# 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

Online documentation training is also available at:
http://theacademy.sdsu.edu/programs/bheta/elearning/
"Understanding Medi-Cal Documentation Records BHE0037"