



ReasonNotes

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Mental Health Documentation Guide

A practical reference for therapists, counselors and mental health professionals.

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SECTION 1: UNDERSTANDING DOCUMENTATION TYPES AND LEGAL FOUNDATIONS

Every mental health clinician maintains several categories of clinical documentation. Understanding what each type is, what it must contain, and who can access it is foundational to compliant practice.

CORE DOCUMENT TYPES

1. INTAKE/ASSESSMENT DOCUMENTATION

- Presenting problem and chief complaint
- Psychiatric history (prior diagnoses, hospitalizations, medications)
- Family history of mental illness and substance use
- Social history (relationships, employment, housing, legal)
- Medical history and current medications
- Mental status examination (MSE)
- Risk assessment (suicidal ideation, homicidal ideation, self-harm)
- Substance use screening
- Diagnostic formulation with ICD-10 codes
- Initial treatment recommendations

2. TREATMENT PLAN

- Diagnosis (ICD-10 code and description)
- Measurable, time-limited goals tied to the diagnosis
- Specific objectives with target dates
- Planned interventions linked to each goal
- Frequency and modality of sessions

- Estimated duration of treatment
- Client signature and date
- Clinician signature, credentials, and date
- Review/update schedule (typically every 90 days)

3. PROGRESS NOTES (detailed in Section 2)

4. PSYCHOTHERAPY NOTES (detailed in Section 2)

5. DISCHARGE SUMMARY

- Reason for termination
- Summary of treatment provided
- Goals achieved and unmet
- Recommendations for ongoing care
- Referrals made
- Client status at discharge

KEY FEDERAL LAWS GOVERNING MENTAL HEALTH DOCUMENTATION

HIPAA Privacy Rule (45 CFR Parts 160 and 164)

- Establishes baseline privacy protections for all health information
- Provides enhanced protections specifically for psychotherapy notes
- Requires Notice of Privacy Practices for all clients
- Sets standards for minimum necessary disclosure

42 CFR Part 2 (Substance Use Disorder Records)

- Originally enacted in 1975 to encourage people to seek SUD treatment
- Final rule published February 2024, effective April 16, 2024
- Compliance required by February 16, 2026
- Now aligned more closely with HIPAA while retaining special protections
- Key changes: single consent for treatment/payment/healthcare operations; new patient rights for accounting of disclosures; new "SUD Counseling Notes" category analogous to psychotherapy notes; civil/criminal enforcement aligned with HIPAA penalties; breach notification requirements now match HIPAA Breach Notification Rule
- Records STILL cannot be used in criminal proceedings against the patient without consent or court order

FERPA (Family Educational Rights and Privacy Act)

- Applies to school-based mental health services
- Student treatment records maintained by a physician, psychiatrist, psychologist, or other recognized professional are excluded from "education records" and carry different access rules

State Laws

- Many states have mental health confidentiality laws that are MORE restrictive than HIPAA (HIPAA is a floor, not a ceiling)
- Always comply with whichever law -- federal or state -- provides greater protection to the client

SECTION 2: PSYCHOTHERAPY NOTES VS. PROGRESS NOTES

THE CRITICAL LEGAL DISTINCTION

This is one of the most misunderstood areas of mental health documentation. Getting it wrong can expose you to liability, insurance disputes, and ethical complaints. The distinction carries real legal weight.

HIPAA DEFINITION OF PSYCHOTHERAPY NOTES (45 CFR 164.501)

Psychotherapy notes are defined as notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private, group, joint, or family counseling session that are SEPARATED FROM the rest of the patient's medical record.

To qualify as psychotherapy notes under HIPAA, they must:

- (a) Be recorded by a mental health professional
- (b) Document or analyze the contents of a counseling conversation
- (c) Be physically SEPARATE from the medical record -- kept in a different location, separate file, or separate electronic system. Colored paper in the same chart does NOT qualify as separate.

WHAT PSYCHOTHERAPY NOTES DO NOT INCLUDE (per HIPAA):

- Medication prescription and monitoring
- Session start and stop times
- Modalities and frequencies of treatment
- Results of clinical tests
- Summaries of: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date

These excluded items belong in progress notes, not psychotherapy notes.

AUTHORIZATION REQUIREMENTS (45 CFR 164.508)

Psychotherapy notes receive the HIGHEST level of HIPAA protection:

- A covered entity MUST obtain specific written authorization before using or disclosing psychotherapy notes for ANY purpose
- This authorization CANNOT be combined with authorizations for other types of PHI (can only be combined with another psychotherapy notes authorization)
- An authorization for psychotherapy notes is separate from general consent for treatment, payment, or healthcare operations

LIMITED EXCEPTIONS (no authorization needed):

1. Use by the ORIGINATOR of the notes for treatment
2. Use for the covered entity's own training programs
3. Use by the covered entity to defend itself in legal proceedings brought by the patient
4. Disclosures required by law (e.g., mandatory reporting of abuse)

5. Disclosures to the HHS Secretary for HIPAA compliance investigations

6. Disclosures to avert a serious and imminent threat to health or safety (duty to warn situations)

CRITICAL POINT: Insurance companies CANNOT require disclosure of psychotherapy notes as a condition of payment. They can require progress notes and treatment plans, but not psychotherapy notes.

PROGRESS NOTES: WHAT THEY MUST CONTAIN

Progress notes are part of the medical record and should include:

- Date and duration of service
- CPT code billed
- Presenting issues addressed in session
- Diagnosis (ICD-10) being treated
- Interventions used and clinical rationale
- Client's response to interventions
- Progress toward treatment plan goals (or lack thereof with rationale)
- Risk assessment updates (when indicated)
- Plan for next session
- Clinician signature with credentials and date

PRACTICAL GUIDANCE: WHAT GOES WHERE

IN THE PROGRESS NOTE (medical record):

"Client reported increased anxiety (GAD-7 score: 14, up from 11).

Utilized cognitive restructuring to address catastrophic thinking about job performance. Client identified 3 automatic thoughts and generated alternative interpretations. Assigned thought record for homework. Will continue CBT interventions targeting workplace anxiety. No SI/HI. Next session in 1 week."

IN THE PSYCHOTHERAPY NOTE (separate):

"Client's anxiety about work performance appears connected to

relationship with critical father -- pattern of seeking approval from male authority figures.

Countertransference note: I noticed feeling protective of client when she described her supervisor's feedback, which may mirror her family dynamic. Consider exploring attachment patterns in future sessions."

JAFFEE V. REDMOND, 518 U.S. 1 (1996)

This landmark Supreme Court decision established the psychotherapist- patient privilege in federal courts.

FACTS: Police officer Mary Lu Redmond shot and killed Ricky Allen in the line of duty. Allen's estate sued. During discovery, the court ordered disclosure of notes from Redmond's counseling sessions

with Karen Beyer, a licensed clinical social worker. Neither Redmond nor Beyer complied.

HOLDING: The Supreme Court ruled 7-2 that confidential communications between a psychotherapist and patient are protected from compelled disclosure under Federal Rule of Evidence 501. The Court found that "reason and experience" -- the standard for recognizing evidentiary privileges -- compelled this result because:

1. All 50 states already recognized some form of the privilege
2. Effective psychotherapy depends on an atmosphere of confidence and trust
3. The public interest in facilitating mental health treatment outweighs the evidentiary benefit of disclosure

CRITICAL EXTENSION: The Court explicitly held that the privilege applies to licensed clinical social workers, not just psychiatrists and psychologists. This was significant because it extended federal protection to the most common providers of outpatient mental health treatment.

LIMITATION: The privilege is not absolute. Courts have recognized exceptions for threats of future harm (duty to warn/protect), child abuse reporting, and court-ordered evaluations where the privilege is waived.

PRACTICAL IMPLICATIONS FOR CLINICIANS

- Your therapy notes CAN be protected from subpoena in federal court
- The privilege belongs to the CLIENT, not the therapist
- Only the client (or their legal representative) can waive it
- Document the therapeutic relationship carefully -- the privilege applies to communications made "in confidence" for purposes of obtaining treatment
- If you receive a subpoena, do NOT release records without client consent or a court order -- consult your malpractice carrier and an attorney

SECTION 3: DOCUMENTATION REQUIREMENTS BY LICENSE TYPE

While all mental health professionals share core documentation standards, specific requirements vary by license type and state. Below are the key distinctions.

LICENSED CLINICAL SOCIAL WORKER (LCSW)

Scope: Diagnosis and treatment of mental, emotional, and behavioral disorders using psychotherapy and counseling interventions. Social work assessment includes biopsychosocial perspective.

Documentation specifics:

- Biopsychosocial assessment is the expected intake format
- Must document social determinants of health (housing, employment, community resources, support systems)
- Notes should reflect systems-oriented perspective
- Supervision documentation required during pre-licensure period (typically 2 years post-masters,

3,000+ hours)

- Many states require continuing education documentation in ethics and cultural competency

LICENSED PROFESSIONAL COUNSELOR (LPC) / LICENSED MENTAL HEALTH

COUNSELOR (LMHC)

Scope: Assessment, diagnosis, and treatment of mental and emotional disorders through counseling and psychotherapy.

Documentation specifics:

- Clinical mental health assessment at intake
- Treatment plans with measurable goals
- Must document within scope of practice (cannot prescribe, cannot administer complex psychological testing in most states)
- Pre-licensure supervision documentation requirements vary significantly by state (typically 2,000-4,000 hours)
- Some states require documentation of specific modality training

LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT)

Scope: Diagnosis and treatment of mental and emotional disorders within the context of marriage, couples, and family systems.

Documentation specifics:

- Relational assessment and family systems formulation expected
- When treating couples/families, document: who is the identified patient, who is present in session, confidentiality agreements among parties, "no secrets" policies
- Must address whose record notes belong in (identified patient vs. couple/family file)
- Document systemic interventions and relational dynamics
- Must maintain clarity about who the "client" is for insurance billing purposes

PSYCHOLOGIST (PhD/PsyD)

Scope: Full range of assessment, diagnosis, and treatment. Uniquely qualified for complex psychological and neuropsychological testing.

Documentation specifics:

- Psychological testing reports require extensive documentation: tests administered, raw scores, normative comparisons, interpretation, diagnostic conclusions, recommendations
- Must document informed consent for testing
- Integrated reports combine clinical interview, behavioral observations, test results, and diagnostic formulation
- Some states allow prescriptive authority with additional training (requires medication management documentation)
- Supervision documentation for pre-doctoral interns and postdoctoral fellows

UNIVERSAL REQUIREMENTS ACROSS ALL LICENSE TYPES

Every clinical note, regardless of license type, should include:

- Clinician's full name, credentials, and license number
- Date of service
- Client identifying information
- Signature (handwritten or electronic with authentication)
- If under supervision: co-signature of supervisor with credentials
- If using a supervisee or intern: clear identification of who provided the service vs. who supervised

IMPORTANT: Check your state licensing board's specific documentation requirements. Many boards publish practice guidelines or administrative rules that specify minimum documentation standards. Failure to meet these standards can result in disciplinary action independent of any insurance or HIPAA issues.

SECTION 4: MODALITY-SPECIFIC DOCUMENTATION REQUIREMENTS

Different therapeutic modalities require different documentation elements to demonstrate fidelity, justify medical necessity, and satisfy payer requirements. Below are the key documentation elements for major modalities.

COGNITIVE BEHAVIORAL THERAPY (CBT)

Required documentation elements:

1. COGNITIVE CONCEPTUALIZATION

- Identified cognitive distortions (e.g., all-or-nothing thinking, catastrophizing, mind reading, personalization)
- Core beliefs and intermediate beliefs identified
- Use the five-part CBT model: Situation, Thoughts, Emotions, Physical Sensations, Behaviors

2. SESSION STRUCTURE

- Mood check and symptom rating (use validated measures: PHQ-9,

GAD-7, BDI-II, BAI)

- Bridge from previous session
- Agenda setting (document collaboratively set agenda)
- Homework review (document compliance and outcomes)
- Skill teaching / cognitive restructuring / behavioral experiments
- New homework assigned
- Session summary and feedback

3. INTERVENTIONS TO DOCUMENT

- Cognitive restructuring: document the automatic thought, the distortion type, evidence for/against, and the alternative thought
- Behavioral activation: document target behaviors, activity scheduling, pleasure/mastery ratings
- Exposure work: document hierarchy level, SUDS ratings pre/during/ post, habituation achieved
- Behavioral experiments: document prediction, experiment design, outcome, what was learned

4. PROGRESS MEASUREMENT

- Document standardized measure scores at regular intervals
- Note trajectory: improving, stable, or declining
- If declining, document clinical rationale for continued treatment

CBT PROGRESS NOTE TEMPLATE

Date: _____ Session #: _____ Duration: _____ CPT: _____

Diagnosis: _____

Subjective: Client report of symptoms, mood rating, significant events since last session. [Include PHQ-9/GAD-7 score if administered]

Objective: Behavioral observations, affect, engagement level.

Homework completion: [completed/partially completed/not completed -- with reason if not completed].

Assessment: Cognitive distortions identified this session: _____.

Automatic thoughts explored: " _____ " (direct quote).

Alternative thought developed: " _____."

Progress toward treatment goals: [progressing/stable/regressing].

Functional status: [improved/unchanged/declined] in [domain].

Plan: Homework assigned: _____. Interventions planned for next session: _____.

Risk: [No SI/HI endorsed. OR: See risk assessment documentation.]

DIALECTICAL BEHAVIOR THERAPY (DBT)

DBT has unique documentation requirements due to its structured, multi-component treatment model.

1. TREATMENT TARGET HIERARCHY (must be documented in this order)

- Life-threatening behaviors (suicidal behavior, self-harm, homicidal)
- Therapy-interfering behaviors (missing sessions, non-compliance, behaviors that damage therapeutic relationship)

- Quality-of-life-interfering behaviors (substance use, housing instability, relationship crises, employment problems)
- Skills acquisition and generalization

2. DIARY CARD DOCUMENTATION

- Diary cards must be reviewed at the start of each individual session
- Document: whether card was completed, key ratings and trends
- Track daily ratings of: emotions (0-5 or 0-10 scale), urges (self-harm, substance use), target behaviors (presence/absence), skills used (from all four modules)
- If diary card not completed, document this as a therapy-interfering behavior and the intervention used to address it

3. SKILLS TRAINING GROUP DOCUMENTATION

- Document attendance
- Skills module being taught (Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness)
- Specific skills covered in session
- Client participation level and comprehension
- Homework assigned and reviewed

4. PHONE COACHING DOCUMENTATION

- Date, time, and duration of call
- Presenting crisis or skills question
- Skills coached and client's application
- Outcome of call (crisis resolved, referred to emergency services, etc.)

5. CONSULTATION TEAM DOCUMENTATION

- Date of team meeting
- Cases discussed
- Recommendations made
- Therapist adherence and burnout addressed

DBT INDIVIDUAL SESSION NOTE TEMPLATE

Date: _____ Session #: _____ Duration: _____ CPT: _____

Diary Card Reviewed: [Yes/No -- if no, address as TIB]

Target Hierarchy:

Life-threatening behaviors: [present/absent; if present, detail] Therapy-interfering behaviors: [present/absent; if present, detail] Quality-of-life behaviors: [present/absent; if present, detail]

Chain Analysis Conducted: [Yes/No]

If yes: Target behavior: _____

Vulnerability factors: _____

Prompting event: _____ Links (thoughts, emotions, behaviors): _____

Consequences: _____ Solution analysis / skills to apply: _____

Skills Used/Taught This Session: _____

Homework: _____

Risk Assessment: _____

Plan: _____

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EMDR documentation must reflect fidelity to the eight-phase protocol. The EMDR Fidelity Rating Scale (EFRS) evaluates adherence, and documentation should support this.

THE EIGHT PHASES AND WHAT TO DOCUMENT

PHASE 1: HISTORY TAKING AND TREATMENT PLANNING

- Presenting problem and trauma history
- Target memories identified for processing
- Negative cognitions associated with each target
- Positive cognitions desired
- Current triggers and future template needs
- Client readiness assessment
- Treatment sequencing plan

PHASE 2: PREPARATION

- EMDR process explained to client (informed consent)
- Safe/calm place exercise established and documented
- Resource Development and Installation (RDI) if used
- Container exercise or other stabilization techniques
- Client's ability to manage disturbance between sessions assessed
- Type of bilateral stimulation selected (eye movements, taps, tones)

PHASE 3: ASSESSMENT

- Target memory/image identified
- Negative cognition (NC): exact wording documented
- Positive cognition (PC): exact wording documented
- Validity of Cognition (VOC) scale rating (1-7)
- Emotions identified
- Subjective Units of Disturbance (SUD) rating (0-10)
- Body location of disturbance

PHASE 4: DESENSITIZATION

- Sets of bilateral stimulation administered

- Changes in image, cognition, emotion, and sensation noted
- Channels of association followed
- SUD ratings tracked throughout
- Blocked processing identified and interventions used
- SUD at end of desensitization (target: 0 or ecologically valid)

PHASE 5: INSTALLATION

- Positive cognition installed
- VOC rating (target: 7)
- Any blocking beliefs identified

PHASE 6: BODY SCAN

- Body scan conducted after installation
- Residual tension or sensation noted
- Additional processing if needed

PHASE 7: CLOSURE

- Session closure procedures used
- Client stability assessed at end of session
- Safe/calm place exercise used if needed
- Client instructed to keep a log of any disturbance between sessions
- SUD level at session end documented PHASE 8: REEVALUATION (beginning of next session)
- Review of previously processed target
- Current SUD level
- Any new material that emerged between sessions
- Decision: continue with same target, move to next target, or address new material

EMDR SESSION NOTE TEMPLATE

Date: _____ Session #: _____ Phase(s): _____ Duration: _____

Target Memory: _____

NC: " _____ " PC: " _____ " VOC (start): ____ VOC (end): ____ SUD (start): ____ SUD (end): ____

Emotions: _____

Body Location: _____

BLS Type: [Eye movements / Taps / Tones]

Sets Completed: ____

Channels of Association: _____

Processing Notes: _____

Body Scan: [Clear / Residual sensation: _____]

Closure: [Complete processing / Incomplete - used containment]

Client Status at End of Session: _____ Homework/Between-Session Instructions:

Plan for Next Session: _____

PSYCHODYNAMIC THERAPY

Psychodynamic documentation differs from structured therapies because the work is process-oriented and often longer-term.

KEY DOCUMENTATION ELEMENTS

1. PSYCHODYNAMIC FORMULATION

- Presenting problem understood through developmental lens
- Key developmental experiences and attachment history
- Unconscious conflicts and defense mechanisms identified
- Relational patterns and object relations
- How current symptoms connect to underlying dynamics
- Update formulation as understanding deepens over treatment

2. SESSION DOCUMENTATION

- Themes explored (e.g., loss, abandonment, control, identity)
- Defenses observed (e.g., intellectualization, projection, splitting, denial, reaction formation)
- Affect states and shifts during session
- Free associations or dreams reported and explored
- Interpretations offered and client's response
- Working alliance quality

3. TRANSFERENCE AND COUNTERTRANSFERENCE

- Transference patterns: document how client relates to therapist in ways that mirror other relationships Example: "Client became deferential and apologetic after expressing disagreement, mirroring reported pattern with critical parent."
- Countertransference: document your emotional reactions and how they inform understanding (these observations typically belong in psychotherapy notes, not progress notes)
- Enactments: document any relational enactments and how they were processed

4. PROGRESS MEASUREMENT

- Because psychodynamic goals are often less concrete, document observable changes in: affect tolerance, relational patterns, self-reflection capacity, symptom reduction, functional improvement
- Use standardized measures (OQ-45, PHQ-9, GAD-7) alongside qualitative assessment to satisfy insurance requirements

- Document how insight translates to behavioral change **IMPORTANT FOR INSURANCE:** Psychodynamic work must still demonstrate medical necessity. Frame progress notes around functional impairment and symptom reduction even when the therapeutic focus is on insight and relational patterns. Insurance reviewers do not deny treatment based on modality -- they deny based on failure to demonstrate necessity and progress.

SECTION 5: RISK ASSESSMENT DOCUMENTATION AND SAFETY PLANNING

Inadequate risk documentation is one of the most common findings in malpractice cases. This section covers what to document and when.

WHEN TO CONDUCT AND DOCUMENT A RISK ASSESSMENT

- At intake (every client, every time)
- When a client endorses suicidal or homicidal ideation
- When a client reports self-harm behavior
- After a significant loss, crisis, or destabilizing event
- When there is a change in clinical status (worsening symptoms, substance relapse, relationship breakdown)
- At discharge or termination
- When changing level of care
- Periodically during ongoing treatment (recommended: at minimum every 90 days, or per your organization's policy)

THE COLUMBIA SUICIDE SEVERITY RATING SCALE (C-SSRS)

The C-SSRS is the most evidence-based and widely validated suicide risk screening tool available. It has been validated across 103 languages and implemented in military, healthcare, education, corrections, and community settings.

The scale assesses two domains:

SUICIDAL IDEATION (rated on a 1-5 scale):

1. Wish to be dead
2. Non-specific active suicidal thoughts
3. Active suicidal ideation with any methods (not plan) without intent to act
4. Active suicidal ideation with some intent to act, without specific plan
5. Active suicidal ideation with specific plan and intent **SUICIDAL BEHAVIOR (categorized):**
 - Actual attempt
 - Interrupted attempt
 - Aborted attempt
 - Preparatory acts or behavior
 - Non-suicidal self-injurious behavior

RISK LEVELS

- No/Low Risk: No suicidal ideation or behaviors reported
- Moderate Risk: Suicidal thoughts with some intent or planning but no action taken
- High Risk: Suicidal ideation with intent, plan, or recent suicidal behaviors

WHAT TO DOCUMENT IN A RISK ASSESSMENT

1. RISK FACTORS IDENTIFIED

- Previous suicide attempts (single strongest predictor)
- Family history of suicide
- Access to lethal means (firearms, medications, etc.)
- Current substance use
- Recent losses or stressors
- Social isolation
- Chronic pain or medical illness
- History of trauma or abuse
- Recent psychiatric hospitalization
- Demographic risk factors (age, gender, veteran status)
- Non-suicidal self-injury history

2. PROTECTIVE FACTORS IDENTIFIED

- Reasons for living
- Social support and connectedness
- Children or dependents
- Religious or spiritual beliefs
- Fear of death or pain
- Engagement in treatment
- Future orientation (plans, goals)
- Problem-solving skills
- Therapeutic alliance

3. CLINICAL JUDGMENT AND RATIONALE

Document your assessment of risk level AND your reasoning: "Based on the presence of [specific risk factors] and the absence/presence of [specific protective factors], current risk is assessed as [low/moderate/high]. This assessment is based on [C-SSRS score, clinical interview, collateral information, etc.]."

4. INTERVENTIONS AND PLAN

Document what you DID in response to the risk level:

- Safety planning completed (see below)
- Means restriction counseling provided
- Frequency of sessions adjusted

- Consultation obtained (with whom, date)
- Higher level of care considered/arranged
- Emergency services contacted (if applicable)
- Family/support system notified (with consent or duty to protect)
- Medications reviewed/adjusted (or referral for medication evaluation)

THE STANLEY-BROWN SAFETY PLAN

Developed by Barbara Stanley, PhD and Gregory K. Brown, PhD, this is the gold-standard evidence-based safety planning intervention. A safety plan should be completed whenever ANY level of suicidal risk is identified.

THE SIX STEPS

Step 1: WARNING SIGNS

Document the specific thoughts, feelings, moods, images, situations, or behaviors that indicate a crisis may be developing.

Example: "Thinking 'no one would care if I were gone,' feeling numb, withdrawing from friends, not sleeping for 2+ nights."

Step 2: INTERNAL COPING STRATEGIES

Activities the person can do ALONE to distract or self-soothe without contacting anyone.

Example: "Go for a walk, listen to music playlist, practice box breathing, take a hot shower, journal."

Step 3: SOCIAL CONTACTS AND SOCIAL SETTINGS FOR DISTRACTION

People and places that provide healthy distraction (the person does NOT need to disclose their suicidal state to these contacts).

Example: "Call sister Maria (555-1234), go to coffee shop on Main Street, visit the dog park."

Step 4: PEOPLE TO ASK FOR HELP

Family members or friends the person can tell they are in crisis and ask for help.

Example: "Call partner Alex (555-5678) and say 'I'm having a hard time and need support.' Call best friend Jordan (555-9012)."

Step 5: PROFESSIONALS AND AGENCIES TO CONTACT

Example: "Call therapist Dr. Smith (555-3456), call psychiatrist Dr. Jones (555-7890), call 988 Suicide and Crisis Lifeline, text HOME to 741741 (Crisis Text Line), go to nearest ER."

Step 6: MAKING THE ENVIRONMENT SAFE

Identify and document lethal means and plan for restriction.

Example: "Medications locked in safe -- partner holds key. Firearms removed from home and stored at brother's house."

DOCUMENTATION REQUIREMENTS

- Keep a copy of the safety plan in the client's chart
- Give the client a copy (wallet card, photo on phone, paper copy)
- Document the date it was created and any updates
- Document that means restriction was discussed and what actions were taken
- Review and update the safety plan regularly

SECTION 6: MEDICAL NECESSITY -- THE THREE PILLARS

Insurance reviewers evaluate your documentation against three pillars of medical necessity. Every progress note should clearly address all three.

PILLAR 1: DIAGNOSIS

- Active ICD-10 diagnosis documented
- Diagnosis supported by documented symptoms
- Diagnosis is a covered condition under the client's plan

PILLAR 2: FUNCTIONAL IMPAIRMENT

- Document HOW the diagnosis impairs the client's daily functioning
- Be specific: "Client's panic attacks have caused her to miss 8 days of work in the past month" -- not just "client has panic attacks"
- Address impairment in relevant domains: occupational, social, academic, self-care, relationships, daily activities
- Use measurable language whenever possible

PILLAR 3: INTERVENTION AND RATIONALE

- Document what you actually DID in the session
- Explain WHY you chose that intervention (link to diagnosis and goals)
- Document the client's RESPONSE to the intervention
- Show how the intervention moves toward treatment plan goals

THE MEDICAL NECESSITY FORMULA

"[Client] presents with [diagnosis] which causes [specific functional

impairment]. In today's session, [specific intervention] was used to address [specific symptom/goal]. Client responded by [specific response]. Continued treatment is indicated because [rationale -- e.g., symptoms persist at clinically significant levels, client is making measurable progress but has not yet achieved treatment goals, or new stressors have emerged requiring additional support]."

DOCUMENTING WHEN PROGRESS IS SLOW OR ABSENT

This is where many clinicians get into trouble. If a client is not improving, you must document:

- Clinical rationale for why progress is slow
- What modifications to the treatment plan are being considered
- Why continued treatment at the current level is still necessary
- What would happen if treatment were discontinued

Example: "Despite 12 sessions of CBT, client's PHQ-9 has decreased only from 18 to 15. Slow progress is attributed to ongoing domestic conflict and client's recent bereavement. Treatment plan modified to incorporate grief-focused interventions. Discontinuation of treatment at this time would place client at risk of functional decline given active stressors and continued moderate-severe depressive symptoms."

SECTION 7: AUDIT-PROOF DOCUMENTATION

WHAT INSURANCE AUDITORS ACTUALLY LOOK FOR

Insurance audits can be triggered randomly or by patterns in your billing. Understanding what auditors look for helps you create documentation that withstands scrutiny.

COMMON AUDIT TRIGGERS

- Billing the highest-level psychotherapy code (90837, 53+ minutes) for the majority of clients
- Seeing clients more frequently than typical for their diagnosis
- Unusual combination of codes not typically matched with diagnoses
- High volume of add-on codes (e.g., crisis codes, E/M with therapy)
- Billing patterns that differ significantly from peers in your area
- Tips or complaints from clients or other providers
- Random selection (all providers are subject to random audit)

WHAT AUDITORS REVIEW

1. TIME DOCUMENTATION

- CPT code must match documented session duration
- 90832: 16-37 minutes of psychotherapy
- 90834: 38-52 minutes of psychotherapy
- 90837: 53+ minutes of psychotherapy
- Document actual start and stop times or total minutes
- If you consistently bill 90837, your notes must reflect 53+ minutes of face-to-face psychotherapy content

2. MEDICAL NECESSITY

- Does the documentation support that treatment was necessary for THIS client at THIS frequency?
- Is there an active diagnosis with documented symptoms?
- Is functional impairment described?
- Are interventions linked to the diagnosis and treatment goals?

3. TREATMENT PLAN CURRENCY

- Is the treatment plan up to date (reviewed at least every 90 days)?
- Are goals measurable and time-limited?
- Do session notes reference treatment plan goals?
- Has the plan been updated to reflect changes in presentation?

4. PROGRESS DOCUMENTATION

- Is there evidence the client is making progress?
- If not progressing, is there documented rationale for continuing?
- Is the treatment plan being modified when goals are met or when interventions are not working?

5. CONSISTENCY AND COMPLETENESS

- Are notes completed in a timely manner (within 24-72 hours)?
- Is there a note for every session billed?
- Are all required elements present (date, duration, diagnosis, interventions, plan)?
- Are credentials and signatures present on every note?

6. CLINICAL SPECIFICITY

- Auditors flag generic, copy-paste notes that lack individualization
- "Client discussed feelings" is insufficient
- "Client processed grief related to mother's death (3 weeks ago), identified guilt about not visiting more frequently, used cognitive restructuring to examine evidence for and against self-blame" -- this is what auditors want to see

AUDIT SURVIVAL CHECKLIST

- ☐ Every note has date, start/stop time, CPT code, ICD-10 diagnosis
- ☐ Every note has clinician signature with full credentials
- ☐ Treatment plan is current (updated within 90 days)
- ☐ Session notes reference treatment plan goals by name/number
- ☐ Interventions are specific (not just "supportive therapy")
- ☐ Client's response to intervention is documented
- ☐ Progress (or clinical rationale for lack of progress) is documented
- ☐ Risk assessment is documented when clinically indicated
- ☐ Informed consent is signed and in the chart
- ☐ No notes are backdated or altered without notation
- ☐ Time documented supports the CPT code billed
- ☐ Medical necessity is demonstrated in every note

SECTION 8: COMMON DOCUMENTATION ERRORS THAT LEAD TO CLAIM DENIALS

The following errors are the most frequent causes of mental health claim denials. Each is preventable.

ERROR 1: INSUFFICIENT DOCUMENTATION OF MEDICAL NECESSITY

Problem: Notes describe what was discussed but not why treatment is necessary.

Denial language: "Documentation does not support medical necessity for the service provided."

Fix: Every note must connect the diagnosis to functional impairment and the intervention to a treatment goal. Use the three-pillar framework from Section 6.

ERROR 2: MISMATCHED CPT AND TIME

Problem: Billing 90837 (53+ min) but notes reflect 45 minutes of clinical content, or no time is documented at all.

Denial language: "Time documented does not support the level of service billed."

Fix: Document actual start and stop times. If billing 90837, your note must reflect at least 53 minutes of psychotherapy. Remember: documentation time does not count toward the therapy time.

ERROR 3: DIAGNOSIS NOT SUPPORTING SERVICE

Problem: Using a diagnosis code that does not justify the type or frequency of service. Example: billing weekly 90837 for "Z-code" diagnoses (e.g., Z63.0 Problems in relationship with spouse) without a co-occurring clinical diagnosis.

Denial language: "Diagnosis does not support medical necessity for the service billed."

Fix: Ensure the primary diagnosis is a clinical condition (F-codes) that justifies the service. Z-codes can be listed as secondary but generally should not be the sole diagnosis for ongoing psychotherapy.

ERROR 4: STALE TREATMENT PLANS

Problem: Treatment plan has not been updated in 6+ months, goals have been met but not revised, or plan does not reflect current presentation.

Denial language: "Treatment plan does not reflect current goals and objectives."

Fix: Review and update treatment plans at minimum every 90 days. When goals are met, document this and establish new goals or begin discharge planning.

ERROR 5: GENERIC OR CLONED NOTES

Problem: Notes are identical or nearly identical from session to session. Obvious copy-paste without individualization.

Denial language: "Documentation appears duplicated and does not reflect individualized services."

Fix: Each note must be unique and session-specific. Document the specific content, interventions, and client responses for that particular session.

ERROR 6: MISSING PRIOR AUTHORIZATION

Problem: Providing services that require prior authorization without obtaining it, or continuing services after authorization expires.

Denial language: "Services were not authorized" or "Authorization has expired."

Fix: Track authorization dates and session limits. Request re-authorization before the current authorization expires. Document all authorization numbers in the chart.

ERROR 7: INCOMPLETE CLIENT INFORMATION

Problem: Wrong or missing client demographics, insurance ID numbers, dates of birth, or other identifying information on claims.

Denial language: "Unable to identify member" or "Information does not match our records."

Fix: Verify demographics and insurance at every visit or at minimum every 30 days. Keep copies of insurance cards.

ERROR 8: LATE CLAIM SUBMISSION

Problem: Claims submitted after the payer's filing deadline (typically 90-365 days depending on the payer).

Denial language: "Claim submitted past timely filing deadline."

Fix: Submit claims within 48 hours of service when possible. Track filing deadlines by payer. Keep proof of timely submission.

ERROR 9: MISSING SIGNATURES OR CREDENTIALS

Problem: Notes not signed, or signed without credentials and license number.

Fix: Every note must include full signature, credentials (e.g., LCSW, LPC, PhD), and license number. If supervised, both the provider and supervisor must sign.

ERROR 10: FAILURE TO DOCUMENT RISK ASSESSMENT

Problem: Client mentions suicidal ideation or self-harm, but the note does not document a formal risk assessment.

Fix: Any mention of SI, HI, or self-harm triggers documentation of a risk assessment, risk level determination, and plan of action.

SECTION 9: TELEHEALTH-SPECIFIC DOCUMENTATION REQUIREMENTS

Telehealth mental health services are now permanently covered by Medicare and most commercial payers, but they carry specific documentation requirements beyond standard in-person notes.

REQUIRED TELEHEALTH DOCUMENTATION ELEMENTS

In addition to all standard progress note elements, telehealth notes must include:

1. MODALITY OF SERVICE DELIVERY

- Specify: synchronous video, audio-only, or other
- If audio-only: document that you have video capability but the client either lacks video capability or did not consent to video

2. LOCATION OF BOTH PARTIES

- Document the state/jurisdiction where the CLIENT is located (you must be licensed in that state)
- Document your location (originating site vs. distant site)

3. PLATFORM USED

- Document the HIPAA-compliant platform used (e.g., Zoom for Healthcare, Doxy.me, platform built into EHR)
- Do NOT use consumer-grade platforms (regular Zoom, FaceTime, Skype) unless a public health emergency exception applies

4. TECHNOLOGY ISSUES

- Document any technology disruptions (dropped connection, audio/video quality issues)
- Document how disruptions were handled and whether they affected the session

5. CONSENT

- Document that informed consent for telehealth was obtained
- Many states require specific telehealth consent separate from general treatment consent
- Document that the client was informed of the risks and limitations of telehealth

6. ENVIRONMENTAL ASSESSMENT

- Document that the client was in a private setting appropriate for therapy
- If privacy concerns were noted, document how they were addressed
- Document whether others were present in the room with the client

7. EMERGENCY PROTOCOLS

- Document that the client's physical location was confirmed (for emergency dispatch if needed)
- Document local emergency resources for the client's location
- Have an emergency contact on file for the client

BILLING CODES AND MODIFIERS

Place of Service Codes:

- POS 10: Telehealth provided in client's HOME
- POS 02: Telehealth provided to client at other location (community center, school, satellite clinic) Modifiers:
 - Modifier 95: Synchronous audio-video telehealth service
 - Modifier 93: Audio-only telehealth service
 - Modifier GT: Largely phased out; previously used for distant site practitioners under CAH Optional Payment Method II CPT Codes:
- Same psychotherapy codes apply (90832, 90834, 90837)
- Use appropriate modifier to indicate telehealth delivery

MEDICARE IN-PERSON VISIT REQUIREMENT (effective 2026)

- For NEW clients starting mental health telehealth services after January 30, 2026: An in-person, non-telehealth visit is required within 6 months PRIOR to the first telehealth mental health service.
- For ESTABLISHED clients who began telehealth mental health services on or before January 30, 2026: At least one in-person visit is required every 12 months.
- Exceptions may be granted for access barriers when appropriately documented.
- Document compliance with this requirement in the chart.

STATE-SPECIFIC CONSIDERATIONS

- You must hold a valid license in the state where the CLIENT is physically located at the time of service
- The Counseling Compact (active in select states as of 2025-2026) may simplify cross-state practice for LPCs
- Interstate compacts for psychologists (PSYPACT) and social workers are also expanding
- Some states require specific telehealth training or CE credits
- Prescribing via telehealth has additional requirements that vary by state (DEA registration, Ryan Haight Act compliance)
- Always check the specific telehealth laws for BOTH your state and the client's state

SECTION 10: RECORD RETENTION REQUIREMENTS

HIPAA does not set a universal record retention period. Requirements vary by state, license type, payer contracts, and client population.

GENERAL GUIDELINES

Adults: In the absence of a specific state requirement, retain records for 7-10 years after the last date of service.

Minors: Retain until the client reaches the age of majority (18 in most states) PLUS the standard adult retention period.

Medicare/Medicaid: Retain for at least 10 years (some sources recommend longer due to extended audit and fraud investigation timelines).

SELECTED STATE REQUIREMENTS (verify current law in your state)

California: 7 years after last date of treatment

Minors: until age 18 + 7 years

New York: 6 years after last service (or until age 22,
whichever is longer)

Texas: 5 years after last treatment date

Florida: 5 years after last contact

Pennsylvania: 5 years after last patient contact

Ohio: Varies by license type; generally 5-7 years

NOTE: Many states -- including California, North Carolina, Tennessee, and Connecticut -- default to 7 years after the professional relationship ends.

BEST PRACTICES

- When in doubt, retain longer rather than shorter
- Maintain a records retention policy in writing
- Use HIPAA-compliant methods for records destruction (shredding, certified electronic deletion)
- Document the destruction of records (date, method, who authorized)
- Consider malpractice statute of limitations in your state (the record should be kept at least through the limitations period)

SECTION 11: QUICK-REFERENCE TEMPLATES

UNIVERSAL PROGRESS NOTE (SOAP FORMAT)

CLIENT: _____ DATE: _____ SESSION #: _____

CPT CODE: _____ DURATION: _____ min (Start: _____ End: _____)

DIAGNOSIS: _____ (ICD-10: _____)

TREATMENT MODALITY: _____

S (Subjective):

Client reports: [mood, symptoms, significant events, response to homework/interventions between sessions, medication adherence if applicable]. Quote client when possible for specificity.



O (Objective):

Appearance: _____ Affect: _____

Behavior: _____ Speech: _____

Thought process: _____ Orientation: _____ Standardized measures administered: _____ Score: _____

Homework completion: [completed / partial / not completed]

A (Assessment): [Clinical assessment of current status, progress toward treatment plan goals, and clinical formulation] Treatment Goal 1 (_____): [progressing / stable / regressing] Treatment Goal 2 (_____): [progressing / stable / regressing]

Risk Assessment: [No current SI/HI. OR: See attached risk assessment.]

Functional Status: [improved / stable / declined] in [domain].

P (Plan): Interventions planned for next session: _____

Homework assigned: _____

Referrals made: _____

Coordination of care: _____

Next appointment: _____

Frequency: [weekly / biweekly / monthly / other: _____] Rationale for continued treatment: _____

CLINICIAN: _____ CREDENTIALS: _____ LICENSE #:

SIGNATURE: _____

DATE SIGNED: _____

RISK ASSESSMENT TEMPLATE

CLIENT: _____ DATE: _____

REASON FOR ASSESSMENT: _____

SUICIDAL IDEATION

- ☐ Wish to be dead
- ☐ Non-specific active thoughts ("life isn't worth living")
- ☐ Active ideation with methods but no plan
- ☐ Active ideation with some intent, no specific plan
- ☐ Active ideation with specific plan and intent SUICIDAL BEHAVIOR (lifetime and recent):
- ☐ Prior attempts: _____ (number, most recent: _____)
- ☐ Interrupted attempts: _____
- ☐ Aborted attempts: _____



- ☐ Preparatory behavior: _____
- ☐ Non-suicidal self-injury: _____

HOMICIDAL IDEATION

- ☐ Absent [] Present -- details: _____
- ☐ Identified target: _____

RISK FACTORS PRESENT

- ☐ Previous attempts [] Access to lethal means
- ☐ Family hx of suicide [] Current substance use
- ☐ Recent loss/stressor [] Social isolation
- ☐ Chronic pain/illness [] Recent hospitalization
- ☐ History of trauma [] Command hallucinations
- ☐ Impulsivity [] Hopelessness
- ☐ Other: _____

PROTECTIVE FACTORS PRESENT

- ☐ Reasons for living: _____
- ☐ Social support [] Children/dependents
- ☐ Spiritual beliefs [] Engaged in treatment
- ☐ Future orientation [] Problem-solving ability
- ☐ Fear of death/pain [] Other: _____ RISK LEVEL: [] None [] Low [] Moderate [] High [] Imminent CLINICAL RATIONALE:
- _____

INTERVENTIONS

- ☐ Safety plan completed/reviewed (date: _____)
- ☐ Means restriction counseled
- ☐ Session frequency adjusted to: _____
- ☐ Consultation obtained with: _____ (date: _____)
- ☐ Higher level of care: [] considered [] recommended [] arranged
- ☐ Emergency services contacted
- ☐ Support system notified: _____ (with consent / duty to protect)
- ☐ Medications reviewed/referral made
- ☐ Other: _____ CLINICIAN: _____ CREDENTIALS: _____
- _____ SIGNATURE: _____ DATE: _____

TREATMENT PLAN TEMPLATE

CLIENT: _____ DATE: _____

DIAGNOSIS: Primary: _____ (ICD-10: _____)

Secondary: _____ (ICD-10: _____)

PRESENTING PROBLEM 1: _____

Goal 1: [Specific, measurable, achievable, relevant, time-limited] Objective 1a: _____

Target date: _____ Objective 1b: _____ Target date: _____

Interventions: _____

Frequency: _____

PRESENTING PROBLEM 2: _____

Goal 2: _____ Objective 2a: _____ Target date: _____ Objective 2b:

_____ Target date: _____

Interventions: _____

Frequency: _____

MODALITY: [] Individual [] Couples [] Family [] Group

SESSION FREQUENCY: _____

ESTIMATED DURATION OF TREATMENT: _____

PLAN REVIEW DATE: _____

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____ Credentials/License #:

REVIEW/UPDATE LOG

Date: _____ Goals met: _____ Goals revised: _____ New goals: _____

Clinician: _____ Client signature: _____

SECTION 12: LEGAL CITATIONS AND REFERENCES

FEDERAL STATUTES AND REGULATIONS

- Health Insurance Portability and Accountability Act (HIPAA): Public Law 104-191 (1996)
- HIPAA Privacy Rule: 45 CFR Parts 160 and 164
- Psychotherapy Notes Definition: 45 CFR 164.501
- Authorization for Psychotherapy Notes: 45 CFR 164.508(a)(2)
- Confidentiality of Substance Use Disorder Patient Records: 42 CFR Part 2 (Final Rule published February 16, 2024; compliance required February 16, 2026)
- HIPAA Breach Notification Rule: 45 CFR Parts 160 and 164, Subpart D
- Mental Health Parity and Addiction Equity Act (MHPAEA): Public Law 110-343 (2008)
- CARES Act (Section 3221): Public Law 116-136 (2020) -- required alignment of 42 CFR Part 2 with HIPAA

CASE LAW

- Jaffee v. Redmond, 518 U.S. 1 (1996): Established federal psychotherapist-patient privilege; extended to licensed clinical social workers
- Tarasoff v. Regents of the University of California, 17 Cal.3d 425 (1976): Established duty to protect identifiable third parties from serious threats by patients (adopted in modified form by most states)

CLINICAL TOOLS AND SCALES REFERENCED

- Columbia Suicide Severity Rating Scale (C-SSRS): Developed at Columbia University; available at cssrs.columbia.edu
- Stanley-Brown Safety Planning Intervention: Developed by Barbara Stanley, PhD and Gregory K. Brown, PhD; available at suicidesafetyplan.com
- SAFE-T Protocol (Suicide Assessment Five-Step Evaluation and Triage): SAMHSA resource combining C-SSRS with structured clinical decision-making
- EMDR Fidelity Rating Scale (EFRS): Available through the EMDR Foundation (emdrfoundation.org)

CPT CODES FOR PSYCHOTHERAPY (2026)

- 90791: Psychiatric Diagnostic Evaluation (no medical services)
- 90792: Psychiatric Diagnostic Evaluation (with medical services)
- 90832: Psychotherapy, 16-37 minutes
- 90834: Psychotherapy, 38-52 minutes
- 90837: Psychotherapy, 53+ minutes
- 90846: Family/couples therapy without patient present
- 90847: Family/couples therapy with patient present
- 90853: Group psychotherapy
- +90833: Psychotherapy add-on to E/M, 16-37 min
- +90836: Psychotherapy add-on to E/M, 38-52 min
- +90838: Psychotherapy add-on to E/M, 53+ min
- 90839: Psychotherapy for crisis, first 60 minutes
- +90840: Psychotherapy for crisis, each additional 30 minutes

PROFESSIONAL ORGANIZATIONS AND RESOURCES

- American Psychological Association (APA): apa.org
- National Association of Social Workers (NASW): socialworkers.org
- American Counseling Association (ACA): counseling.org
- American Association for Marriage and Family Therapy (AAMFT): aamft.org
- EMDR International Association (EMDRIA): emdria.org
- Linehan Institute (DBT): linehaninstitute.org
- Beck Institute (CBT): beckinstitute.org

- Suicide Prevention Resource Center (SPRC): sprc.org
- SAMHSA (Substance Abuse and Mental Health Services Administration): samhsa.gov

DISCLAIMER

This guide is provided for educational and informational purposes only. It does not constitute legal advice. Laws and regulations vary by state and change frequently. Always consult with a healthcare attorney, your malpractice insurance carrier, your state licensing board, and your professional association for guidance specific to your practice, location, and circumstances.

Documentation requirements may differ based on your payer contracts, practice setting (private practice, agency, hospital, school), client population, and state regulations. This guide represents general best practices and should be adapted to your specific context.

Last updated: March 2026

END OF GUIDE