Novarra.

The Behavioral Health Practice Playbook

Notes that hold up, a schedule that stays full,
and claims that pay the first time.

For therapists, counselors, case managers, and the people who run their practices

2026 edition

START HERE

Three things decide whether a practice is calm or chaotic.

Most of the stress in a behavioral health practice does not come from the clinical work. It comes from the work around it: notes that pile up, a calendar with holes in it, and claims that come back unpaid.

Those three problems are connected. A late note delays a claim. A denied claim eats the hour you would have spent calling a client who missed. A missed appointment is revenue you cannot bill at all. Fix one and the other two get easier.

This guide is the short version of what well-run practices do about each of them. It takes about twenty minutes to read. Every chapter ends with a checklist you can use at your next staff meeting, and the last pages give you a thirty-day plan.

1 **Notes that hold up**
What a payer, an auditor and the next clinician each need to see

2 **Treatment plans people use**
Goals, measures, and reviews that are more than paperwork

3 **A schedule that stays full**
What a no-show costs, and the six habits that prevent them

4 **Claims that pay the first time**
The clean claim, the common codes, and the denials you can stop

5 **Staying on the right side of the rules**
Privacy and compliance basics, in plain words

6 **Choosing software**
Twenty questions to ask any vendor, including us

7 **Your first thirty days**
One change a week

A note on what this is

This guide is general education. It is not legal, clinical or billing advice. Payer policies and state rules differ and change, so confirm anything that matters with your payers, your licensing board and your own counsel before you rely on it.

CHAPTER 1

Notes that hold up

A good note is not a long note. It is one that four different readers can each follow without asking you a question.

Who reads your note

- **The next clinician**, who needs to pick up where you left off.
- **The client**, who has a right to read most of their record.
- **The payer**, who needs to see that the service was necessary and was what you billed.
- **An auditor**, months or years later, with nothing but the page.

The golden thread

Auditors use this phrase for a simple idea: every part of the record should connect to the part before it.

1. The **assessment** identifies what is wrong and how it affects the client's life.
2. The **diagnosis** names it.
3. The **treatment plan** sets goals that answer the assessment.
4. Each **session note** says which goal it worked on, what you did, and how the client responded.
5. The **review or discharge** says what changed.

When a note cannot be traced back to a goal on the plan, that is where a reviewer stops reading and starts recouping.

What every progress note needs

- [ ] The date, and the start and stop time or total minutes
- [ ] How the session was held: in person, video or phone. For telehealth, where the client was.
- [ ] Who was present
- [ ] The diagnosis being treated
- [ ] The goal or objective from the plan that the session worked on
- [ ] What you did, named as an intervention, not just "provided support"
- [ ] How the client responded, and their progress or lack of it
- [ ] Risk, when it is relevant: what you asked and what you found
- [ ] The plan for next time
- [ ] Your signature, your credentials and the date you signed

Pick one format and keep to it

FORMAT	THE LETTERS	OFTEN USED FOR
SOAP	Subjective, Objective, Assessment, Plan	Medical and integrated settings
DAP	Data, Assessment, Plan	Outpatient therapy
BIRP	Behavior, Intervention, Response, Plan	Community programs and case management

None is better than the others. What matters is that everyone in the practice uses the same one, so a supervisor can review ten notes in the time it used to take to read three.

The same session, written two ways

Will not hold up

"Client came in and talked about work stress. Provided supportive listening. Client seems to be doing better. Will continue weekly."

Will hold up

"Goal 1: reduce panic episodes. Client reports two episodes this week, down from five. Reviewed thought record; practiced paced breathing in session and client used it without prompting. PHQ-9 is 11, down from 16 at intake. Denies thoughts of self-harm. Plan: continue weekly CBT, add one exposure exercise as homework."

The second note is only a few lines longer. It names the goal, the intervention, the response and a measure. That is the whole difference. Both examples are made up.

Write it the same day

A note written a week later is a weaker note and a slower claim. Many payers and state programs set a deadline for completing documentation, often between 24 and 72 hours, and most expect the note to be signed before the claim goes out. Set one rule for your practice, write it down, and make it visible when someone is behind.

Psychotherapy notes are a different thing

HIPAA gives special protection to "psychotherapy notes": a clinician's own notes analyzing a conversation, kept separate from the rest of the record. They are not part of what a client can generally demand to see, and they need a specific authorization to release.

That protection does **not** cover medication information, session start and stop times, the type and frequency of treatment, test results, or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis and progress. Those belong in the regular record. If your private impressions and your billable progress note live in the same document, you have lost the protection.

If you do case management

A case management note answers a different question: what did you do to connect this person to what they need? Targeted case management is generally built on four activities, and your note should make clear which one the contact was.

- **Assessment** of what the person needs
- **Planning**: developing or revising the care plan
- **Referral and linkage** to services
- **Monitoring and follow-up** to see that it happened

Record who you contacted, how, for how long, and what comes next. Driving a client somewhere, or providing the service yourself, is usually not billable as case management. Each state's Medicaid program sets its own rules here.

Checklist for your next staff meeting

- [ ] We use one note format across the practice.
- [ ] Every note names the plan goal it worked on.
- [ ] We have a written deadline for finishing notes, and we can see who is behind.
- [ ] Notes are signed before the claim is sent.
- [ ] Private psychotherapy notes are kept apart from progress notes.
- [ ] Associates' notes are co-signed by their supervisor where our rules require it.

CHAPTER 2

Treatment plans people use

A treatment plan that is written at intake and never opened again protects no one. A plan that is on the screen every session makes the notes almost write themselves.

What a usable plan has

- **Goals in the client's own words.** "I want to be able to drive to work again" is a goal. "Reduce anxiety" is a category.
- **Objectives you can measure.** How often, how much, by when.
- **Interventions.** What you will do, and how often you will meet.
- **A target date and a review date.** Many payers and states expect a review about every ninety days. Check yours.
- **The client's participation.** Their signature, or a note that they took part and agreed.

Measure it, briefly and often

Measurement-based care means giving the same short questionnaire at regular intervals and using the trend to guide treatment. It takes a client two minutes and it gives you a number an auditor understands.

MEASURE	WHAT IT SCREENS	SCORE RANGE	COMMON CUT POINTS
PHQ-9	Depression	0 to 27	5 mild, 10 moderate, 15 moderately severe, 20 severe
GAD-7	Anxiety	0 to 21	5 mild, 10 moderate, 15 severe
C-SSRS	Suicide risk	Screening questions	Follow your risk protocol on any positive answer

Give the measure at intake and then every few sessions or monthly. Put the score in the note. When a score stops moving, that is your cue to change the plan, and writing that down is exactly what "medical necessity for continued care" looks like on paper. Some payers also reimburse a brief standardized assessment separately, so ask each of yours.

Checklist

- [ ] Every active client has a plan with at least one measurable objective.
- [ ] We know which plans are due for review this month.
- [ ] We give at least one standard measure on a schedule, and the scores appear in the notes.

CHAPTER 3

A schedule that stays full

An empty hour is the one thing in a practice you can never bill, never appeal and never get back.

What a no-show really costs

Take one clinician who books 25 sessions a week at an average of $110 collected per session.

NO-SHOW RATE	SESSIONS LOST A WEEK	LOST IN A YEAR
5%	1.25	about $6,600
10%	2.5	about $13,200
20%	5	about $26,400

Based on 48 working weeks. Put your own numbers in: sessions a week, times your average collected, times your no-show rate, times 48.

Multiply that by the number of clinicians and the cost of doing nothing becomes obvious. It is also a clinical problem: clients who miss early sessions are the ones most likely to drop out.

Six habits that prevent them

1. **Remind twice.** Once two days before and once the same day. Text messages get read; ask each client how they want to be reached and get their consent.
2. **Make it recurring.** The same day and time every week becomes a habit. A fresh appointment every time becomes a decision.
3. **Book the next one before they leave.** Or before the video call ends.
4. **Have an attendance policy, in writing, signed at intake.** State the notice you need and any fee. Be aware that some programs, Medicaid among them, restrict charging clients for missed appointments.
5. **Keep a waitlist and use it.** A cancellation with a day's notice is a slot you can fill, if you know who wants it.
6. **Offer to switch to video.** "I can't get there" is often a transportation problem, not a motivation problem.

The front door matters as much

A person who calls three practices usually books with the first one that answers. Aim to respond to every new inquiry the same day and to offer a first appointment within a week. Send intake paperwork electronically so the first session is spent on the client, not on a clipboard.

Know your real capacity

If a clinician needs 25 kept sessions a week and your no-show rate is 10%, you need about 28 on the calendar. Track booked, kept, cancelled and missed sessions per clinician every week. You cannot manage what you only notice at the end of the month.

Checklist

- [ ] We know our no-show rate, by clinician, for last month.
- [ ] Reminders go out automatically, twice.
- [ ] Ongoing clients are on a recurring schedule.
- [ ] Every client signed our attendance policy.
- [ ] We have a waitlist and someone owns it.
- [ ] New inquiries get an answer the same day.

CHAPTER 4

Claims that pay the first time

Most denied claims were lost before the session started. The fix is almost never in the billing office. It is at the front desk and in the note.

What a clean claim needs

- [ ] The client's name, date of birth and member ID exactly as the payer has them
- [ ] Coverage that was active on the date of service
- [ ] A rendering clinician who is credentialed with that payer
- [ ] The right billing and rendering NPI
- [ ] A diagnosis code that supports the service
- [ ] The correct procedure code, modifiers, place of service and units
- [ ] An authorization number, when the payer requires one
- [ ] A signed note that matches what was billed

The codes most practices use

CODE	SERVICE	TIME
90791	Diagnostic evaluation	Not timed
90832	Psychotherapy, 30 minutes	16 to 37 minutes
90834	Psychotherapy, 45 minutes	38 to 52 minutes
90837	Psychotherapy, 60 minutes	53 minutes or more
90846	Family therapy without the client present	26 minutes or more
90847	Family therapy with the client present	26 minutes or more
90853	Group psychotherapy	Per session
90839	Psychotherapy for crisis, first hour	30 to 74 minutes
90840	Crisis, each additional 30 minutes	Added to 90839

The time is the time spent in psychotherapy with the client, which is why the start and stop times belong in the note. Billing 90837 for a 50-minute session is one of the most common findings in an audit.

Medicaid and community programs often use other codes for services such as case management and skills training, commonly billed in 15-minute units. They vary by state, so use your state's fee schedule and provider manual.

Telehealth

Payers generally want two things on a telehealth claim: a place of service that says where the client was (commonly 02 for somewhere other than home, 10 for the client's home) and a modifier that says how the session was held. The exact combination differs by payer, and audio-only visits often have their own rules. In the note, record the client's location, that they consented to telehealth, and that you used a secure platform.

Rejected is not the same as denied

Rejected

The claim never got into the payer's system, usually because of a format or identity error. Fix it and send it again. No appeal is needed, and the filing clock is still running.

Denied

The payer processed the claim and decided not to pay. Read the reason code. Then correct and resubmit, or appeal, within that payer's deadline.

The denials you can prevent

WHY IT WAS DENIED	HOW TO STOP IT
Coverage ended or changed	Verify eligibility before the first visit and again each month, and every January.
No authorization	Track the visits or units approved and the end date. Ask for more before they run out.
Filed too late	Send claims within days, not weeks. Medicare allows a year from the date of service; many commercial plans allow only 90 to 180 days; Medicaid varies by state.
Clinician not credentialed	Do not schedule a clinician with a payer's members until that payer confirms they are in network.
Code and diagnosis do not match, or a modifier is missing	Build payer rules into your system so the claim is checked before it leaves.
Another insurer is primary	Ask about other coverage at intake and at every plan-year change.

WHY IT WAS DENIED	HOW TO STOP IT
Duplicate claim	Check status before resubmitting. A correction is sent as a corrected claim, not a new one.

Four numbers to watch every month

NUMBER	WHAT IT TELLS YOU	A COMMON TARGET
First-pass rate	Share of claims paid without being touched twice	95% or better
Denial rate	Share of claims denied	Under 5%
Days in A/R	How long money takes to arrive	Under 40 days
A/R over 90 days	Money that is going stale	Under 15% of the total

Self-pay clients

Federal law requires you to give uninsured and self-pay clients a Good Faith Estimate of what their care is expected to cost. Give it in writing before care begins, keep a copy, and update it when the plan changes. Keeping a card on file with the client's written agreement makes collecting far easier than chasing balances afterward.

Checklist

- [ ] Eligibility is verified before the first visit and monthly after.
- [ ] We can see every authorization, its remaining units and its end date.
- [ ] Claims go out within three days of the session.
- [ ] Someone works rejections and denials every day.
- [ ] We know our denial rate and our top three denial reasons.
- [ ] Self-pay clients get a Good Faith Estimate.

CPT is a registered trademark of the American Medical Association. Code descriptions here are shortened; use the current code set for billing.

CHAPTER 5

Staying on the right side of the rules

You do not need a compliance department. You need a short list of things that are actually done, and proof that they were.

Privacy and security

- **A signed Business Associate Agreement with every vendor that touches client information.** That means your record system, your email, your video platform, your texting service and your billing company. If a vendor will not sign one, do not put client information in it.
- **One login per person.** Shared passwords make it impossible to say who saw what.
- **Two-step sign-in** for everyone, and access limited to what each role needs.
- **An audit trail** that shows who opened which record and when.
- **A security risk analysis**, written down and revisited regularly. The Security Rule requires one, and it is the first document asked for after a breach.
- **A breach plan.** Know who decides, who is notified and by when. Notice to affected clients is due without unreasonable delay and no later than 60 days after discovery.

Clients' access to their records

Clients have a right to see and get copies of most of their record, generally within 30 days of asking. Federal information-blocking rules also discourage practices from making that access unreasonably slow or difficult. Decide in advance how a client asks, who answers, and how you record that you did.

Substance use treatment records

If your program is federally assisted and provides substance use disorder treatment, 42 CFR Part 2 applies, and it is stricter than HIPAA about consent and redisclosure. The rule was updated in 2024 to work more closely with HIPAA, with compliance required by February 2026. If you treat substance use, make sure your consent forms and your software handle Part 2 records properly.

Telehealth across state lines

The rule of thumb is that you must be authorized to practice in the state where the client is sitting during the session. Interstate compacts are expanding this for some professions, but they do not cover everyone and you must apply to use them. Ask each new telehealth client where they will be, and record it.

Supervision

If you employ associates or interns, document supervision as carefully as you document treatment: who supervised, when, and which notes they reviewed and co-signed. Payers differ on whether and how supervised services can be billed.

How long to keep records

State law and your payer contracts decide this. Seven years after the last service is common for adults, and longer for minors, often until several years past the age of majority. Write your retention rule down and follow it.

Checklist

- [ ] We have a signed BAA for every system that holds client information.
- [ ] Everyone has their own login with two-step sign-in.
- [ ] We completed a written risk analysis in the last twelve months.
- [ ] We have a written process for record requests.
- [ ] We record each telehealth client's location.
- [ ] Supervision and co-signatures are documented.

CHAPTER 6

Choosing software

Twenty questions to ask any vendor before you sign, including us.

Notes and clinical work

1. Can each note be linked to a goal on the treatment plan?
2. Are standard measures such as the PHQ-9 and GAD-7 built in, scored, and charted over time?
3. Can a supervisor review and co-sign, and can I see what is waiting?
4. Can I see which notes are late, across the practice?
5. Are private psychotherapy notes kept separately from the record?
6. Does it handle group sessions and case management, or only individual therapy?

Scheduling and clients

7. Are text and email reminders included, or sold as an extra?
8. Can clients complete intake forms and sign consents before the first visit?
9. Is video built in, and covered by the same BAA?
10. Is there a client portal for messages, forms and payments?

Billing

11. Does a signed note create the claim, or does someone retype it?
12. Can I check eligibility from inside the system?
13. Are claims checked for errors before they are sent?
14. Does it track authorizations and warn me before they run out?
15. Are payments posted from the payer's remittance automatically?
16. Can I take card payments and keep a card on file?

Security and cost

17. Will you sign a BAA before I enter any client information?
18. Is there two-step sign-in, role-based access and a record of who opened what?
19. What does it cost for all of my people, including the ones who do not see clients?
20. If I leave, can I export my clients' records in a usable form, and what does that cost?

Read the price list twice

The price on a vendor's home page is rarely what a practice pays. Ask what reminders, telehealth, claims and the client portal each add, and what a front-desk person or a biller costs.

CHAPTER 7

Your first thirty days

Do not try to change everything at once. One change a week, measured, is enough to see a difference in a month.

WEEK 1: NOTES

Choose one note format for the practice. Set a deadline for finishing notes and tell everyone what it is. At the end of the week, count how many notes were signed on time.

WEEK 2: SCHEDULE

Work out last month's no-show rate for each clinician. Turn on two reminders for every appointment. Move ongoing clients to a recurring time.

WEEK 3: CLAIMS

List last month's denials and group them by reason. Pick the largest group and fix its cause, not its symptoms. Verify eligibility for every client seen next week.

WEEK 4: MEASURE

Start giving one standard measure on a schedule. Put four numbers on one page: notes signed on time, no-show rate, denial rate and days in A/R. Look at that page every month.

What good looks like in ninety days

- More than 90% of notes signed within your deadline
- A no-show rate under 10%
- A denial rate under 5%
- Money arriving in under 40 days

FROM THE PEOPLE WHO WROTE THIS

We built Nuvero around these three problems.

Nuvero is the record system from Novarra for therapy and case management practices. The treatment plan sits beside the note, so every note names its goal. Reminders, recurring sessions and video are part of the calendar. Signing the note creates the claim, checked before it is sent. Measures are scored and charted for you.

It is $95 a month for each clinician. Schedulers, billers and office managers sign in free. You build your plan yourself and see the total before you give us a card.

Build your plan at novarra.cloud

This guide is general education for practice owners and staff. It is not legal, clinical, coding or billing advice, and it does not create a professional relationship. Laws, payer policies and code sets change and differ by state and plan. Confirm requirements with your payers, your licensing board and qualified counsel. Examples are illustrative and do not describe real clients. © 2026 Novarra. You are welcome to share this guide within your practice.