**Procedural Standard 99-7 August 21, 2013**

TO: All DES Staff

FR: A. E. Adams, Ph.D. Director, Disability Evaluation Services

BY: Sherry Campanelli, Program Compliance Manager

**RE: Progress Notes and Documentation of Case Files**

**Purpose:** The purpose of this memorandum is to emphasize the importance of progress notes for documenting actions performed, and interactions with applicants, interested parties or agency personnel regarding cases reviewed by the DES.

**Background: Progress notes (PN)** is the term DES uses for the method of documenting a Disability Evaluation Services (DES) case record. Progress notes document the course of an applicant’s disability review from the moment of intake at DES to the time of closure and beyond. They are also a primary vehicle for DES staff to efficiently and effectively communicate with each other about the course of a disability review or when processing subsequent claims and appeals of adverse claims actions. Progress notes serve as a permanent, legal record of events relating to an applicant’s disability determination process. They allow others outside DES including our customer agency representatives and Hearings Officers as well as the client and their representatives a retrospective review of what occurred during the disability review process. Progress notes also document that DES is compliant with the rules and regulations governing our work, e.g.-HIPAA.

Progress notes are part of the case file. The case file is a permanent written collection of documents and information required to determine disability.[[1]](#footnote-1) The case file or copies of it may be requested and viewed by the client/their representative and/or be used in legal proceedings. All DES staff may be involved at some point in entering progress notes as they record the actions they take on cases. Therefore, it is important that all staff understand the importance of progress notes and be able to enter them appropriately and timely so that the disability determination process is fully documented.

**Procedure:** Progress notes fall into the following major categories:

1. **General** progress notes are those that provide information about what is happening on the case; what actions the agency (DES) is taking; what actions the client has/is taking, and/or what communications are occurring regarding the case with the client/others as well as providing the vehicle for identifying critical case information, e.g. expedited status. General progress notes provide information about how the case has progressed since the last note including classification of process statuses as defined within the agency. General progress notes indicate the opening and closing of a case and all activities in between. General progress notes may also be used to record individual case activities that occur on a closed case, e.g. inquiries, etc.
2. **Purchase decisions** are entered as progress notes such as the decision to request a consultative examination.
3. **Disability Determination process decisions** at each step up to and including the final decision are recorded in progress notes as well as the rationale behind the decision in brief form. Examples include request for CEs, need for a residual functional capacity, sufficiency of available information, and the basis for return as a ‘501’. Typically assigned staff is required to enter a progress note at each major ‘status’ in the process.
4. Progress notes also **record activities** related to the individual that are not necessarily a part of the process of disability determination itself, e.g. – processing of requests for release of information; selection of case for Quality Assurance review.
5. **Coding** for certain systems reporting is also required to be entered in progress notes as instructed. Examples include RACC1 for ‘reasonable accommodations.’

About progress notes content at DES:

1. Progress notes tell the story of who, what, when, where and why.
2. The DEScovery system *automatically* generates some progress notes for certain repetitive case processes. DEScovery also automatically records the date and the employee ID number of the staff person who enters a progress note.
3. Some DES procedures specify that standard wording/coding be entered *manually* to document recurring events in the disability determination process. Language and instructions for this type of entry is found in the various procedural manuals or management/supervisory directives for specific staff roles. e.g. [Procedural Standards](file:///G:\DES%20Guide\Procedural%20Standards); [Progress Note Guidelines (Revised);](file:///G:\CTC%20folder\Progress%20Note%20Guidelines%20Revised%209.17.12%20(2).docx) [DA Process Guide](file:///G:\DA%20PROCESS%20GUIDE%202013); training materials and memos; emails from managers.[[2]](#footnote-2) Examples of these situations are as follows:
   1. ND coding/RACC1 coding
   2. Use of ‘255’ code
   3. Curtailment of medical case development
4. When there is not a system-generated or specifically-defined language for a progress note, staff record their actions on a case using the following principles:
   1. Identify the person, their role and/or the relationship if not the client, as well as sufficient information for a re-contact, if necessary, when recording a communication with someone inside or outside DES.
   2. Identify the type of contact whether in person or by telephone.
   3. Describe the event.
   4. Describe why the contact is important to the review process
   5. Recount the transaction
   6. Use simple, explicit and objective language. Avoid negative comments about the client or others even if recording an unpleasant interaction. Avoid language that reflects your opinion.
   7. Avoid abbreviations unless approved by your supervisor or use only commonly accepted medical abbreviations.
   8. **Remember that you are creating an official record that the client and our customers may see and/or that may be part of a legal proceeding so proofread and correct your errors.**
   9. Be brief but complete enough so that the next staff person could continue processing from the point of the latest progress note. Examples:

*Example #1: “T/C to client- DRTA1 to obtain duties/physical demands of past work. Client’s job title “grinder maker” refers to work as a sandwich maker in a deli shop. She stood at a counter and built sandwiches to the customer’s specifications and then wrapped and bagged them. She also worked the cash register. Stood approximately 6 hours and walked back and forth the rest of the day to restock counter. Maximum lift was 20 pounds but often she lifted less than 10 pounds.”*

*Example #2: “Parent returned my call regarding child’s IEP. She has a copy and will mail it to me today. DES PO Box address provided.”*

*Example #3 “-RBC-Call from client. Verified address, SS# & DOB & phone#.  Requesting reschedule of 8/5/2013 CE appt with Dr. X.  Client has another appt to attend.  Will reschedule CE appt. - LGC.”*

*Example #4 “Call from clt.    SS#   demos confirmed.    Clt was calling to confirm the info he had sent in was rec'd. DA reviewed the dates and confirmed all info rec’d. Noted info received from Mass Rehab as well.”*

**Summary**: All actions performed by DES staff and interactions occurring between DES staff and interested parties must be recorded in the applicable applicant’s case file in an objective, concise but complete manner.

1. (variation of MassHealth regulatory definition of a case file.) [↑](#footnote-ref-1)
2. Staff must be adequately familiar with and follow the specific Progress Note requirements/instructions relating to their individual job duties. [↑](#footnote-ref-2)