CenCal HEALTH®
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Behavioral Health Documentation and Review Readiness Manual

Supporting Quality Care, Medical Necessity, and Documentation Excellence. A Practical Guide for Behavioral Health.

Behavioral Health Department

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Introduction

Behavioral health documentation is an essential component of quality care. Documentation supports continuity of treatment, demonstrates medical necessity, promotes communication among providers, and ensures services are accurately reflected in the clinical record.

This manual is intended to support behavioral health providers in maintaining complete, individualized, and clinically meaningful documentation that supports both quality care and audit readiness. It applies to providers rendering Non-Specialty Mental Health Services (NSMHS) under CenCal Health's Medi-Cal managed care benefit, consistent with DHCS All Plan Letter (APL) 26-002. It does not address documentation requirements specific to Specialty Mental Health Services (SMHS), Drug Medi-Cal, or the Drug Medi-Cal Organized Delivery System (DMC-ODS), which are governed separately through the county Mental Health Plan. For additional compliance, coding, and billing requirements, refer to the CenCal Health Provider Manual and other applicable Medi-Cal guidance.

The goal is not perfect documentation. The goal is a clear clinical record that tells the clients' treatment story and supports the services provided.

Why Documentation Matters

High-quality documentation:

Supports Quality Care

Creates a clear record of treatment and member progress over time.

Demonstrates Medical Necessity

Shows why services are clinically appropriate and necessary.

Supports Billing Integrity

Ensures documentation accurately reflects the services rendered and billed.

Promotes Continuity of Care

Allows providers to coordinate and transition care effectively.

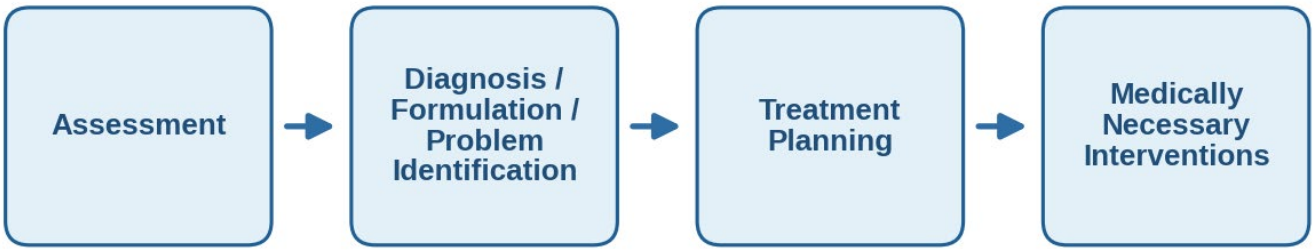
Supports Audit Readiness

Helps providers confidently respond to documentation reviews and audits.

Documentation Standard: The documentation requirements outlined in this manual apply regardless of service modality or documentation platform, including telehealth and in-person services, as well as electronic and paper records. Documentation should be complete, accurate, timely, and reasonably legible.

Connection to Practice

Clinical best practice should demonstrate a clear connection between:



Each component should support the next and tell a consistent clinical story.
See Sections 2 and 3.
A reviewer of clinical documentation should be readily able to understand:

- Who was in attendance/accompanying the client at each appointment as applicable
- Why did the client seek treatment?
- What diagnosis or clinical formulation supports treatment?
- What goals were established?
- What interventions were provided?
- What progress has occurred?
- Why does treatment remain medically necessary?
- What are the criteria for discharge?

Section 1: Required Components of the Medical Record

Client/Member Identification

Each record should include:
✓ Member Name
✓ Date of Birth
✓ Member ID

Informed Consent

Documentation should reflect that informed consent was obtained through either a signed consent form or documented verbal consent. Standardized forms, checklists, etc. may be used as appropriate
Documentation of informed consent should provide a record of a discussion about:
✓ Nature and purpose of treatment
✓ Provider name, credentials, and license type
✓ Risks and benefits of treatment
✓ Alternatives to treatment, including no treatment
✓ Limits of confidentiality
✓ Client rights, including the right to withdraw consent
✓ Billing practices and financial responsibility
✓ Privacy and HIPAA protections
✓ Language access needs, including whether an interpreter was offered, used, or declined
✓ Notice of record-keeping practices, including how records may be accessed, used, or disclosed (e.g., in response to a subpoena, court order, or litigation, client request)

Additional Recommended Elements

✓ Telehealth consent and client's location at the time of service
✓ Emergency/after-hours contact
✓ Crisis procedures
✓ Office policies e.g. cancellations, no shows, late arrivals, appointment lengths etc.

Privacy and HIPAA Acknowledgment

Documentation should indicate that the client received appropriate information about privacy and confidentiality. Providers should also take reasonable steps to protect the confidentiality of paper and digital records through physical and electronic safeguards.[1]

Record Retention

Providers should retain full records for a minimum of ten years.
All NSMHS must be provided in a culturally and linguistically appropriate manner. When services are delivered in a language other than English or an interpreter is used, document the client's preferred language and the interpreter arrangement. The use of

[1] Providers who keep separate psychotherapy process notes should store them separately, since they carry heightened federal protection and generally are not required to be released with the general record

family members may or may not be appropriate and should be considered on a case-by -case basis

For clients age 12 through 17, the applicable consent standard should be identified and utilized — parent or guardian consent, or the minor's own consent to outpatient mental health treatment where permitted under California Family law along with the reasoning for that determination.

Section 2: Initial Assessment & Intake Evaluation

The assessment establishes the foundation for treatment and supports medical necessity.
A complete assessment typically includes:

Presenting Problem

Why is the client seeking treatment? Are there any functional impairments?

Relevant Clinical History

- Mental health history
- Medical history—current and past illness and/or injury
- Current medications (psychiatric and non-psychiatric), including prescriber if known
- Substance use history (if applicable)
- Trauma history and trauma-related experiences (when clinically relevant)
-
- Previous treatment history
- Any special needs or accommodation: language, mobility, vision

Psychosocial Information

Relevant social, family, educational, occupational, and cultural factors, including language preferences and any criminal, civil, or other justice system involvement.

Clinical Observations

Mental status and provider observations.

Standardized Assessment Tools

When clinically appropriate, standardized assessment and screening tools may be used to support symptom identification, diagnostic clarification, treatment planning, and outcome monitoring. Examples include the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Columbia Suicide Severity Rating Scale (C-SSRS), and other validated screening or symptom assessment tools.

Risk Assessment

Current and historical safety concerns.

Diagnosis or Clinical Formulation

Clinical findings should support the diagnosis or formulation.[2]

[2] A formal diagnosis is not required to begin NSMHS. Clinically appropriate NSMHS delivered during the assessment period before a diagnosis is reached, or before it is determined whether the member meets NSMHS or SMHS criteria remain covered, provided assessment documentation supports the service with presenting symptoms, functional concerns, and clinical rationale.

Clinical Rationale/Formulation

Documentation should make clear the medical necessity of treatment.
Coverage does not depend on the service being reflected in an individual treatment plan, and is not affected by a co-occurring substance use disorder or concurrent SMHS, provided services are coordinated and not duplicated

Section 3: Medical Necessity

Medical necessity is one of the most important components of behavioral health documentation.

For members age 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain. For members under age 21, the federal EPSDT (Early Prevention Screening Diagnosis and Treatment) standard applies instead: services that, maintain, improve, or make a condition more tolerable satisfy the standard and should be documented as such.[3]

A simple definition of medical necessity is that:

At the initiation of treatment, it should be clear that services are

- Indicated
- Appropriate
- Efficacious

With the continuation treatment over time services should be:

- Effective
- Efficient

Providers often ask how or they should document and demonstrate the medical necessity of care. It is really throughout the record and is reflected in the assessment and formulation as well as in ongoing progress notes, but perhaps the most succinct documentation of medical necessity is in the treatment plan

Symptoms

What mental health symptoms are occurring?

Functional Impairment

How are mental health symptoms affecting daily life?

Examples:

- Work performance
- School functioning
- Family relationships
- Social functioning
- Sleep
- Self-care

[3] NSMHS — unlike Specialty Mental Health Services (SMHS), delivered through the County Mental Health Plan — is the appropriate level of care for: members 21 and older with mild-to-moderate distress or impairment; members under 21 who are EPSDT-eligible, regardless of severity or diagnosis; and members of any age with a potential, not-yet-diagnosed mental health disorder. Documentation showing significant impairment or a reasonable probability of significant deterioration may instead indicate SMHS criteria and warrant referral to the County Mental Health Plan.

- Ability to maintain safe and stable housing
- Ability to remain and participate safely int the community

Clinical Need

Why is treatment needed now? What is the appropriate intensity and frequency of treatment? Are there applicable evidence-based practices?

Ongoing Need for Treatment

Why should treatment continue?

Examples

A statement such as "Client reports anxiety." will not likely provide sufficient documentation of medical necessity

"Client reports persistent anxiety characterized by excessive worry, sleep disturbance, difficulty concentrating, and irritability. Symptoms continue to interfere with occupational functioning and interpersonal relationships. Ongoing treatment remains medically necessary to reduce symptom severity and improve daily functioning."

Section 4: Treatment Planning

While a thoughtful treatment plan can serve as a very useful roadmap of care for the provider and the client, recent DHCS regulations have removed the requirement of a *formal* treatment plan Instead the elements of a treatment may and should be included in the rest of your clinical record.
The use of structured progress noes (e.g. SOAP, etc) can be helpful. Some providers have found that a simple and succinct statement of medical necessity shout be part of every service note

The key elements of a treatment plans included in the record should document:
✓ Clinical problems being addressed
✓ Measurable goals
✓ Specific objectives
✓ Planned interventions
✓ Therapeutic approach
✓ Periodic review and updates
Goals and interventions should be linked to presenting symptoms, diagnosis, and clinical needs.

Updating the Treatment Plan

Treatment planning is an ongoing process and may be updated throughout the course of treatment to address client needs.
For example, if an additional mental health problem or related issue arises during treatment and needs to be addressed, the diagnosis may be included, the associated problems identified, and treatment goals updated to include those interventions.
The elements of a treatment plan and medical necessity should be reviewed and updated at regular intervals to help assure that clients are making progress and receiving the appropriate level of care.

Example Goal

Restore baseline occupational functioning impaired by anxiety

Example Objective

Client will reduce panic attacks from four times per week to one time per week within 90 days.

Example Intervention

Provider will utilize Cognitive Behavioral Therapy to challenge maladaptive thought patterns and increase coping skills.

Section 5: Progress Notes

A progress note should be completed for each billable service.
Each note should include:
✓ Type of service
✓ Date of service

✓ Duration of service
✓ Location of service (including telehealth and client's location at time of service)
✓ Provider signature and credentials
✓ Clinical interventions utilized
✓ Assessment of client response and Progress toward goals
✓ Other details supporting medical necessity
✓ Plan and next steps

Documentation Tip

The documented service duration should support the procedure code billed.

Writing Strong Progress Notes

Every progress note should make clear:
Why was treatment needed today?
What intervention was provided?
How did the member respond?
What progress occurred?
Why is treatment still medically necessary?
What is the plan moving forward?

Section 6: Risk Assessment Documentation

Risk assessment is an important component of behavioral health treatment.
Standardized risk assessment tools such as the Columbia-Suicide Severity Rating Scale (C-SSRS) may be helpful
As appropriate documentation should include attention to

Risk of suicide

Current thoughts, intent, plan, means, and protective factors.

Risk of other Self-Harm

Current or historical self-injurious behavior.

Risk of Harm to others

Threats, intent, access to means, and protective factors.

Substance Use Concerns

Current use patterns and associated risks.

Protective Factors

Family support, treatment engagement, coping skills, future orientation, community supports.

Safety Planning

Document the plan developed to support client in staying safe in the community.

Section 7: Medication Documentation

When applicable and within provider scope:
✓ Ongoing and changes to medication orders
Informed consent for each medication prescribed
✓ Prescriptions
✓ Medication monitoring including blood levels and drug-drug interactions
Checking CURES related to the use of controlled substances✓ Medication-related progress notes
✓ Side effects
✓ Client response to medication

Section 8: Releases of Information

When information is shared with another party a valid authorization should must be fully HIPAA compliant and include:
✓ Client information
✓ Authorized releasing party
✓ Authorized receiving party
✓ Information to be released
✓ Purpose of disclosure
✓ Expiration date or event
✓ Revocation statement
✓ Redisclosure statement
✓ Member signature
✓ Date signed

Section 9: Coordination of Care

When applicable, documentation may include:
✓ Communication with primary care providers
✓ Communication with psychiatrists
Coordination with ECM providers as appropriate
✓ School collaboration
✓ County behavioral health coordination
✓ Care coordination activities
✓ Collateral contacts
Examples should clearly relate to treatment planning, service coordination, or client care.

Section 10: Discharge/termination Documentation

When treatment ends, documentation should include:

✓ Reason for discharge
✓ Summary of treatment provided
✓ Progress toward goals
✓ Clinical status at discharge
✓ Referrals and recommendations
✓ Follow-up instructions

Section 11: Documentation Integrity, Coding & Billing Alignment

Documentation should accurately reflect the services rendered.
Documentation should:

- Support the service billed
- Reflect individualized treatment
- Demonstrate medical necessity
- Be completed in a timely manner
- Be consistent with the clinical record

Common Concerns

Documentation may not adequately support services when it is:

- Incomplete
- Generic
- Duplicative or "canned"
- Inconsistent with the billed service
- Missing clinical rationale

Audit Readiness

Clinical documentation should be complete, accurate, timely, and consistent with the services billed.
Documentation may be reviewed through routine quality improvement activities, medical record reviews, utilization management processes, payer audits, or regulatory audits. The clinical record should clearly support the medical necessity, frequency, intensity, duration, and type of service billed.
To be considered audit-ready, documentation should demonstrate:

- Medical necessity for treatment
- The client's diagnosis and presenting symptoms
- Functional impairment and clinical need
- The interventions provided
- Progress toward treatment goals
- Session duration
- Clinical rationale for treatment frequency and intensity
- Consistency between the documentation and the CPT code billed

Incomplete, inconsistent, or unsupported documentation may result in additional review, claim denial, payment recoupment, or corrective action.

Psychotherapy Coding Guidelines: 90834 vs. 90837[4]

CPT Code	Session Label (midpoint)	Actual Time Required	Typical Use
90832	30 minutes	16 to 37 minutes	Brief psychotherapy interventions
90834	45 minutes	38 to 52 minutes	Standard weekly therapy sessions
90837	60 minutes	53+ minutes	Extended sessions where appropriate

CPT 90834

Individual Psychotherapy

- 38 to 52 minutes of psychotherapy
- Standard outpatient psychotherapy code
- Appropriate when psychotherapy services are provided for fewer than 53 minutes

Documentation should include:

- Presenting symptoms and clinical status
- Interventions provided
- Progress toward treatment goals
- Ongoing medical necessity for treatment
- Total session time

CPT 90837

Individual Psychotherapy

- 53 or more minutes of psychotherapy
- Extended-duration psychotherapy code
- Appropriate only when the psychotherapy service meets the required time threshold and documentation clearly supports the medical necessity for the extended duration

[4] Time billed includes only time spent with the member, it does not include documentation time. If a provider spends 45 minutes with a client and documents for 10 minutes, they should bill 90834.

Documentation should include:

- All elements required for 90834
- Total session time demonstrating 53+ minutes of psychotherapy
- Clinical rationale supporting the need for the extended session
- Interventions and therapeutic work completed during the additional time
- Evidence that the duration was medically necessary and clinically appropriate

Documentation Expectations[5]

The selected CPT code must accurately reflect the service provided.
Documentation should clearly support:

- The client's diagnosis and clinical presentation
- Medical necessity for treatment
- The interventions provided
- Progress toward treatment goals
- Session duration
- The level of service billed

Medical Necessity and the 90837 Code

CPT code 90837 represents psychotherapy lasting 53 minutes or longer. Because 90837 reflects a higher-intensity service than 90834, it may receive increased scrutiny during medical record reviews and payer audits.
Documentation should clearly support:

- The duration of the psychotherapy service
- The clinical need for the extended session length
- The interventions provided
- Progress toward treatment goals
- Ongoing medical necessity for treatment at this level of intensity

The selected CPT code must accurately reflect the service provided and the documentation contained within the medical record.

Higher Frequency Treatment

Weekly psychotherapy is considered standard outpatient care. Services exceeding weekly frequency should be supported by documentation demonstrating:

[5] These documentation requirements apply the same regardless of whether the service is delivered in person, via telehealth, or by telephone.

- Medical necessity
- Functional impairment
- Treatment goals
- Rationale for increased frequency
- Anticipated duration of intensified treatment
- Plan for transition to routine outpatient treatment when clinically appropriate

Services provided at a frequency greater than once per week may receive additional scrutiny during medical record reviews, utilization management activities, or audits and should be supported by clear clinical documentation.
Examples of circumstances that may support increased treatment frequency include:

- Recent psychiatric hospitalization or crisis episode
- Significant functional impairment
- Severe depression, anxiety, PTSD, OCD, or other serious behavioral health conditions
- Active safety concerns requiring close monitoring
- Evidence-based treatment protocols requiring increased session frequency
- Demonstrated benefit from intensive outpatient psychotherapy with continued clinical need

Extended Course of Treatment

A course of outpatient psychotherapy exceeding 16 sessions should be supported by documentation demonstrating why continued treatment is needed.
Documentation should clearly support:

- Medical necessity and clinical rationale for continued treatment
- Functional impairment or symptoms supporting the need for ongoing care
- Progress toward treatment goals and any updates to the treatment plan
- Anticipated duration of continued treatment
- Plan for transition to routine outpatient treatment, step-down care, or discharge when clinically appropriate

Examples of circumstances that may support continued treatment beyond 16 sessions include:

- Chronic or complex behavioral health conditions requiring a longer course of care
- Slower-than-expected progress toward treatment goals with continued clinical need

- Co-occurring conditions complicating recovery
- A recent exacerbation of symptoms or new stressor affecting the member's clinical presentation
- Ongoing safety concerns requiring continued monitoring

Evidence-based treatment protocols that call for an extended course of care

Compliance & Audit Reminder

Providers are responsible for ensuring that the CPT code submitted accurately represents the service delivered and documented in the clinical record.
As a provider, health plans trust you to deliver medically necessary, cost-effective, and clinically appropriate care. When claims are submitted for services rendered, the provider attests that the services were provided, medically necessary, appropriately documented, and billed in accordance with applicable requirements.[6]

Billing practices that may result in compliance concerns include:

- Billing a higher level of service than was provided
- Billing medically unnecessary services
- Billing services not rendered
- Billing services provided by unqualified or improperly supervised individuals
- Billing services performed by individuals excluded from participation in federal healthcare programs
- Billing services of such poor quality that they fail to meet accepted standards of care
- Submitting claims that are not supported by the clinical record

Complete, accurate, and timely documentation is the best defense during an audit and should clearly support the frequency, intensity, duration, and type of service billed.

Common Documentation Findings & How to Avoid Them

Finding	Recommendation
Medical necessity not clearly documented	Include symptoms, impairment, and clinical need
Missing intervention	Document what therapeutic intervention was used
Missing progress	Describe improvement, barriers, or symptom changes
Missing risk assessment	Include current safety assessment when clinically appropriate

[6] Providers are contractually obligated, under their CenCal Health Provider Services Agreement, to release member medical records to CenCal Health upon request.

Finding	Recommendation
Generic language	Use individualized, client-specific documentation
Missing treatment plan connection	Reference goals and objectives addressed
Documentation does not support billed service	Ensure duration and interventions align with billing

Documentation Readiness Checklist

Intake Assessment

□ Presenting problem documented
□ Clinical history completed
□ Risk assessment completed
□ Diagnosis supported
□ Medical necessity established

Treatment Plan

□ Goals linked to diagnosis
□ Objectives measurable
□ Interventions identified
□ Treatment plan current

Progress Notes

□ Symptoms documented
□ Interventions documented
□ Progress documented
□ Medical necessity documented
□ Risk assessed
□ Plan included
□ Supports billed service
□ Signed with credentials

Final Thoughts

Strong documentation does not need to be lengthy.
Strong documentation is:
✓ Accurate
✓ Individualized
✓ Clinically meaningful
✓ Supportive of medical necessity
✓ Consistent with services rendered
✓ Connected to treatment goals
The best documentation tells the member's treatment story, demonstrates the value of the care provided, and supports high-quality behavioral health services.

Appendix A: Common Documentation Formats & Examples

Behavioral health providers may utilize a variety of documentation formats. Regardless of format, documentation should support medical necessity, reflect the services provided, and demonstrate progress toward treatment goals.

CPT Code	Session Label (midpoint)	Actual Time Required	Typical Use
90832	30 minutes	16 to 37 minutes	Brief psychotherapy interventions
90834	45 minutes	38 to 52 minutes	Standard weekly therapy sessions
90837	60 minutes	53+ minutes	Extended sessions where appropriate

SOAP Note

SOAP is one of the most commonly used clinical documentation formats.

SOAP Component	Documentation Guidance
S – Subjective	Information reported by the client, including symptoms, concerns, experiences, and perceptions.
O – Objective	Observable or measurable information, including mental status observations, behaviors, and relevant clinical findings.
A – Assessment	Clinical interpretation of the information gathered during the session, including progress, barriers, symptom severity, and medical necessity.
P – Plan	Next steps, interventions, homework, referrals, follow-up plans, and ongoing treatment recommendations.

SOAP Note Example

SOAP Component	Example Documentation
S – Subjective	Client reported increased anxiety related to workplace performance expectations. Client described excessive worry, difficulty concentrating, and disrupted sleep occurring several nights per week. Client reported feeling overwhelmed by upcoming deadlines.
O – Objective	Client appeared alert and oriented. Mood was anxious with congruent affect. Speech was clear and coherent. No evidence of thought disorder observed. Member actively participated in session and demonstrated insight into current stressors.
A – Assessment	Symptoms remain consistent with Generalized Anxiety Disorder and continue to interfere with occupational functioning. Therapist utilized cognitive restructuring techniques to

	challenge maladaptive beliefs regarding perfectionism and performance expectations. Client demonstrated increased insight into anxiety triggers and identified two coping strategies to implement between sessions. Ongoing treatment remains medically necessary due to continued functional impairment related to anxiety symptoms. Client denied suicidal or homicidal ideation.
P – Plan	Continue weekly therapy utilizing Cognitive Behavioral Therapy interventions. Client will practice identified coping strategies and complete a thought record between sessions. Follow-up scheduled for next week.

DAP Notes

DAP notes are concise and commonly used in behavioral health settings.

DAP Component	Documentation Guidance
D – Data	Session content, symptoms, observations, and interventions.
A – Assessment	Clinical interpretation, progress toward goals, and medical necessity.
P – Plan	Next steps and treatment recommendations.

DAP Note Example

DAP Component	Example Documentation
D – Data	Client reported increased anxiety related to workplace stress and upcoming deadlines. Therapist utilized cognitive restructuring and psychoeducation regarding the relationship between thoughts, emotions, and behaviors. Client actively engaged in discussion and identified common cognitive distortions contributing to anxiety.
A – Assessment	Client continues to experience anxiety symptoms that interfere with occupational functioning. Increased insight into anxiety triggers and maladaptive thought patterns was observed during the session. Progress noted toward treatment goal of reducing anxiety symptoms through development of coping skills. Ongoing treatment remains medically necessary due to continued functional impairment related to anxiety symptoms. No current safety concerns identified.
P – Plan	Continue weekly CBT sessions. Client will practice cognitive restructuring exercises between sessions and review outcomes at the next appointment. Follow-up scheduled for next week.

BIRP Notes

BIRP notes provide a structured format that emphasizes interventions and member response.

BIRP Note

BIRP Component	Documentation Guidance
B – Behavior	Presenting symptoms, concerns, and observed behaviors.
I – Intervention	Therapeutic interventions provided.
R – Response	Client response to treatment and progress.
P – Plan	Next steps and treatment recommendations.

BIRP Note

BIRP Component	Example Documentation
B – Behavior	Client reported ongoing anxiety characterized by excessive worry, sleep disturbance, and difficulty concentrating related to workplace demands.
I – Intervention	Therapist utilized cognitive restructuring techniques to challenge maladaptive beliefs regarding performance expectations. Psychoeducation provided regarding anxiety symptoms and stress management strategies.
R – Response	Client actively participated in session and demonstrated increased insight into anxiety triggers. Client identified two coping skills to practice before the next appointment and verbalized confidence in implementing them.
P – Plan	Continue weekly therapy focused on anxiety management and cognitive restructuring. Follow up next week.

Comparing Documentation Quality

Less Effective

"Client discussed work stress. Therapist provided support."

Better

"Client reported increased anxiety related to workplace demands. Therapist utilized cognitive restructuring techniques to address maladaptive thought patterns contributing to anxiety symptoms."

Strong

"Client reported increased anxiety characterized by excessive worry, sleep disturbance, and difficulty concentrating related to workplace demands. Therapist utilized cognitive restructuring techniques to challenge maladaptive beliefs regarding performance expectations. Client demonstrated increased insight into anxiety triggers and identified two coping strategies to implement between sessions. Symptoms continue to interfere with occupational functioning, supporting ongoing medical necessity. Client denied suicidal or homicidal ideation. Plan to continue CBT interventions at next session."

Appendix B: EPSDT & Behavioral Health Services for Children and Youth

What is EPSDT?

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federally required Medicaid benefit for members under age 21.
EPSDT is designed to ensure children and youth receive medically necessary services to correct or improve physical and behavioral health conditions.

Key EPSDT Principles

Diagnosis Is Not Always Required to Begin Services

Children and youth may receive medically necessary behavioral health services when symptoms, concerns, or risk factors are identified, even when a formal diagnosis has not yet been established.

Early Intervention Matters

Services may be provided to:

- Prevent worsening symptoms
- Address emerging behavioral health concerns
- Support healthy development
- Improve functioning

Medical Necessity Under EPSDT

For members under age 21, services may be covered when they are necessary to:
Correct
Improve
Maintain
Prevent worsening of a behavioral health condition

Documentation Tips

Document:
✓ Presenting concerns
✓ Functional impacts
✓ Developmental concerns
✓ Family concerns
✓ Clinical observations
✓ Rationale for treatment
Even when a formal diagnosis has not yet been established.

Example

A child experiencing increasing anxiety, school avoidance, emotional dysregulation, and declining functioning may require treatment even if a definitive diagnosis has not yet been assigned.
Documentation should focus on symptoms, functional impairment, and clinical rationale for treatment.

Appendix C: Common Behavioral Health Codes & Modifiers

The following information is provided as a general reference. Providers should verify current CPT, HCPCS, modifier, Medi-Cal, and CenCal billing requirements prior to submitting claims.

Common Psychotherapy Codes

Service	CPT Code
Diagnostic Evaluation	90791
Individual Psychotherapy (16-37 min)	90832
Individual Psychotherapy (38-52 min)	90834
Individual Psychotherapy (53+ min)	90837
Family Therapy Without Member Present	90846
Family Therapy With Member Present	90847
Group Psychotherapy	90853

Modifier	Description
95	Telehealth Services
HO	Associate / Registered Provider
93	Telehealth Services (Synchronous Audio-Only)
33	Preventive Perinatal Depression Counseling
59	More than one non-duplicate service provided on same day (individual therapy and family therapy)

Telehealth Documentation Requirements

When services are provided via telehealth, documentation should include:

✓ Service delivered via telehealth
✓ Date of service
✓ Duration of service
✓ Clinical interventions provided
✓ Medical necessity
✓ Telehealth consent, when applicable
✓ Appropriate modifier usage
✓ Whether the session was audio-only or audio-visual (video), and the applicable modifier (93 for synchronous audio-only; 95 for synchronous video)

Associate Provider Billing

When services are provided by an associate provider, use modifier HO in accordance with current billing requirements.

Providers should ensure:

✓ Associate is appropriately credentialed

✓ Documentation reflects the rendering provider
✓ Services support medical necessity
✓ Billing aligns with credentialing status
✓ Documentation should be signed by a Licensed Clinical Supervisor.

Appendix D: Sample Forms & Templates

Informed Consent for Mental Health Services

Patient Name: _____
Date of Birth: _____
Therapist Name: _____
Credentials / License Type: _____

1. Purpose of This Form

This form provides information about the mental health services you will receive and your rights as a client. Your consent, either signed below or documented verbally in the medical record, is required before treatment begins.

2. Nature and Purpose of Mental Health Services

The purpose of therapy is to help you address emotional, behavioral, or mental health concerns through evidence-based interventions. Sessions may include assessment, psychotherapy, psychoeducation, and other therapeutic techniques as clinically indicated.

3. Therapist Information

Your therapist is (Name/Credentials): _____

4. Risks and Potential Benefits

Potential Benefits:
Improved coping skills and emotional well-being
Enhanced insight into thoughts, feelings, and behaviors
Progress toward treatment goals
Potential Risks:
Emotional discomfort, distress, or temporary worsening of symptoms
Uncovering or confronting difficult personal issues
Your therapist will discuss any risks specific to your treatment as appropriate.

5. Alternatives to Proposed Treatment

You have the right to consider alternatives, including:
Other types of therapy or mental health services
Medication management or combined treatment
Choosing no treatment at this time

6. Limits of Confidentiality

Information shared in therapy is confidential, with the following exceptions:
Danger to self or others: Your therapist must take steps to prevent serious harm.
Child, elder, or dependent adult abuse: Mandated reporting is required by law.
Court orders or legal requirements: Records may be released if required by a court.

7. Client Rights

You have the right to:
Refuse or withdraw consent for treatment at any time
Ask questions about your care
Receive clear information about your therapy and treatment options

8. Fees and Billing Practices

Services are billed to Medi-Cal or, if applicable, you may be responsible for any copayments or fees as discussed. Please ask your therapist if you have questions about billing.

9. Use and Protection of Records

Your mental health records are protected under HIPAA and other privacy laws. Records are used for treatment planning, quality assurance, and billing. Your therapist will not release information without your written consent except as required by law.

10. Consent Acknowledgment

I have read and/or received a verbal explanation of the information above. I understand my rights and the nature of the services.

Consent Method (check one):

☐ Signed consent form (recommended)

☐ Verbal consent documented in the medical record

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Notes / Special Instructions:

_____

_____

_____

_____

Telehealth Consent Form

Patient Name: _____
Date of Birth: _____
Therapist Name: _____
Credentials / License Type: _____

1. Purpose of Telehealth Services

Telehealth involves delivering mental health services via secure video, audio, or other electronic communication technologies. Telehealth allows you to receive therapy remotely while maintaining continuity of care.

2. Therapist Information

Your therapist is (Name/Credentials): _____

3. Nature and Purpose of Telehealth

Telehealth sessions may include assessment, psychotherapy, psychoeducation, and other interventions as clinically indicated. The goals are the same as in-person therapy: improving emotional, behavioral, and mental health functioning.

4. Potential Risks and Benefits

Potential Benefits:

Increased access to mental health services
Convenience and flexibility
Continued treatment during emergencies or barriers to in-person visits

Potential Risks:

Technical difficulties or interruptions (internet issues, audio/video failure)
Confidentiality breaches due to technology
Limitations in assessment or intervention compared to in-person care
Your therapist will discuss any additional risks relevant to your treatment.

5. Alternatives to Telehealth

You have the right to consider alternatives:
In-person therapy at the clinic
Other forms of therapy or mental health services
Choosing no treatment at this time

6. Limits of Confidentiality

Information shared during telehealth sessions is confidential, except as required by law:
Danger to self or others: Your therapist must act to prevent harm.
Child, elder, or dependent adult abuse: Reporting is required.
Court orders or legal requirements: Records may be released if legally mandated.
Telehealth uses secure, HIPAA-compliant platforms, but there is a minimal risk of confidentiality breaches with electronic communication.

7. Client Rights

You have the right to:
Refuse or withdraw consent for telehealth at any time
Receive clear instructions on how to use the telehealth platform

Be informed about the potential risks and benefits of telehealth
Ask questions about your care and the technology used

8. Fees and Billing

Telehealth services are billed to Medi-Cal or your applicable insurance. There are no additional fees for using telehealth unless otherwise communicated.

9. Use and Protection of Records

Your telehealth sessions are documented in your medical record in the same manner as in-person visits. Records are protected under HIPAA and Medi-Cal regulations and are used for treatment, quality assurance, and billing.

10. Technical Requirements and Responsibilities

You agree to:

Be in a private and safe location for the duration of each session to protect confidentiality and ensure personal safety.

Use devices and internet connections that provide reliable video and audio quality.

Notify your therapist promptly if any technical difficulties arise during a session.

For Medi-Cal compliance, you must be physically located within the state of California in a secure and private space for the entire telehealth session. If this is not possible, your session may need to be rescheduled or conducted in person.

11. Consent Acknowledgment

I have read (or received a verbal explanation of) the information above and understand the nature, risks, benefits, and alternatives to telehealth services. I *consent to receive telehealth mental health services.*

Consent Method (check one):

☐ Signed consent form (recommended)
☐ Verbal consent documented in the medical record
Client Signature: _____ Date: _____
Therapist Signature: _____ Date: _____

Notes / Special Instructions: _____

INITIAL ASSESSMENT NOTE

Member Name				Date	
Date of Birth		CPT		Duration	
Provider Name and Credentials					
Place of Service	☐Office ☐Telehealth: ☐*Phone* ☐*Video* Member location: ☐*Home* ☐*Not home*				

Presenting Problem: *Provide a brief description of why the member is seeking services, including primary concerns and reason for referral (if applicable).*

Subjective: *Current symptoms and concerns* *Onset, frequency, and duration of symptoms*
Member's perspective on needs and goals *Relevant stressors or recent changes*

Objective: *Appearance, affect, mood, behavior, engagement* *Mental status observations*

Risk assessment

☐*No risk identified* ☐*Suicidal Ideation* ☐*Homicidal Ideation* ☐*Self-Harm* ☐*Other:*_____

If risk factors were identified, document safety planning, monitoring, or coordination actions

Relevant History: *Mental health history, Medical history (as relevant), Substance use history (if applicable), Psychosocial context (housing, supports, employment/school, major stressors)*

Assessment: *Clinical impression of presenting concerns, Functional impairment and impact on daily life, Diagnosis or diagnostic considerations (if used), Clinical rationale for initiating treatment (medical necessity)*

Diagnosis (if determined)		**ICD-10 code(s)**	

Initial Treatment Plan

Primary Areas of Concern: *Include key symptoms, functional impairments, and/or risk factors identified in the assessment*

Goals and Objectives: *Goals should be specific, measurable, and directly related to the identified problems and impact on functioning*

Interventions / Therapeutic Approach: *Goals should be specific, measurable, and directly related to the identified problems and impact on functioning*

☐Cognitive Behavioral Therapy (CBT)
☐Dialectical Behavior Therapy (DBT)
☐Trauma-Informed /Trauma-Focused Therapy
☐ Skills Training *(e.g., coping, emotional regulation, communication)*
☐Cognitive Behavioral Therapy (CBT)
☐ Other:

☐Psychodynamic / Insight-Oriented Therapy
☐Motivational Interviewing
☐Solution-Focused Therapy
☐Psychoeducation
☐Supportive Therapy

Treatment Plan Review

Plan will be reviewed and updated as clinically indicated and ongoing throughout treatment, with formal review documented at least every _____ days.

Provider Signature and Credentials

Disclaimer: This guide is intended to provide general documentation and audit readiness guidance for behavioral health providers. Providers remain responsible for complying with applicable professional standards, Medi-Cal requirements, regulatory guidance, contractual obligations, and current billing requirements