Charting-by-Exception (CBE) in Private Psychotherapy Practice

Psychotherapy charting standards originated in medical hospitals, psychiatric hospitals, residential treatment programs, and day treatment programs allied with residential programs. For decades, behavioral health utilized a SOAP notes format. Since the SOAP note, more than a dozen charting methods have developed. As the cost of inpatient psychiatric and residential treatment programs increased, inpatient programs adopted one charting system developed from a Management-by-Objectives business model to reduce costs. That system authorized or denied services based on the patients' meeting goals that were specific, measurable, and time limited. Services were further limited by authorizing care only for specific diagnoses. Treatment was considered medically necessary, or appropriate, when patients presented symptoms that supported diagnoses approved by their Healthplan payers and their treatment plans met payers' standard of care. Although those standards were and continue to be proprietary and not disclosed to psychotherapists.

Virtually every facility that implements a charting system does it differently. There are numerous variations of Charting-by-Exception (CBE). Facilities, and individuals using a CBE system have rules. The rules are inherent in each treatment plan for a patient's diagnosis and associated symptoms and functional problems. When implementing CBE in medical settings, unusual or unexpected findings, those outside the norm, are recorded. Uninformed people may have the misconception that CBE results in patient records that give an incomplete picture. Minimizing documentation can be risky in the medical field. For example, nurses' notes with few explanations, little description of key findings, or that fail to mention periodic patient checks could be construed as negligence by a plaintiff's attorney guided by the premise, "not charted, not done". In physical medicine, vital signs, imaging, and labs are objective. Some staff members' observations are objective. Patient reports are subjective and can be unreliable.

A lack of detail might compromise medical patient safety. A patient's medical record is expected to accurately reflect the patient's current condition, and a chart that's missing pertinent information could fail to alert other clinicians to potential problems or complications. Well-designed flow sheets are a key part of a good charting-by-exception system in an ICU, PCU, ED or medical floor. But this form of medical documentation also calls for entries concerning any significant indicator of a patient's condition or change in status, any subsequent interventions and the patient's response.

In the medical field, observations call for specific detail: Recording the color, consistency, and quantity of wound drainage— "about the size of a quarter," for example— rather than noting that a dressing was "bloody." Significant deficits such as lethargy or lack of response

are charted as well. If charting by exception is the rule at a medical facility, staff must pay strict attention to the parameters and know exactly what they are expected to include in a patient record. When uncertain, nurses are expected to discuss the issue with their supervisor or an administrator and request written charting policies. Where treatment plans and rules are not adequate, consultation is the final rule.

Charting by exception cannot be reduced to a simple set of rules. Like any other form of documentation, it requires judgment and common sense in determining what included and what is excluded. The standard should be: "Does this chart tell the minimum necessary story of the patient's condition and of professional assessments and care?"

Charting for behavioral health may be brought together with that for medical treatment when the diagnosis of a patient has an organic pathology and behavioral details are necessary to continuity of care and essential or critical to saving lives.

In all except psychiatric services which require medical intervention, most behavioral health care looks for causes that arise in developmental, sociological or interpersonal life experience. While co-morbid biological factors may be contributing factors, psychiatrists don't prescribe medical interventions based on psychotherapists' charts, preferring to perform their own examination, differential diagnosis, or treatment interventions.

Federal regulations set expectations that psychotherapists' chart notes should include the minimum necessary information. That is often defined as charting that is based on foreseeable need to know in order to provide the care necessary to avoid significant harm. Psychotherapists must balance the requirement to ensure continuity of care against the hazards of charting information that is sensitive, private, or confidential and has no significant bearing on treatment considerations, progress, or outcomes. In psychotherapy, words have power and meaning that may be incomplete, misleading, or harmful depending upon who gains access to the patient's records. Patients may be misquoted, remember differently, and feel offended or betrayed concerning what psychotherapists document in their medical records.

Psychotherapy is reimbursed as a "medical service." The purpose of a medical record is to document medically necessary services. Information that is sensitive, private, and confidential, while interesting, may have potential to cause harm dependent upon who has access. Medical records are not intended to serve as documents that can used to establish proof of innocence, guilt, or culpability. Psychotherapists provide healthcare services and are wise when they consider that documents created for care purposes may be reviewed by patients and attorneys, or family members of minors. When records security fails and privacy is breached, medical records can become public.

There are perspectives that should be considered regarding psychotherapy records:

- Chart notes are processes that may take time away from treatment.
- “Compliant records” may simply demonstrate that services are adhering to the requirements of outside interests, not the patient or the care provider.
- Psychotherapists experience cognitive dissonance when creating detailed chart notes to meet external expectations.
- Psychotherapists can spend many thousands of dollars’ worth of their time charting to meet expectations irrelevant to outcomes or patient satisfaction.
- Psychotherapists resist perverse and irrelevant requirements of external parties.

Psychotherapists are not alone in challenging influence from external parties. Psychotherapists, social psychologists, and economists generally agree there are undesirable consequences when entities outside the caregiving process create policies, rules, or regulations that have perverse impact on those processes.

Standards for Charting-by-Exception in Private Practice Psychotherapy

- The CBE standard is this: Does this document tell the minimum necessary story of the patient’s condition, a psychotherapist’s professional assessment, and appropriate care?
- The patient is receiving services that are within the scope of the independent provider's clinical practice standards.
- The patient is not (a) being treated by an interdisciplinary team in a hospital, day treatment, residential facility, or outpatient clinic, and (b) the independent psychotherapist is also NOT sharing the patient's record with providers who treat the same patient.
- The patient is being treated in accordance with the independent provider's clinical practice standards, guidelines, and treatment plan.
- The level of care and interventions used do not require services beyond treatment as usual for this patient.
- The provider in this case is documenting based on State & Federal regulations, clinical judgment, and common sense when determining what’s included and what is not necessary.

Rationale for Use of CBE in Private Psychotherapy Practice

- CBE effectively supports Federal minimum necessary information requirements. (note: The Minimum Necessary Standard, which can be found under the umbrella of the Privacy Rule, is a requirement that covered entities take all reasonable steps to see to it that protected health information is only accessed to the minimum amount necessary to complete the tasks at a hand.)
- CBE minimizes a level of detail that can potentially harm patients when records are accessed by 3rd parties who are not caregivers. (i.e., attorneys, civil courts, Healthplans, and family.)
- CBE is sufficient if the treatment plan calls for a service pattern that are largely consistent from one session to the next.
- CBE is sufficient if changes in the patient's record can be noted when there is a deviation from the treatment plan, the usual practice pattern, patient baseline, expected outcome, or when a service in a treatment plan is not provided in that session.
- CBE is appropriate when analysis of sensitive, private, or personal information is NOT necessary to provide appropriate and medically necessary care (i.e. the task at hand).
- Appropriate information can include, when deemed clinically essential to ensure the patient will receive appropriate care in the next session and in future treatment.
- Using CBE, the independent provider is less likely to accidentally include information that is not medically necessary and might subsequently be used in litigation, prosecution, or determining the patient's guilt, innocence, or culpability.
- CBE can create chart notes that the patient can better understand and is intended to lower risks of confusion or that s patient may be offended or harmed.
- CBE creates a useful psychotherapy record which physicians can review and quickly understand.

For more information see:
What is the Value of Psychotherapy Charting
https://www.mentorresearch.org/value-psychotherapy-charting