Service Provider Manual

Chapter 7: Progress Notes and Recordkeeping

Missouri Department of Elementary and Secondary Education
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CHAPTER 7: PROGRESS NOTES AND RECORDKEEPING

Missouri Part C State Plan Section XV. (34 CFR 303.119)
Uniform Guidance 2 CFR 200.333 through 200.337

All providers who successfully enroll in the First Steps program to deliver services are required to sign the Missouri First Steps Service Provider Agreement. The agreement includes a requirement for providers to maintain two records for First Steps services: (1) a time and effort/therapy log to record services delivered; and (2) an electronic progress note in the First Steps system (i.e., WebSPOE), according to the Department of Elementary and Secondary Education (DESE) requirements.

The requirements for documenting delivered services, as outlined in the provider agreement, align with common practices in the billing industry, including private insurance and Medicaid (MO HealthNet).

This chapter describes the documentation required for therapy logs and progress notes, including the timeline, content, format and person responsible for maintaining such records.

SECTION I: REQUIRED DOCUMENTATION FOR SERVICES

Documentation is necessary to confirm First Steps were services delivered to a child and family, and substantiate the provider’s payment for such services. Documentation should be written in family friendly language, free of jargon, and provide a brief yet clear description of the activities that took place during the visit.

If the parent provides consent to release the information, then documentation of First Steps services in the child’s paper file or electronic record may be shared with others (e.g., school district, physician). In some situations, a provider may not want to divulge specifics about a sensitive situation in a written note (e.g., situations of domestic abuse, information the family disclosed in confidence). Instead, the provider should discuss sensitive situations with the Service Coordinator or System Point of Entry (SPOE) Director.

The following providers are not required to maintain a therapy log or a progress note for First Steps services: Assistive Technology Providers, Family Member Transportation and Transportation Providers.

The following disciplines are required to maintain a therapy log and a progress note for First Steps services: Applied Behavioral Analysis (ABA) Consultant and Implementer, Audiologist, Counselor, Dietician, Interpreter, Nurse (Registered Nurse (RN) and Licensed Practical Nurse (LPN)), Occupational Therapist and Assistant (COTA), Optometrist, Ophthalmologist, Orientation and Mobility Specialist, Paraprofessional, Physical Therapist and Assistant (PTA), Physician, Psychologist, Special Instructor, Speech-Language Pathologist and Assistant (SLPA), Social Worker, Translator.

The format of the progress note for First Steps services depends on how the provider chooses to maintain his/her therapy log.
A. Therapy Log

A therapy log is a chart, time sheet or summary table used to record the details of a delivered service. A therapy log is required for the following First Steps services: evaluation/assessment, direct services, consultation, family education/training, group services and teletherapy.

Providers are not required to include Individualized Family Service Plan (IFSP) meetings or Early Intervention Team (EIT) meetings in a therapy log because the Service Coordinator is responsible for attendance records at these meetings.

A therapy log for applicable First Steps services must be maintained with the following components: timeline, person responsible and content.

1. Timeline

A therapy log containing each date of service must be on file in one of the following ways: (1) a paper or electronic copy is kept on file at the provider’s location; or (2) an electronic daily therapy log is entered in WebSPOE.

Regardless if the therapy log is maintained at the provider’s location or in WebSPOE, the log must be completed prior to submitting a claim. Best practice is to complete a therapy log immediately after each service is delivered.

2. Person Responsible

The provider delivering the service (i.e., the performing provider) is responsible for maintaining the therapy log.

3. Content for a Therapy Log

The content of a therapy log depends on where the log is maintained.

a) Paper Log at the Provider’s Location

If maintaining the therapy log in a paper copy, then the content of the log must include the following information:

- **Child’s Name**: The child’s name as it is listed in WebSPOE.
- **Child’s Date of Birth**: The child’s date of birth as it is listed in WebSPOE.
- **Date of Service**: The date the service was delivered.
- **Setting**: The location of the service (e.g., home).
- **Treatment**: The type of service provided (e.g., physical therapy).
- **Length of Visit**: The time in and time out for each visit (e.g., 11:00 am to 11:45 am).
• **Provider Name**: The printed name of the provider delivering the service.

• **Provider Signature**: The original signature of the provider delivering the service.

b) **Electronic Log at the Provider’s Location**

If maintaining a therapy log at the provider’s office in an electronic format (e.g., excel document, agency data system), then the above content is also required. However, for the provider signature, an electronic signature is acceptable as long as the printed report reads “electronically signed by” and the provider’s name.

c) **Electronic Log in WebSPOE**

If maintaining the therapy log in WebSPOE, then the performing provider must enter a daily therapy log in the child’s record with the following information:

• **Date of service**: The date the service was delivered.

• **Length of visit**: The time in and time out for each visit (e.g., 11:00 am to 11:45 am).

• **Setting**: The location of the service (e.g., home).

• **Visit Summary**: This is a narrative summarizing the activities conducted at the visit, which should include documentation of a cancelation or no-show visit.
  - If the service is an evaluation/assessment, then the provider can write “see written report” in the visit summary.
  - If a visit with a family is shorter or longer than detailed in the authorization, then the provider must document this and explain the difference.

• **Provider Comments (optional)**: This is additional space to document information related to the family but is not related to progress toward IFSP outcomes (e.g., the family is moving to another state, new phone number, new job).

**Note**: The child’s name, date of birth, provider name, treatment (i.e., provider specialty) and entry date pre-populates in WebSPOE. The provider signature is electronically signed when the provider logs into WebSPOE.

When a daily therapy log is printed from WebSPOE, both the pre-populated information and information entered by the provider appear in the log.
B. Progress Note

A progress note is a record entered in WebSPOE that explains the activities the provider conducted or the discussions the provider had during visits with the child and family throughout a particular month. A progress note is required for the following First Steps services: direct services, consultation, family education/training, group services and teletherapy.

If a daily therapy log is not entered in WebSPOE, then the performing provider must enter a progress note in WebSPOE.

Providers are not required to enter a progress note for IFSP meetings or EIT meetings because the Service Coordinator is responsible for attendance records at these meetings.

Providers are not required to have a progress note for an evaluation or an assessment because documentation of this activity is the provider’s written report. However, if the first visit with the family includes administering a test, then the provider must include the activities conducted during the visit in the progress note. The provider may include the test results in the progress note, but it is not required.

A progress note for First Steps services must be maintained with the following components: timeline, person responsible and content.

1. Timeline

A progress note must be entered no later than 30 days from claim submission. Best practice is to complete a progress note by the last day of each month in which services are delivered.

2. Person Responsible

The performing provider or an agency/billing administrator can enter a progress note in WebSPOE.

3. Content for a Progress Note

The performing provider or the billing administrator must enter the following information:

- **Month**: The month in which services were delivered.

- **Date(s) of Service**: The date(s) that services were delivered, including any dates for no-show visits. If no billable services were delivered in a particular month, then the provider may check the box “No Services Delivered” and the provider can enter a progress note to document attempts to deliver services or contacts with the family.

- **Were any visits canceled or made up this month?**: This is documentation to support any missed visits and/or compensatory services. If a visit with a family is shorter or longer than detailed in the authorization, then the provider must document this and explain the difference in the note.
• **Progress Summary**: This is a narrative summarizing the activities conducted at visits throughout the month. Each progress note should address all of the IFSP outcomes the provider is working on, which may be both child and family outcomes.
  
  o For child outcomes, the provider should relate the note to the child’s progress.
  
  o For family outcomes, the provider should relate the note to the activities completed by the family, which may include information about siblings or other family members if it is appropriate based on the IFSP outcome.

• **Provider Comments (optional)**: This is additional space to document information related to the family but is not related to progress toward IFSP outcomes (e.g., the family is moving to another state, new phone number, new job).

**Note**: The provider name, treatment (i.e., provider specialty) and entry date pre-populates in WebSPOE.

When a monthly progress note is printed from WebSPOE, both the pre-populated information and information entered by the provider or administrator appear in the log.

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### C. Revisions to Required Documentation for Service

If information was omitted or erroneously recorded in a therapy log or monthly progress note, then the provider should revise the documentation as soon as possible.

If the therapy log is maintained in a paper copy, the provider should make a correction to the paperwork and include his or her initials along with the date of the revision (e.g., J.D. 10/1/16).

For revisions to a daily therapy log or monthly progress note maintained in WebSPOE, the provider should use the following procedures:

• **Edit a Note**

  A daily therapy log or monthly progress note may be edited until it has been reviewed by the Service Coordinator. To edit, the provider selects the note for revision, makes the necessary changes and saves the note again.

• **Delete a Note**

  If a daily therapy log or monthly progress note has been entered in error and needs to be corrected, the provider can contact the SPOE Director to request the note be deleted in its entirety. The system maintains a copy of the original note and the new, corrected note displays on the screen.
SECTION II: DATA ENTRY

There are several ways a daily therapy log or a monthly progress note can be entered in WebSPOE. Providers can enter a daily therapy log or monthly progress note when a child’s record is active or after the child’s record has been closed (i.e., inactive).

A. Child Record is Active

When the child’s record and the provider’s authorization for service are both active, the provider can enter documentation for delivered services in WebSPOE by logging into the system and going to the My EI Kids link in the middle of the Home Page. After clicking on this link, the provider selects a child’s name from the list.

Once in the child’s record, the provider clicks on the Services tab and then clicks on Progress Notes in the drop down menu. There is a button to enter either a daily therapy log or a monthly progress note. After selecting the button for Daily Therapy Log or Monthly Progress Note, the provider enters information related to the date(s) of service. “Saved Successfully” appears in a green message bar at the top of the screen when the required documentation is complete.

Once saved, the log or the note can be reviewed by selecting a specific line from the grid on the screen. A provider may also review documentation entered by other providers assigned to serve the same child and family.

If the child’s record is active but the provider’s authorization is inactive, then the provider has 90 days to access the child’s record in WebSPOE through the Progress Notes Due link on the Home Page. This link contains a listing of all progress notes that are due (i.e., notes not completed within the last 30 days).

Using these procedures, a daily therapy log or monthly progress note can be entered in the child’s record when it is active, or up to 90 days from the date the child’s record was inactivated or the authorization ended.

B. Child Record is Inactive

When the child’s record is inactive, the provider has 90 days from inactivation to access the child’s record in WebSPOE through the Progress Notes Due link on the Home Page.

After the 90-day timeline has passed, the provider can enter documentation of delivered services in WebSPOE by logging into the system and going to the Provider Account Management tab at the top of the screen. From the drop down menu of the tab, the provider selects Authorization Search to locate the authorization. The provider either enters the authorization number or the child’s name to locate the authorization.
Search for an Authorization. When searching for an authorization, the provider should check the filter for Active, Inactive or All within the search results, as applicable to the status of the child’s authorization.

Once the correct authorization is found, double click on the authorization to display the “Authorization Detail” page. At the bottom of this page there are several buttons. Find the button labeled “Enter Progress Notes.” Click the “View Progress Notes” button to display the Progress Notes page. Select either the “Add Daily Therapy Log” or “Add Monthly Progress Note” button to enter a progress note for the child.

Using these procedures, there is no timeline for entering a daily therapy log or a monthly progress note in a child’s record that has been inactivated.

C. Claim Submission

Beginning in January 2017, a reminder to enter required documentation appears in WebSPOE. For users who have claim entry access, when the user logs into WebSPOE to enter a claim, a message appears to remind the user to enter a daily therapy log or monthly progress note.

The reminder appears when the user accesses the Provider Account Management tab and then either selects Claim Entry or Authorization Search – Enter Claim. The message says: “Reminder: a daily therapy log or monthly progress note is required for all delivered services prior to entering claims.”
SECTION III: RECORDKEEPING

According to the Missouri First Steps Service Provider Agreement, the provider agrees to maintain accurate clinical records for a period of time after ending services with a child and family. Clinical records maintained in WebSPOE (e.g., claim and payment data, daily therapy logs, progress notes, the child’s IFSP, uploaded evaluation reports) are kept without time limits.

Clinical records maintained at the provider’s location must be retained by the provider for at least five years, including:

- Financial records (e.g., therapy logs, progress notes, evaluation reports)
- Medical or educational records (e.g., physician prescriptions, hospital discharge summaries, physician records)

Upon request, the provider must make available to DESE, or its designee, all records necessary to assure the appropriateness of payments and compliance with state and federal regulations or state laws applicable to First Steps.

All First Steps services are subject to federal, state and local audits and financial monitoring. For more information about activities related to audits and monitoring, see Chapter 9: Billing and Accountability.
SECTION IV: FREQUENTLY ASKED QUESTIONS

Question 1: Is the time spent writing a therapy log or monthly progress note billable time?

   Answer: No.

Question 2: If a provider maintains a paper therapy log, is a daily therapy log in WebSPOE required?

   Answer: No.

Question 3: If a provider maintains a paper therapy log, is a monthly progress note in WebSPOE required?

   Answer: Yes.