided practicing his relapse prevention skills over the weekend. Now that he has talked about it individually, he reports feeling supported and to be able both to try the skills tonight and to use the therapist's support tomorrow in the sharing with the group what he has done or not done.**
Data Field	**Signature Instruction**
Provider Signature /Credentials	The lead clinician for each group should write and sign each note with his/her credentials.

Co-Provider Signature/ Credentials (if applicable)	A co-provider of a group should sign note with his/her credentials, if applicable.
Data Field	**Supervisor/Designee Daily Clinical Summary Functioning Instruction**
Functioning: Observed or Reported (may include mood, affect, behavior, cognitive functioning, etc.)	Document, as appropriate, person's functioning, their signs and symptoms in one or more of the following areas: would expect in intensive services some note about signs and symptoms. 1. General ability of person to function in group/individual setting since last visit. This can be reported by person, or by others who have observed or interacted with person. **Example: Person was able to activily participate in the group today, was able to provide examples when prompted. Person needed to be prompted and redirected to listen to other members of the group.** 2. Observed or reported functioning of person in area of focus for today's group activities/topics/interactions. **Example: Person continues to struggle with listening to other group members without interrupting.** **3.** Observed functioning of person in group session that would impact his/her ability to participate in the session or to benefit from the session. **Example: Person appeared more agitated today than last group.**
Data Field	**Stressors Instruction**
Stressors/ Extraordinary Events	Identify any current, notable stressors or any unusual events that have occurred in the person's life outside of the program that may have an impact on the person's behavior and interaction in the group, may need to be addressed in group, or may need another type of intervention. If none were identified, check *None reported* box. **Example: The person's mother died last week but she chose not to share that with other group members**

Data Field	New Issue(s) and Additional Information Instruction
New Issue(s) Presented Today/ Additional Information/Plan	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that can be resolved during the session, check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. **Example: Person reported that she was a victim of abuse/neglect at the age of twelve as recorded on the Comprehensive Assessment Update of this date.** Plan to overcome lack of progress - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. This section can be used to document additional information the staff person identifies as important and is not appropriate document elsewhere. **Example #1: Provider will meet individually with person to discuss and assess Individualized Action Plan to determine whether modifications should be made.**
Data Field	**Signatures and Medicare Information Instruction**
Supervisor/Designee Signature/ Credentials	**Legibly** record signature and credentials of either the program's supervising staff licensed to supervise provider staff or the supervisor's designee. Name should also be printed.
Date	The date of the signature
Physician's signature/ credential (if applicable)	If physician signature is required, then it should be a Legible signature and credentials. Name should also be printed.
Date	The date of the signature.
Data Field	Medicare "Incident To" instructions.
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and credentials of	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service.

Medicare Provider on Site:	Note: The presence of an appropriate licensed supervising professional is one of the key requirements for an "incident to" service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided.
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Start Time	Indicate actual time the session started. **Example: 3:00 PM Recommend eliminating this**
Stop Time	Indicate actual time the session stopped. **Example: 3:34 PM Recommend eliminating this**
Total Time	Indicate the total time in the program today. **Example: 5 hours**
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.