

## **Medi-Cal Fee for Service Provider Documentation Tip Sheet**

### **Behavioral Health Assessment**

- Completed within 30 calendar days of the client's assessment session
- Legibly document the following elements:
  - Client was given beneficiary protection information and Freedom of Choice information
  - Date of assessment
  - Identifying information (age, gender, ethnicity, etc.)
  - Presenting problems/needs
  - Client or family strengths
  - Past mental health history/treatment
  - Risk assessment
  - Current functioning
  - School/work history, social history, family history
  - Developmental history (when client is a child)
  - Medical history (include current medications, allergies, physical health issues, primary care physician or documentation of referral provided when client has no PCP)
  - Mental Status Exam
  - Substance use assessment
  - Cultural assessment
  - DSM diagnoses
  - Clinical conclusion
  - Provider's printed name, signature, and credentials
  - Date of form completion

### **Treatment Plan**

- Completed within 30 calendar days of the client's assessment session
- Legibility document the following elements:
  - Client strengths (how will these be used to help the client meet his/her goals?)
  - Areas of need (barriers to goals)
  - Goals (what do they want to achieve as a result of treatment)
  - Objectives (steps to reach goals – language is measurable and observable)
  - Interventions (include frequency and duration)
  - Coordination of resources/referrals
  - Outline if client was offered a copy of the plan, if the plan was explained in the client's preferred language and if not, explain why
  - Client's participation/agreement with the plan, signature and date signed
  - Provider's printed name, signature and credentials
  - Date of form completion

## **Progress Notes**

### **General requirements of all progress notes**

Each claimed service must have a separate, legible progress note documenting the following elements:

- Date of service
- Diagnosis
- Length of session
- Provider's printed name, signature, and credentials
- Date progress note completed

In addition to the above, specific requirements for **Individual Psychotherapy** notes include:

- Client's complaints, symptoms, appearance, orientation
- Any change in cognitive capacity
- Changes from previous visits
- Potential for harm
- Any new precipitator
- Any new strengths
- Focus of the session
- Provider intervention
- Progress towards treatment plan goals

In addition to the above, specific requirements for **Family Psychotherapy** notes include:

- Identification of all those present, their contribution and response to interventions

In addition to the above, **Medication Management** notes must include:

- Medications prescribed, modified, discontinued and rationale
- Current compliance level and issues
- Client reactions to medications
- Tests and lab results (when applicable)
- Side effects/adverse reactions
- There must be a signed consent for use of psychotropic medications in the client's medical record. It should be kept up to date, effective until terminated or for a maximum of one calendar year from the date of consent, whichever is earlier

For more detailed information refer to the "Record Keeping and Medical Record Requirements" section of the Fee-For-Service Provider Operations Handbook (located under the "Manuals" tab), available at the Optum Website: [www.optumsandiego.com/content/sandiego/en/county-staff---providers/fee-for-service-providers.html](http://www.optumsandiego.com/content/sandiego/en/county-staff---providers/fee-for-service-providers.html)

Online documentation training is also available at:

<https://theacademy.sdsu.edu/programs/rihs/continuing-education/elearning/>  
"Understanding Medi-Cal Documentation Records BHE0037"