CONTRA COSTA HEALTH

CMU Review Training

Presented by:

Behavioral Health Services (BHS)

Care Management Unit (CMU)

INTRODUCTIONS

Welcome

Purpose of Training

Updates

Review CMU Workflow

Review Clinical Forms

Quality Reviews

Review Claims Process

Review Provider Portal

Housekeeping\Breaks

Zoom Tips

Break around 10:45

Question Format

Presenter Introductions

Contra Costa Health Services Behavioral Health Division

MISSION STATEMENT

The mission of Contra Costa Behavioral Health, in partnership with members, families, staff, and community-based agencies, is to provide welcoming, integrated services for mental health, substance use, homelessness and other needs that promote wellness, recovery, and resiliency while respecting the complexity and diversity of the people we serve.

VISION STATEMENT

Contra Costa Behavioral Health envisions a system of care that supports independence, hope, and healthy lives by making accessible behavioral health services that are integrated, responsive, compassionate, and respectful.

CCMHP - Care Management Unit (CMU) - Contact Information

- 1330 Arnold Drive Suite 143 Martinez, CA 94553
- (925) 372-4400
  - CMU Clinicians Option 1
  - Claims Department Option 4
  - Provider Services Option 6
- Fax: (925) 372-4410

CCMHP - Care Management Unit (CMU) - Team

- *CMU/Provider Services Program Manager*

  Gina Griffiths, LCSW

- **CMU/Provider Services Clinicians**

  Kim Kirkland, LMFT   Taylor Culbertson, LMFT   Cheryl Kehner, LMFT

- **CMU Clerical Supervisor**

  Sandra Lopez

- **Clerks**

  Alyssa Clarke & Mukesh Chauhan- Claims

  Doug Hand & Austin White – CMU

  Vijay Dugal & Adrianna Pinon-Cheek – Provider Services

  Kelly Saelaw – CMU & Provider Services

CCMHP PROVIDER NETWORK REQUIREMENTS

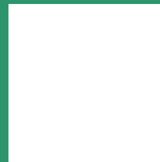
- **Reminder of Provider Requirements**
  - Return calls within 1 business day of the member's original contact/voice-mail, to schedule intake appointment or address routine matters.
  - Offer an appointment within 10 business days of member's first contact.
  - Keep voice mail clear, return calls even if practice is full.
  - Have an established plan for 24-hour crisis response, detailed on your outgoing voice message.
  - Participate in at least one training meeting a year.
  - Notify Provider Services of ANY changes, i.e. address, name, tax status.
  - Keep Provider Services updated on availability changes.
  - Respond to CMU, Provider Services, and Access Line communications within 1 business day.

ACCESS Line

The Gateway to Contra Costa County’s Behavioral Health System of Care

The ACCESS Line welcomes members to integrated services for mental health and substance use.

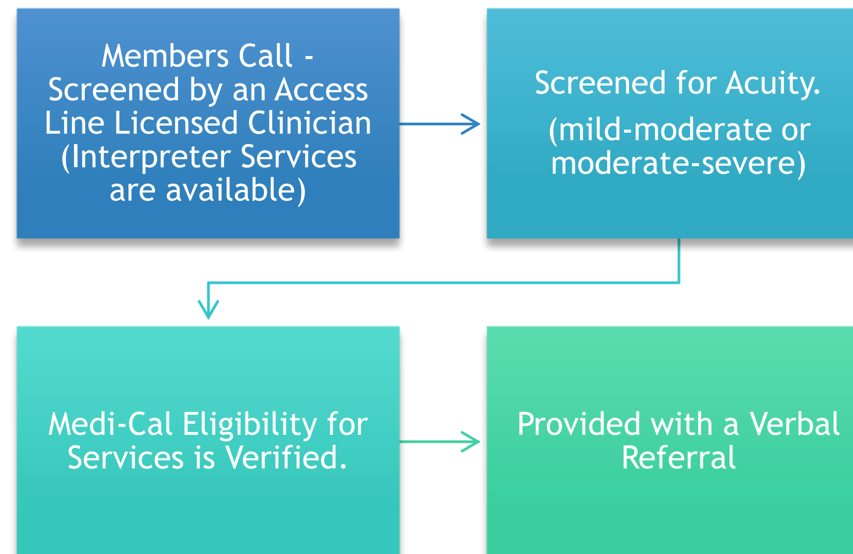
It is the main point of entry into the county’s Mental Health Clinics and Substance Use Disorder treatment programs.



The line offers 24-hour availability and assistance in all languages via staff or interpreters.

CCMHP – ACCESS LINE
1-888-678-7277

ENTRY POINT FOR SERVICE DELIVERY

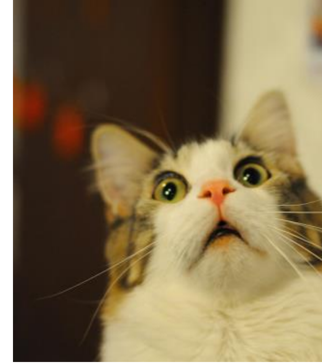


A Screening is NOT always required

Members may reach out directly to network providers to schedule an appointment.

In the past, providers were advised to instruct the member to call the Access Line for a Screening.

Now, providers may start seeing a member even if the member has not been “screened”.



What to do when a member contacts you directly

1) Verify Contra Costa County Medi-Cal eligibility (and possible duplication of services) by any one of the ways listed below:

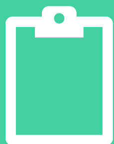
- Provider Portal – look under the "patient" tab, then "search all patients". You'll need the member's name, birthdate, and MRN/CIN.

- Contact CMU – either via CRM or calling 925-372-4400, option 1.

2) Once eligibility is confirmed, follow the regular workflow addressed in later slides.

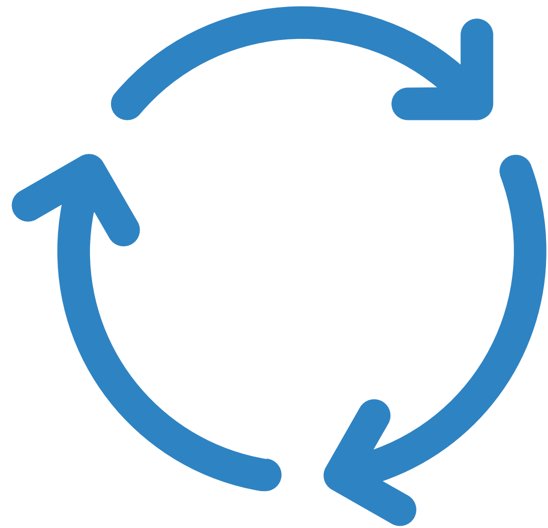
Reminders/Tips:

Please offer an appointment within 10 business days for newly referred members, as required by DHCS. If you do not have available appointments within this time-frame, or do not have openings altogether, please inform CMU of your availability ASAP.



Make sure your outgoing message includes your full name and license and who to call in the event of a crisis (211).

QUESTIONS



The Care Management Unit (CMU)

Overview of CMU Lines of Business/Programs

Specialty Mental Health Services (Moderate/Severe)		Non-Specialty Mental Health Services (Mild/Moderate)	
Responsibility	• The Contra Costa Mental Health Plan (CCMHP) is responsible for service delivery.	Responsibility	• Contra Costa Health Plan (CCHP) is responsible for service delivery. They delegate oversight to the Contra Costa Mental Health Plan (CCMHP).
Medical Necessity Criteria	• Adheres to Medi-caid Title XI criteria.	Medical Necessity Criteria	• Adheres to Medi-Cal guidelines which are less restrictive than Title XI.
Forms	• Registration & Admission Form • MH Assessment • Problem List • Discharge Form	Forms	• Registration & Admission Form • MH Assessment • Discharge Form

How will I know my member's acuity?

Provider Portal will display the acuity – Mild/Moderate or Moderate/Severe under the "Patient" tab.

If the acuity displayed does not match what you feel the member's acuity is, call CMU to consult.

What to do when acuity changes…

If there IS NOT a need for a "new" or "additional" service:

Contact CMU to update the member's acuity in our system.

You may call or create CRM with Subtopic "Behavioral Health Other"

If there IS a need for a "new" or "additional" service:

Complete a Transition of Care Tool and submit to CMU.

Submit the TOC Tool via Provider Portal using the "Create Referral" tab and select the member (if you do not have the tab, contact CMU).

Entering a TOC in Provider Portal

- Can either enter from the home page by selecting "Create Referral" then select the member or enter from the member page by selecting "New Referral".

Priority: Select Routine

Type: Search Transition of Care (BHS Transition of Care will populate)

Reason: Let default to Portal Request

Class: Select Incoming (to CCRMC/Health Centers or BHS Access)

Referral By: Enter Provider and Location/POS

Referral To; Provider Specialty: Behavioral Health

Diagnosis (coded): Enter Diagnosis code

Questionnaire: Provide responses to questions – additional questions will populate or be disabled based on answers

Notes; Note Type: Allow default

Notes; Add direct contact phone number: Add direct contact phone number

Notes; Text Box: Add required note

Entering a TOC in Provider Portal

Referral To

Provider

Location/POS

Department

Provider specialty

Behavioral Health [75]

✓ General Information | Diagnoses/Services

Diagnoses (free text)

Diagnoses (coded)

Depression, major, recurrent, moderate [711036]

Add

Services

Services (free text)

Services (coded)

Procedure | Revenue code | Modifiers | Qty | Unit type

Add

✓ General Information | Diagnoses/Services

Notes

Note type

Portal Comments/Attachments [18039]

Your most direct contact number (with area code) in case we need to reach you. No main numbers if possible, please.

99999999

Test BHS ACCESS RFL

Please Attach Supporting Patient Clinical Notes/Medical Justification

Add file

Back | Request Referral | Cancel Request

TOC - Care Coordination

Providers must coordinate with one another to facilitate care transitions and guide referrals.

Providers should continue to provide necessary behavioral health services during the transition period and coordinate the transition of care or service referral with the receiving provider.

Care decisions should be made via a person-centered, shared decision-making process with the person in care.

DHCS requires providers to ensure the referral loop is closed.

Consents, Registration & Admission, Mental Health Assessment, & Discharge.

Consents

- All providers must ensure they have Informed Consent, Release(s) of Information, and a Telehealth Consent on file.
- CMU does not currently have a template for Informed Consent or Release of Information. There is a template for the Telehealth Consent.
- Telehealth Consents:
  - DHCS mandates members must understand their right to in-person services.
  - Based on member's preference, Telehealth services may be provided.
    - When Telehealth Services are provided a Consent must be in place.
    - This can be a one-time consent, or you may indicate the client consented in each note.

Special Note on Telehealth Services

- If office practices allow for verbal consent, a written Telehealth Policy must be in place.

- If a member decides they would like to transition to an in-person provider, the Telehealth provider needs to help facilitate this transition. The Telehealth provider should call CMU to initiate this process.

- A HIPAA compliant Telehealth Platform must be used.
  - If a platform is HIPAA compliant, you will be able to enter into a Business Associate Agreement (BAA) with the vendor.
  - **Psychiatrists** may only bill the 99202 and 99212 E&M series via video or in person. Phone services may not be provided for these codes.

DHCS Telehealth Policy Model Language

Written Consent Communication

1. I agree to receive health care services via telehealth. I understand that:
    a. I have the right to access Medi-Cal covered services through an in-person, face-to-face visit or through telehealth.
    b. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
    c. Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example______.
2. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

Verbal Consent Communication

"Under Medi-Cal you have the option to receive services in person in a face-to-face visit or via telehealth. If you have trouble accessing in person services due to transportation, Medi-Cal provides coverage for transportation services when other resources have been reasonably exhausted. There may be limitations or risks related to receiving services through telehealth rather than in person. For example______. If you choose to receive services by telehealth, you may change your mind at any time by letting us know. If you change your mind about using telehealth, you will still have access to Medi-Cal covered services.
Knowing all of this, do you want to have the option of receiving services from us now or in the future via telehealth? (Yes/No)."

CMU Workflow Overview

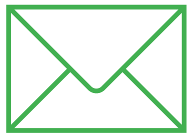
IMMEDIATELY AFTER 1ST MEETING: COMPLETE AND SUBMIT MEMBER REGISTRATION & ADMISSION FORM.

COMPLETE THE SPECIALTY/NON-SPECIALTY SECTIONS OF THE MH ASSESSMENT ACCORDINGLY WITHIN 60 DAYS OF FIRST SESSION. *ONLY SUBMIT TO CMU WHEN REQUESTED VIA THE QUALITY REVIEW PROCESS.*

Network Provider member Registration & Admission Form

- If your member is a no-show, you do NOT need to inform CMU. No-shows are not billable.
- Recommend having member complete a printed copy at first session.
- Network Provider submits form to CMU within 7 days of first appointment and prior to submitting any claims. For Moderate/Severe members a new Registration is required annually.
- Choose "***BHS Registration Form***" Subtopic if submitting via Provider Portal.

Submitting Documentation



Care Management Unit
1330 Arnold Drive #143
Martinez, CA 94553

925-372-4410

Provider Portal

Member Registration and Admission Form (Page 1 of 2)

CONTRA COSTA HEALTH

Network Provider
Client Registration & Admission

CLIENT NAME

Client's Current Last Name	First	Middle	Gen (Sr., Jr)	Medi-Cal Card #(CIN)

SSN:	Date of Birth	Legal Sex ☐Female ☐Male ☐Nonbinary

Street Address	City	State	Zip-Code+4

Telephone Number | **Telephone Type:** ☐Cell ☐Fax ☐Home ☐Message ☐Pager ☐Work

Living Arrangement: | **# of Dependants Under 18:** | **# of Dependants Over 18:**

Preferred Language: | **Mother's Maiden Name:**

Race (Check all that apply):

- ☐ Other Race
- ☐ Declined to State
- ☐ Unknown
- ☐ American Indian/Alaska Native – American Indian
- ☐ American Indian/Alaska Native – Alaska Native
- ☐ Asian – Asian Indian
- ☐ Asian – Bangladeshi
- ☐ Asian – Bhutanese
- ☐ Asian – Burmese
- ☐ Asian - Cambodian
- ☐ Asian - Taiwanese
- ☐ Asian - Filipino
- ☐ Asian - Hmong
- ☐ Asian - Indonesian
- ☐ Asian - Japanese
- ☐ Asian - Korean
- ☐ Asian - Loatian
- ☐ Asian - Malaysian
- ☐ Asian - Okinawan
- ☐ Asian – Pakistani
- ☐ Asian – Sri Lankan
- ☐ Asian – Thai
- ☐ Asian – Thai
- ☐ Asian - Vietnamese
- ☐ Asian - Iwo Jiman
- ☐ Asian - Maldivian
- ☐ Asian - Nepalese
- ☐ Asian - Singaporean
- ☐ Native Hawaiian/Other Pacific Islander - Polynesian
- ☐ Native Hawaiian/Other Pacific Islander - Micronesian
- ☐ Native Hawaiian/Other Pacific Islander - Melanesian
- ☐ Native Hawaiian/Other Pacific Islander – Other Pacific Islander
- ☐ Native Hawaiian/Other Pacific Islander – Native Hawaiian
- ☐ White - European
- ☐ White – Middle Eastern of North African
- ☐ White - Arab
- ☐ Black/African American – African American
- ☐ Black/African American – African American
- ☐ Black/African American – African
- ☐ Black/African American – Bahamian
- ☐ Black/African American – Black
- ☐ Black/African American – Dominican Islander
- ☐ Black/African American – Dominican
- ☐ Black/African American – Hatitian
- ☐ Black/African American – Jamaican
- ☐ Black/African American – Tobagoan
- ☐ Black/African American – Trinidadian
- ☐ Black/African American – West Indian
- ☐ Black/African American – Madagascar
- ☐ White – White/Other Caucasian
- ☐ Asian – Other
- ☐ Samoan
- ☐ Guamanian

Ethnicity Origin (check one)

- ☐ Declined to State
- ☐ Unknown
- ☐ Not Hispanic or Latino
- ☐ Spaniard - Andalusian
- ☐ Spaniard - Asturian
- ☐ Spaniard - Castillian
- ☐ Spaniard - Catalonian
- ☐ Spaniard - Belearic Islander
- ☐ Spaniard - Gallego
- ☐ Spaniard - Valencian
- ☐ Spaniard - Canarian
- ☐ Spaniard - Spaniard
- ☐ Spaniard - Spanish Basque
- ☐ Mexican - Mexican American
- ☐ Mexican - Mexicano
- ☐ Mexican - Mexican
- ☐ Mexican - Chicano
- ☐ Mexican - La Raza
- ☐ Mexican - Mexican American Indian
- ☐ Central American - Central American
- ☐ Central American - Costa Rican
- ☐ Central American - Guatemalan
- ☐ Central American - Honduran
- ☐ Central American - Nicaraguan
- ☐ Central American - Panamanian
- ☐ Central American - Salvadoran
- ☐ Central American - Central American Indian
- ☐ Central American - Canal Zone
- ☐ South American - Argentinean
- ☐ South American - Bolivian
- ☐ South American - Chilean
- ☐ South American - Colombian
- ☐ South American - Ecuadorian
- ☐ South American - Paraguayan
- ☐ South American - Peruvian
- ☐ South American - South American
- ☐ South American - Uruguayan
- ☐ South American - Venezuelan
- ☐ South American - Criollo
- ☐ Latin American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Dominican
- ☐ Other

Birth Country:	Birth State:	Birth County:

Member Registration and Admission Form (Page 2 of 2)

Client Name: ____________ **Client Date of Birth:** ____________

Education Level (check all that apply)

Type:
☐Highest Grade Completed: ______ ☐None ☐Decline to State

Employment Status:

☐Full Time	☐Retired	☐Not Employed
☐Part Time	☐Self-employed	☐Unknown
☐Student - Full Time	☐On Active Military Duty	
☐Student - Part Time	☐Disabled	

Guarantor Information (Complete for minor client under 18)

Relation to Client	Current Last Name, First Name	Date of Birth	Legal Sex	Telephone Number: ☐Cell ☐Home ☐Message ☐Pager ☐Work ____________

***** **PROVIDER** USE ONLY *****

Facility/Place of Service – Location (City):		**Group Name:** (if applicable)
Date of First Contact with Client:	**Referral Source:**	**1st Assessment Offer Date:** **2nd Assessment Offer Date:** **3rd Assessment Offer Date** **Assessment Start Date:**
Treatment Appointment:		**1st Treatment Offer Date:** **2nd Treatment Offer Date:** **3rd Treatment Offer Date:** **Treatment Start Date:**
ICD-10 Code:	**ICD-10 Description:**	

Legal/Court Status

☐Temporary Conservatorship (WI Code Section 5353)
☐LPS Conservatorship (WI Code Section 5358)
☐Murphy Conservatorship (WI Code Section 5008)
☐Probate (Probate Code, Division 4, Section 1400)
☐Parolee PC 2974 (Penal Code, Section 2974)
☐Representative Payee (WI Code Section 5686)
☐Juvenile Court, Dependent of the Court (WI Code, Section 300)
☐Juvenile Court, Ward - Status Offender (WI Code Section 601)
☐Juvenile Court, Ward - Juvenile Offender (WI Code Section 602)
☐Not Applicable ☐Unknown/Not Reported

Substance Use? ☐Yes ☐No ☐ Unknown SU ICD-10 Code: ____________

Has the client experienced a tramatic event? ☐Yes ☐No ☐ Unknown

Provider Printed Name/License ____________ **Signature** ____________ **Date** ____________

Member Registration Page 2 Highlights

- For members under the age of 18, The Guarantor Information MUST be completed.

Guarantor Information (Complete for minor client under 18)				
Relation to Client	Current Last Name, First Name	Date of Birth	Legal Sex	Telephone Number: ☐Cell ☐Home ☐Message ☐Pager ☐Work

- Referral Source = Person who referred the member to your practice. May or may not be the Access Line.
  - If member found your contact information online, referral source = "self".
- 1st Treatment Offer Date = date next appt was offered. If member does not accept move on to 2nd.

Medi-Cal Eligibility Verification

Check eligibility within the first few days of every month and mid month.

Eligibility can change from month to month. Check via Provider Portal or the AEVs Line.

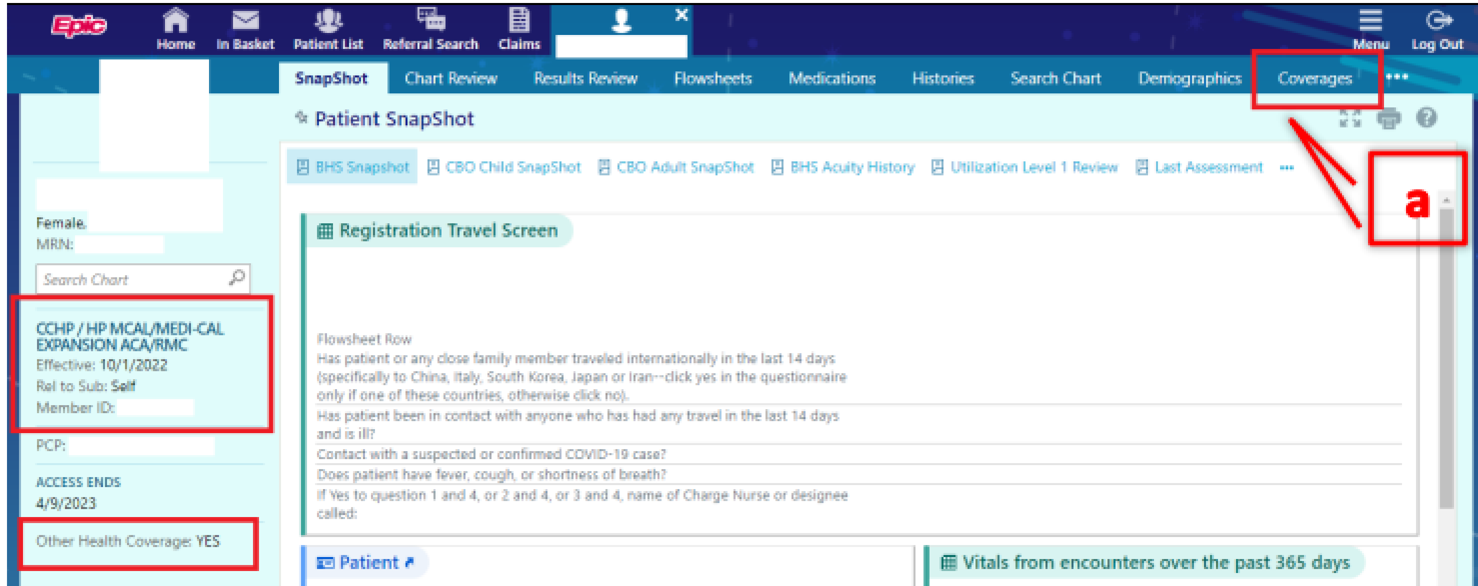
If member loses Medi-Cal eligibility, CMU will not be able to pay the claims.

Make sure to verify coverage with member as well.

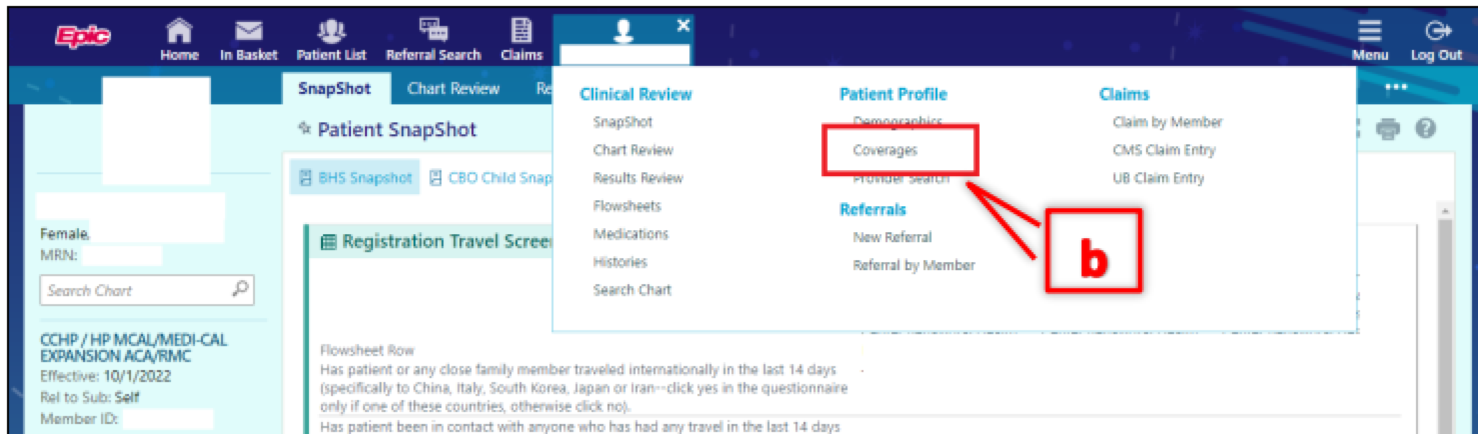
1. Open a patient's record (see tip sheet #1). You will see managed care coverage information on the Patient Story Board. If **Other Health Coverage** indicator says **YES**, you must always review coverages and coverage details for additional information.

2. You can access Coverages two ways:

   a. On the patient menu toolbar, Click the Coverages tab (next to Demographics tab).



   b. Hover over the patient's name to see a drop-down menu. Click on Coverages.



The most current Coverage will be displayed with the effective date.

3. To see past coverages, click the **Past checkbox in Filters**.

4. If needed, click **Detail Report** button to see the coverage details. You can also click on ID card i if temporary CCHP ID card is requested by or needed for member

Coverage Detail Report

Important reminders:

- CCHP can only confirm CCHP coverage information.
- Any Other Health Insurance information is provided to us from DHCS for Medi-Cal members only and must be updated with DHCS.
- Other Health Coverage benefit verification should be done directly with the other insurance.
- Filing Order information indicates a member's other insurance coverage as a guideline to bill payers in correct sequence.

***For more details, please see the list of Tip Sheets on the Provider Portal Home page.

Questions About the member Registration Form or Medi-Cal Eligibility?

Network Provider Mental Health Assessment

Network Provider Mental Health Assessment

1

Complete the "**Network Provider Mental Health Assessment**" within 30-60 days of first appt.(30 is preferred) and annually thereafter for mod/severe members.

2

The same assessment form may be used for Annual Assessments as well.

CONTRA COSTA HEALTH

Network Provider Mental Health Assessment

Beneficiary: ____ MRN: ____ DOB: ____

Check one: ☐ Specialty ☐ Non-Specialty

Provider Last Name, First Name (and Group name, if applicable) ____ Location ____

PRIMARY REASON FOR REFERRAL	*Beneficiary-Identified Problems, History of Beneficiary-Identified Problem(s), Impact of Beneficiary-Identified Problem(s), Beneficiary-Identified Impairment(s):*

FUNCTIONAL IMPAIRMENTS (check all that apply) - SPECIALTY MH ONLY:

☐ Family Relations	☐ Social/Peer Relations	☐ Episodes of decompensation & increase of symptoms, each of extended duration
☐ School Performance/Employment	☐ Physical Health	☐ Other:
☐ Self-Care	☐ Substance Use/Abuse	☐ Other:
☐ Food/Shelter	☐ Activities of Daily Living	☐ Other:
COMMENTS:		

MENTAL STATUS: (check and/or describe if abnormal or impaired) - SPECIALTY MH ONLY:

Appearance/Grooming:	☐ Unremarkable	☐ Remarkable for:			
Behavior/Relatedness:	☐ Unremarkable	☐ Motor Agitated	☐ Inattentive	☐ Avoidant	☐ Impulsive
	☐ Hostile	☐ Suspicious/Guarded	☐ Motor Retarded	☐ Other:	
Speech:	☐ Unremarkable	☐ Remarkable for:			
Mood/Affect:	☐ Unremarkable	☐ Depressed	☐ Elated/Expansive	☐ Anxious	☐ Labile
	☐ Irritable/Angry	☐ Other:			
Thought Processes:	☐ Unremarkable	☐ Concrete	☐ Distorted	☐ Disorganized	☐ Blocking
	☐ Odd/Idiosyncratic	☐ Paucity of Content	☐ Circumstantial	☐ Tangential	☐ Obsessive
	☐ Flight of Ideas	☐ Racing Thoughts	☐ Loosening of Assoc	☐ Other:	
Thought Content:	☐ Unremarkable	☐ Suicidal Ideation	☐ Homicidal Ideation	☐ Paranoid Ideation	
Perceptual Content:	☐ Unremarkable	☐ Hallucinations	☐ Delusions	☐ Flashbacks	☐ Dissociation
	☐ Depersonalization	☐ Derealization	☐ Ideas of Reference		
Fund of Knowledge:	☐ Unremarkable	☐ Remarkable for:			
Orientation:	☐ Unremarkable	☐ Remarkable for:			
Memory:	☐ Intact	☐ Impaired			
Intellect:	☐ Unremarkable	☐ Remarkable for:			
Insight/Judgment:	☐ Unremarkable	☐ Remarkable for:			
COMMENTS:					

TRAUMA HISTORY/EXPOSURE (Include any psychological, emotional response to an event that is deeply distressing or disturbing.):	
	☐ *Experience w/Homelessness* Involvement with: ☐ *Juvenile Justice* ☐ Child Welfare System

***Specify Specialty or Non-Specialty by selecting check box

Non-Specialty: Complete Primary Reason for Referral and Trauma History/Exposure Boxes

Specialty: Above PLUS Functional Impairments and Mental Status boxes

Network Provider Mental Health Assessment

Beneficiary: ______ MRN: ______ DOB: ______

MENTAL HEALTH HISTORY (Including past diagnoses, suicide attempts, violence, hospitalizations, and other outpatient treatments & responses):

BIRTH AND DEVELOPMENTAL HISTORY: (Did Beneficiary meet developmental milestones? Were there environmental stressors? Include prenatal and perinatal events, including trauma during pregnancy.) - **SPECIALTY MH ONLY:**

SUBSTANCE USE HISTORY				CURRENT SUBSTANCE USE						
Type	Prenatal Exposure	Past Use	Age at First Use	None/ Denies	Current Use	If Current Use			In Recovery	Client-perceived Problem?
						Mild	Mod	Sev		
Alcohol	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Amphetamines	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Cocaine/Crack	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Opiates	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Hallucinogens	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Sleeping Pills, Pain Killers, Valium, or Similar	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
PCP (phencyclidine) / designer drugs (ghb)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Inhalants (paint, gas, glue, aerosols)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Marijuana / hashish	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Tobacco / nicotine	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Caffeine (energy drinks, sodas, coffee, etc.)	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐
Over the counter/other substance:	☐	☐		☐	☐	☐	☐	☐	☐	Y ☐ N ☐

Previous community-based treatment / Inpatient psychiatric admissions / Intoxication/detox/withdrawal management-based admissions and response:

MEDICAL HISTORY:	Last Physical:		Primary Care Provider:	

☐ If client has no PCP, then referral information has been provided (CCCHS Clinic @1-800-495-8885 or Private PCP)

Allergies (MANDATORY): ______ ☐ No Known Allergies

Include severity of symptoms for allergies:

Relevant Health History (including surgeries or significant medical /developmental conditions, as reported by client):

PSYCHIATRIC MEDICATION HISTORY (Include relevant responses, side effects and compliance):

CURRENT PSYCHIATRIC & NON-PSYCHIATRIC PRESCRIPTION & O.T.C. MEDICATIONS (use page 4 if needed):

Name of Medication	Dosage/ Frequency	Prescribed by	Date Prescribed	Date Last Taken

RX Compliant: ☐ Yes ☐ No ☐ Unknown Explain:

Non-Specialty:

- Mental Health History
- Substance Use History/Current SU
- Medical History
- Current Medications

Specialty:

- Above PLUS
- Birth and Development History

Network Provider Mental Health Assessment

Beneficiary: ______ MRN: ______ DOB: ______

RELEVANT FAMILY PSYCHOSOCIAL HISTORY including mental illness, substance abuse, abuse/neglect (physical, sexual, emotional, etc.), suicide (suicide attempt/ unexplained death), and any education/school history - SPECIALTY MH ONLY:	*Family Involvement:* ☐ Very ☐ Moderate ☐ Minimal ☐ Not at all

PSYCHOSOCIAL FACTORS (Living situation, daily activities, social support, cultural and linguistic factors, Legal or justice-involved history, Family history & current family involvement, Military history, Tribal affiliation, LGBTQ, & BIPOC):

SAFETY RISK: ☐ None Identified ☐ Not Currently Acute ☐ Danger to Self ☐ Danger to Others ☐ Domestic Violence ☐ Inability to Care for Self ☐ Physical Abuse ☐ Sexual Abuse ☐ Neglect

FORM(S) COMPLETED: ☐ CPS ☐ APS ☐ Duty to Warn ☐ Safety Plan

Provide additional detail for any box checked above:

Beneficiary Strengths (include information on strengths in achieving goals, personal motivation, drive, interest, resilience, & coping skills) - SPECIALTY MH ONLY:

Beneficiary Protective Factors: (include available resources, supports (including support persons), interpersonal relationships, systems, activities)

Clinical Summary/Medical Necessity (justification for medical necessity/impairments):

Client meets Specialty Mental Health Medical Necessity: ☐ Yes ☐ No (if "no" identify transition plan on page 4)

	DSM-V CODE:	DSM-V NAME: *Must write full diagnosis narrative, no abbreviations*	ICD-10 CODE:
(P)			
(S)			

Substance Use Issue: ☐ Yes ☐ No DSM-V Code: ICD-10 Code:

Service Recommendations:

Modality	Frequency		Duration
☐ Individual Therapy ☐ Group Therapy	☐ Weekly	☐ Other: ______	☐ 3 months ☐ 6 months
☐ Family Therapy ☐ (MD) Med Mgt	☐ 2x/Month		☐ 12 months

Provider: (Print) (Signature) (Licensure) (License/Regist. #) Date

Provider's Signature certifies that the above information is accurate, and all required documentation is on file.

Non-Specialty:

- Psychosocial Factors
- member Protective Factors
- Clinical Summary/Medical Necessity
- DSM-V Code/Name/ICD-10 Code
- Service Recommendations
- Signature and Date

Specialty:

- Above PLUS
- Relevant Family Psychological History
- member Strengths

"Client meets Specialty Mental Health Medical Necessity" – if "no" a transition plan is NOT required.

Network Provider Mental Health Assessment

Beneficiary: ____________ MRN: ____________ DOB: ____________

Space for Data Continuation *(Specify which item you are continuing from)*

Non-Specialty AND Specialty

- Name/MRN/DOB
- Additional info as needed

CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Mental Health Beneficiary Problem List

Provider Name: ____________ Location: ____________

Beneficiary Name: ____________ MRN: ____________

ICD-10 code	Code Description (DSM-5)	Date Identified	Date Resolved	Problem Identified by (Name & Credentials)	Problem Resolved by (Name and Credentials)

Printed Name ____________ Signature/License/Designation ____________ Date ____________

MHC-000 Draft 05-09-22 MH Client Problem List

Page 1 of 1

Problem List

***Only required for specialty mental health members

***Live document, update as needed throughout treatment

Network Provider Mental Health Assessment Guidelines

Should be completed within 60 days of first session and annually thereafter for mod/severe clients.

Use Page 4 for Narrative that Exceeds the Space Provided Elsewhere on the Form.

If ongoing services are indicated, check "Yes" for the question "member meets Specialty Mental Health Medical Necessity. *If it is for a non-specialty member, you **do not** need to submit a transition plan.*

Problem List does not need to be exhaustive. Only identify symptoms (dx) you are addressing in sessions.

Signature is needed for the provider. Signature can be electronic.

Signature Date Should Match your Progress Note documenting that you Completed the Assessment.

Questions about the Mental Health Assessment Form & Problem List?

Progress Notes & Discharge Form

Progress Notes

- While providers do not need to use the Progress Note template provided by CMU, providers do need to ensure progress notes include all the same elements.

- Progress notes need:
  - Member's name/MRN
  - Date of the service
  - Begin Time & Total minutes of service
  - CPT code (type of service)
  - Location of the service
  - To identify whether interpreter services were used or if the service was provided in another language other than English.
  - Problem/Behavioral Health need addressed during the service.
  - Interventions used during the service and member's response.
  - Plan – plan for next session as well as overall plan for treatment.
  - Notes must be signed within 3 business days of the service.

CMU’s Progress Note Template

Beneficiary: ______________________ **MRN:** ______________

Last Name, First Name (Please print.)

Service Begin Date: ________ Begin Time: ________ Total Minutes: ________

Type of MH Service:

- ☐ Assessment (90791)
- ☐ Assessment (90792)
- ☐ Individual (90832)
- ☐ Individual (90834)
- ☐ Individual (90837)
- ☐ Family w/client (90847)
- ☐ Group (90853)
- ☐ Psychotherapy for Crisis, first hour (90839)
- ☐ Psychotherapy for Crisis, each addtl 30 min (90840)
- ☐ MH Plan Dev (H0032)
- ☐ Collateral (H2021)
- ☐ Other: ________
- ☐ Not a billable service

Location Group:

- ☐ Office (11)
- ☐ Telehealth other than clt home (02)
- ☐ Telehealth clt home (10)
- ☐ Phone other than clt home (02)
- ☐ Phone clt home (10)
- ☐ School

Telehealth only: Client understands their right to in-person services and consents to Telehealth: ☐ Yes ☐ No

Interpreter Services Provided: ☐ Yes ☐ No

Name of Interpreter: ________ Language: ________

☐ Service provided in another language by clinician: ☐ Spanish ☐ Other: ________

Does client have restricted pregnancy-only Medi-Cal? ☐ Yes ☐ No

If yes, please document either: a) how the pregnancy affects the client’s mental health issues OR
b) how the client’s mental health issues affect the pregnancy

Chart to: goals/strategies on Partnership Plan, impairment related to diagnosis, progress and/or barriers to recovery, and/or unplanned events.

1. **Problem/Behavioral Health Need Addressed:** (Describe problem/need, reason for contact, status update, clinical impression).
2. **Focus of Activity:** (Describe type of service rendered, how the service addressed client’s behavioral health need, how the client responded – symptoms, condition, diagnosis, and/or risk factors).
3. **Plan:** (Describe next steps – action steps by provider of client, collaboration with the client or other providers, updates to the problem list as appropriate).

CLINICIAN: ________ (Print) ________ (Signature, Registration/License #) ________ Date ☐ **Late Entry**

Discharge Form

- At the conclusion of services, submit the Discharge Form to CMU.
- Providers remain responsible for their clients until an official discharge is submitted.
  - Complete for members that have:
    - Successfully completed treatment,
    - Unexpectedly withdrawn from services, or
    - Not made contact for an extended period of time (this should align with your office policies).
- Complete the form in its entirety. All fields are required for DHCS reporting.

CMU’s Discharge Form

Network Provider Discharge Form

Consumer Name:
Consumer DOB:
Consumer MRN:

Discharge Date | Provider Name

Facility/Place of Service – Location (City) | Group Name (if applicable)

Legal Class at Discharge ☒ W60000 Voluntary

Residential Living Arrangement: *(check one response)*

- ☐ Adult Residential Facility
- ☐ Alcohol Abuse Facility
- ☐ Community Treatment Facility
- ☐ Crisis Residential Facility
- ☐ Drug Abuse Facility
- ☐ Foster Family Home
- ☐ Group Home (Level 1-12 Child)
- ☐ Group Quarters
- ☐ Homeless - No Residence
- ☐ Homeless, No Identifiable Residence
- ☐ House or Apartment
- ☐ House or Apt. with Supervision
- ☐ House or Apt. with Support
- ☐ Justice Related
- ☐ Large Board & Care
- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with others
- ☐ Lives with relatives
- ☐ Other
- ☐ Res Tx Cnter (Level 13-14 Child)
- ☐ Satellite Housing
- ☐ Single Room
- ☐ Small Board & Care
- ☐ Supported Housing
- ☐ Temporary Arrangement
- ☐ Unknown / Not Reported

Substance Use: ☐ Yes ☐ No ☐ Unknown | SU ICD-10 Diagnosis Code: F

Discharge Reason:

- ☐ Completed Tx/Goals Reached/Referred
- ☐ Completed Tx/Goals Not Reached/Referred
- ☐ Mutual Agreement - Treatment Goals partially met
- ☐ Mutual Agreement - Treatment Goals Not Met
- ☐ Client Withdrew, AWOL, AMA, TX Goals partially met
- ☐ Client Withdrew, AWOL, AMA, No Improvement
- ☐ Client Deceased
- ☐ Client Moved Out of Area
- ☐ Client incarcerated
- ☐ Client Discharged, Administrative
- ☐ Other

Employment Status: *(check one response)*

- ☐ Full time, 35 hours or more per week (comp)
- ☐ Part time, less than 35 hours per week (comp)
- ☐ Homemaker, Not Seeking Work
- ☐ Unemployed, actively looking for work
- ☐ Other
- ☐ Resident / Inmate of institution
- ☐ Retired
- ☐ Student, Full Time
- ☐ Unknown / Not Reported
- ☐ Volunteer Worker
- ☐ Disabled
- ☐ Full time, 35 hours or more per week (non-comp)
- ☐ Homemaker, Seeking Work
- ☐ Part time, less than 35 hours per week (non-comp)
- ☐ Student, Employed Part Time
- ☐ Student, Part Time
- ☐ Unemployed, not seeking wrk
- ☐ Full-time training
- ☐ Part-time training

Discharge Status:

- ☐ Still a patient or expected to return
- ☐ Discharged to home, self-care, foster care, shelter care
- ☐ Unplanned discharge
- ☐ Discharged/transferred to Jail
- ☐ Other
- ☐ Unknown / Not Reported
- ☐ Left against medical advice
- ☐ Deceased
- ☐ AWOL
- ☐ Discharged/transferred to Residential/Board and Care (not locked, supervised living, no treatment)
- ☐ Discharged/transferred to Community Residential Treatment (not locked, custodial)
- ☐ Discharged/transferred to Community Treatment Facility (locked, no nursing care)
- ☐ Discharged/transferred to Skilled Nursing Facility/ Intermediate Care Facility (unlocked or locked)
- ☐ Discharged/transferred to Acute Care Hospital or Psychiatric Health Facility (PHF)
- ☐ Discharged/transferred to State Hospital
- ☐ Discharged or transferred to another short term hospital
- ☐ Discharged or transferred another type of institution
- ☐ Left against medical advice
- ☐ Discharged/ transferred to medical unit

Referred To: (may choose up to 3)

- ☐ Self
- ☐ Mental Health Access Line
- ☐ Low Fee Mental Health Clinic
- ☐ Family
- ☐ Central County Adult OP
- ☐ Central County Children SVS
- ☐ Child Protective Services
- ☐ Community Based Organization
- ☐ Dept. Social Services – Foster
- ☐ East County Adult OP
- ☐ East County Children’s SVS
- ☐ Jail
- ☐ Juvenile Hall
- ☐ Kaiser
- ☐ Referral Data Missing/NA
- ☐ School or College
- ☐ West County Adult – El Portal OP
- ☐ West County Children SVS
- ☐ Other

Beneficiary instructed by: (check all that apply) ☐ Phone ☐ Voice Mail ☐ In Person ☐ By Letter; that if Mental Health Services are needed in the future to: ☐ Call this Provider ☐ Call their Social Worker ☐ Call the Access Line @ 1-888-678-7277

TREATMENT SUMMARY / DISCHARGE PLAN / ADDITIONAL INFO:

ICD-10 Code: F | **DSM5 Description:**

Signature/License | Printed Name | Date

It’s Time For A Break
EXMEN

Quality Reviews

Quality Reviews – General Information

- CMU will conduct periodic quality reviews for approximately 10% of a provider’s caseload (ranging between 1-6 charts) per year (this is subject to change).

- Documents to submit will include:
  - Initial consents
  - Most recent Network Provider Mental Health Assessment
  - Progress notes for the specified period (3 months)

Quality Reviews – Notification of Review and Provider's response

- Until everyone is acclimated to the new process:
  - CMU will send an email, without any Protected Health Information (PHI) alerting provider of the review.
  - CMU will also send a "staff message" in Provider Portal with the same review notification + the member's name/DOB.

- Upon notification of the review, providers will have 2 weeks to send documents to CMU via CRM in Provider Portal (one CRM per member).
  - If not using provider portal, documents may be faxed.

Quality Reviews – After Provider Submits the Requested Documents

- CMU will complete the review and send the provider a final summary.
  - The summary will provide an overview of strengths, feedback on any areas to improve, corrections needed, and possible corrective action.
- Providers should acknowledge receipt of the Quality Review.
- Additionally, the provider should respond with any requested additional documentation and/or a corrective action plan.
  - The response may be sent through a CRM in Provider Portal.

***Only reason for recoupment is related to issues of fraud, waste, or abuse

***CMU to update/refine this new process as needed in the future

Quality Reviews: Submitting Documents

- Navigate to In Basket from your home screen
- Select New Msg

New Customer Service Request

Topic: Behavioral Health Portal Communication

Subtopic: Behavioral Health Other

Summary:

Priority
- High
- Routine
- Low

Associated Site

Site: Heftsi Assaf, MFCC - Patient

Your name here

Member

Member: Select Patient

Details

Details:

Additional Documents

Documents: Add files

97.7 MB Total Allowed 0 Files

Submit

CLAIMS

DUE DATE GUIDELINES

Due dates for claims: Claims must be submitted within 15 days of the date of the service being claimed, but no later than the 10th day of the following month, or the claim may be denied.

Denied or deferred claims: Corrected claims, or Informal Appeals of denied claims, must be received by CMU within 30 days of the Claim Explanation of Benefits date. **After one year from the date of service, claims are non-payable by Medi-Cal**. Please follow up on denied/deferred claims promptly.

Eligibility: Providers must check members' eligibility at the beginning of **every** month to prevent denial of claims due to the member no longer being eligible. This also applies to members who have been recently referred for services.

3 Ways to submit claims

1 - PROVIDER PORTAL

2 - AVAILITY

3 - MAIL

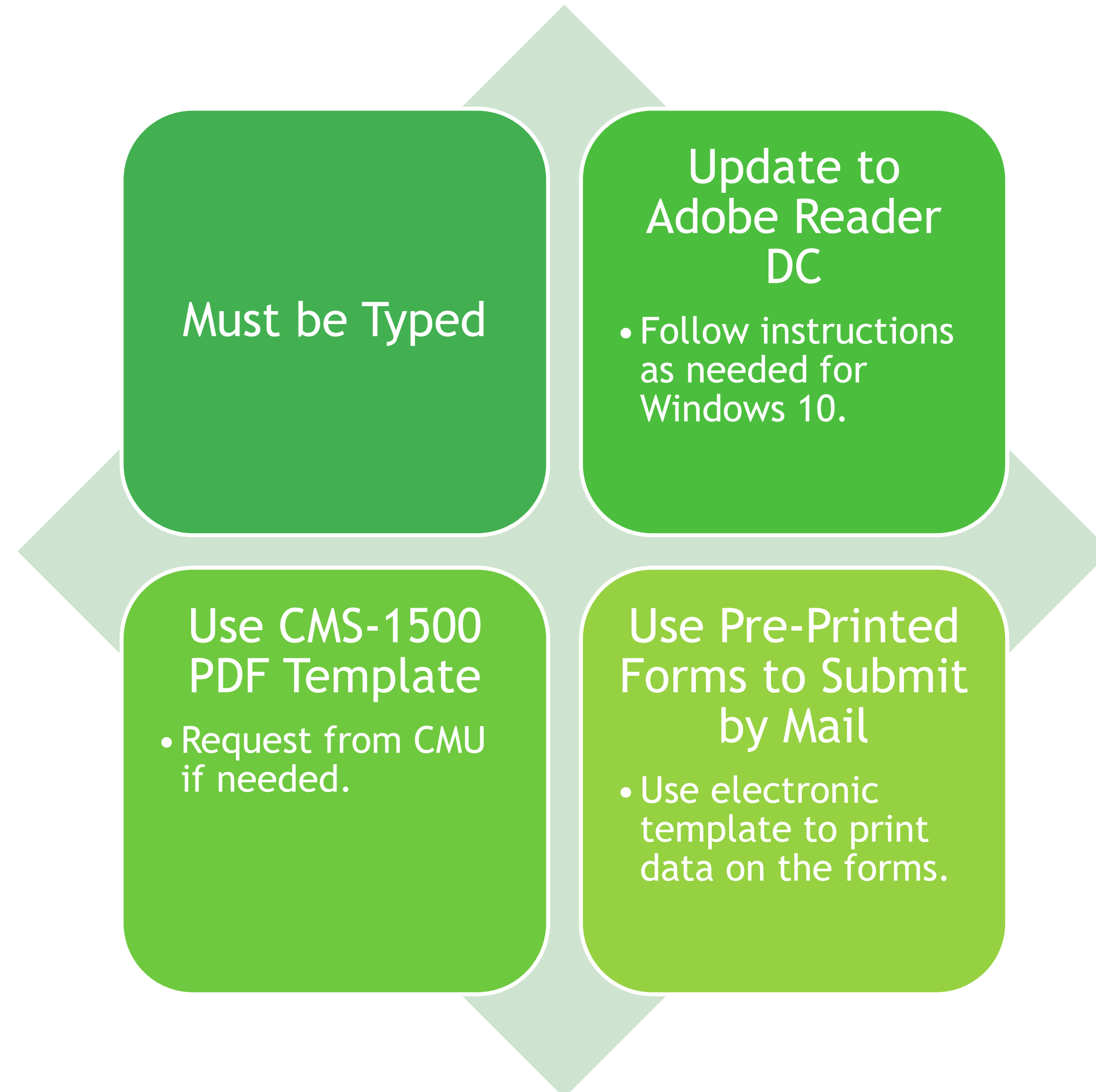
Snail Mail

Not recommended but is available if needed

Mail to:

P.O. Box 5143, Lake Forest, CA 92609

CMS-1500 FORM – For claims submitted via mail



Availity

This option is recommended for larger groups or providers already registered with Availity. Payer ID = CCMHP.

Availity is a Clearinghouse.

Must have software needed to submit 837 claims. Usually software is included with EHR systems.

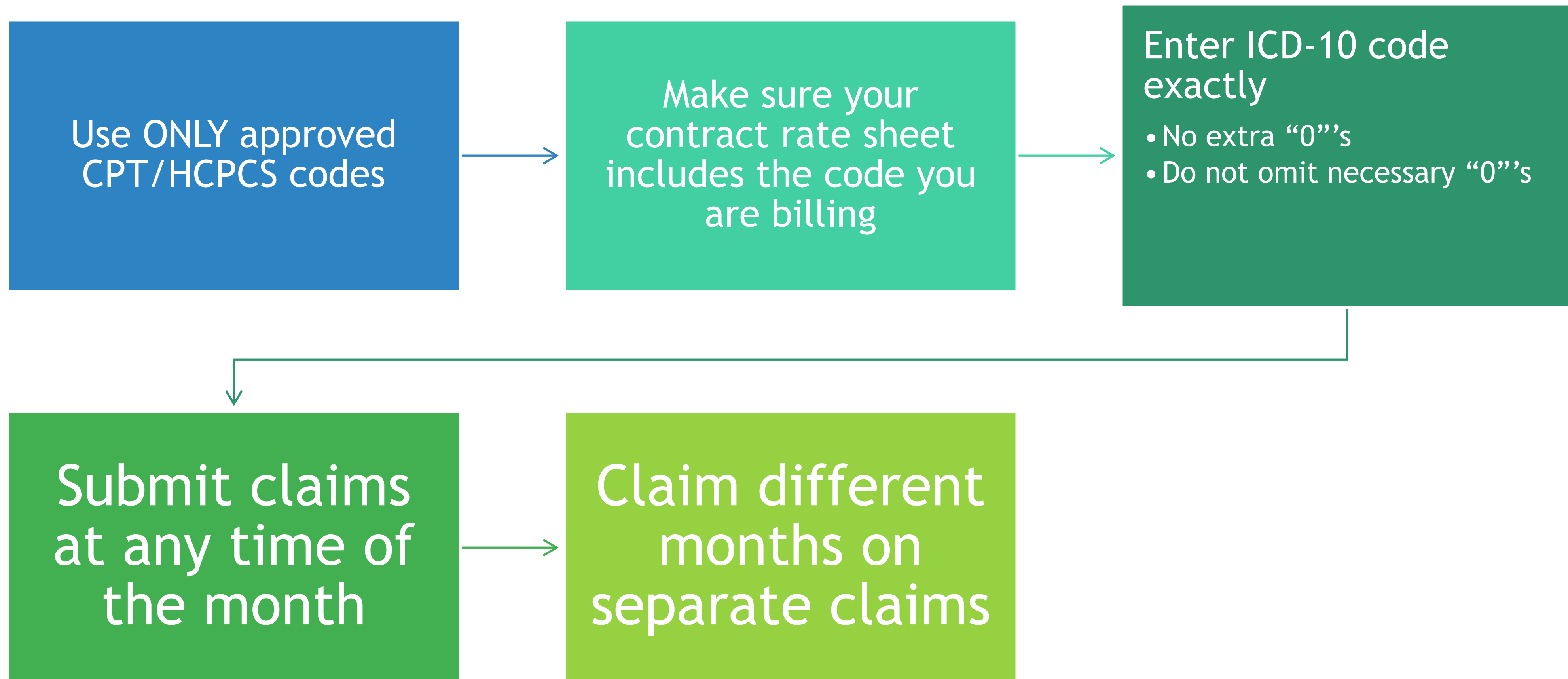
Any questions/problems – contact Availity directly: https://www.availity.com/ediclearinghouse.

Provider Portal

CMU Recommends using this option

Live demo – will review the steps

TIPS ON CLAIMS (1 of 2)



MORE TIPS ON CLAIMS (2 of 3)

Place of Service Codes (Box 24b)

- Use code “11” for Face-to-Face.
- Use code “02” for Telehealth (phone/video) services when the member is in the community/other than members' home.
- Use code “10” for Telehealth (phone/video) services when the member is in their home.

MORE TIPS ON CLAIMS (3 of 3)

Modifier Code (Box 24d)

- For 2 CPT codes on the same day, use modifier 59 (Does not apply to HCPCS codes)
  - Refer to CPT Tip Sheet for which line to add the 59 modifier.
- For Telehealth Services:
  - Phone = modifier 93
  - Video = modifier 95
  - Phone service for any HCPCS code = modifier SC
- For Group services
  - When using G2212 = modifier HQ

SAMPLE OF PRINTED REMITTANCE ADVICE

Below is a snapshot & key to reading your RA

CRUISER, GAIL

Page 1 of 1

CONTRA COSTA HEALTH SERVICES

Behavioral Health Services - Remittance Detail Report

Remittance Advice - Business Group: BHS BUSINESS GROUP   Account: BHS CHECKING ACCOUNT

1 **Vendor:** CRUISER, GAIL
123 MAIN STREET
WISCO, CA 94555-0123

Check Number: 09876
Check Date: 09/21/2019
Check Amount: $491.40

PATIENT NAME	DOB	MRN	CLAIM #	SERVICE DATE	CPT CODE	BILLED	DISALLOWED AMOUNT	CODE(S)	NET PAYMENT
Service Provider: CRUISER, GAIL [789012]									
STAIRS, ROMAN	08/18/2010	300001236	10107777	08/06/2019	90834	70.20	0.00	C	70.20
STAIRS, ROMAN	08/18/2010	300001236	10107777	08/20/2019	90834	70.20	0.00	C	70.20
			Claim Total - 10107777			140.40	0.00		140.40
VILLE, LOUIS	04/08/2003	300123456	10107599	08/01/2019	90834	70.20	0.00	C	70.20
			Claim Total - 10107599			70.20	0.00		70.20
VILLE, LOUIS	04/13/2003	300123456	10107601	08/01/2019	90834	70.20	0.00	18,CD	0.00
** CLAIM DENIED **			Claim Total - 10107601			70.20	0.00		0.00
GAS, PETRO	05/04/2010	300268123	10207498	08/14/2019	90834	70.20	0.00	C	70.20
GAS, PETRO	05/04/2010	300268123	10207498	08/28/2019	90834	70.20	0.00	C	70.20
			Claim Total - 10207498			140.40	0.00		140.40
SELL, CAROL	03/03/1994	300988106	10107483	08/06/2019	90834	70.20	0.00	C	70.20
SELL, CAROL	03/03/1994	300988106	10107483	08/20/2019	90834	70.20	0.00	C	70.20
			Claim Total - 10107483			140.40	0.00		140.40
			PROVIDER TOTAL - 5 CLAIMS			*561.60*	*0.00*		*491.40*

Markers on the sample: 2 (column headings), 3 (service provider line), 4 (patient names), 5 (claim details), 6 (net payment), 7 (claim denied), 8 (reason code)

9 **Total Remittance Amount** **$491.40**

10

CODE(S) DESCRIPTION
[18] 18-Duplicate claim/service. Generated by EDI claim load
[C] Contracted Rate Payment
[CD] Claim Denied

1. Vendor Name, Address, Check Number, Check Date & Check Amount
2. Description of each column on the RA
3. Service Provider Name
4. Patient/Client Name
5. Patient/Client information & claim submitted (DOB, MRN, Claim#, Service Date, CPT Code, Billed Amount, Disallowed amount)
6. Contract Rate Payment = Net Payment for claim submitted
7. Claim Denied Verbiage
8. Claim Paid and/or Denied Reason (see #10 for reason code description)
9. Total Remittance Amount for this check cycle
10. Code (s) Description

INFORMAL APPEALS for Denied Claims

Review RA or Claim record in Provider Portal.

If you are unable to determine reason for denial, or you disagree, contact CMU:

Message through Portal

Call 925-372-4400 Option 4

Have your records handy for reference when you call

IF the informal appeal is denied by CMU, a Notice of Action (NOA) will be issued.
The NOA goes to both the provider and the member.
A formal appeal process is delineated in the NOA.

CPT Codes

CPT Code	Description	Units allowed per day	Allowable Modifiers	May not be billed with:	Notes
90785	INTERACTIVE COMPLEXITY, PER OCCURRENCE	1	93, 95	90839,90840,T1013	This must be billed with another service as a base code
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION 15 MINUTES	1	59, 93, 95	90792, 90832-90834, 90836-90838, 90847, 90853, 96116	May bill assessment w/ 90839, 90840, 96127, 99202-99205, 99212-99215 using a 59 modifier on one of these codes
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION 15 MINUTES	1	59, 93, 95	90791, 90832-90834, 90836-90838, 90847, 90853, 96116	May bill assessment w/ 90839, 90840, 96127, 99202-99205, 99212-99215 using a 59 modifier on one of these codes
90832	PSYCHOTHERAPY W/ PATIENT 16-37 MINUTES	1	59, 93, 95	90791, 90834, 90837, 90839, 90840	
90834	PSYCHOTHERAPY W/ PATIENT 38-52 MINUTES	1	59, 93, 95	90791, 90832, 90837	
90837	PSYCHOTHERAPY W/ PATIENT 53-67 MINUTES	1	59, 93, 95	90791, 90832, 90834, 90839, 90840	
90839	PSYCHOTHERAPY FOR CRISIS, FIRST 30-74 MINUTES	1	None	90791, 90792, 90832, 90834, 90837, 90847, 90853	Must be performed in person
90840	PSYCHOTHERAPY FOR CRISIS, EACH ADDTL 30 MINUTES	13	None	90791, 90792, 90832, 90834, 90837, 90847, 90853	Must be billed with 90839. Must be performed in person
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINUTES	1	59, 93, 95	90791, 90792, 90839, 90840	
90853	GROUP PSYCHOTHERAPY, 15 MINUTES	1	59, 93, 95	90791, 90792, 90839, 90840	

LMFT, LCSW, LPCC, PsyD, & PHD Codes

CPT Code	Description	Units allowed per day	Allowable Modifiers	May not be billed with:	Notes
90885	REVIEW OF HOSPITAL RECORDS	1	59, 95	90791, 90792, 90839, 90840	
96110	DEVELOPMENTAL SCREENING, 15 MINUTES (PER INSTRUMENT)	1	59, 95		
96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT, 15 MINUTES (PER INSTRUMENT)	1	93, 95		
96130	PSYCHOLOGICAL TESTING EVALUATION, 1ST HOUR	1	59, 93, 95	Psychiatry Codes	
96131	PSYCHOLOGICAL TESTING EVALUATION, EACH ADDITIONAL HOUR	22	59, 93, 95	Psychiatry Codes	Must be billed with 96130
G2212	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE BEYOND THE MAXIMUM TIME, EACH ADDTL 15 MIN	14	SC	H2011, H2021	May only be billed with assessment/therapy/ psychiatric codes
H0032	MENTAL HEALTH SERVICE PLAN DEVELOPMENT, 15 MINUTES (family tx w/o member)	96	SC	G2212	
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	32	SC	G2212	
H2021	COMMUNITY BASED WRAP AROUND SERVICES, 15 MIN (COLLATERAL)	96	SC	G2212	
T1013	SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES, 15 MIN	variable	SC	90785 & 90885	Bill the number of units needed to cover the service provided.

LMFT, LCSW, LPCC, PsyD, & PHD Codes

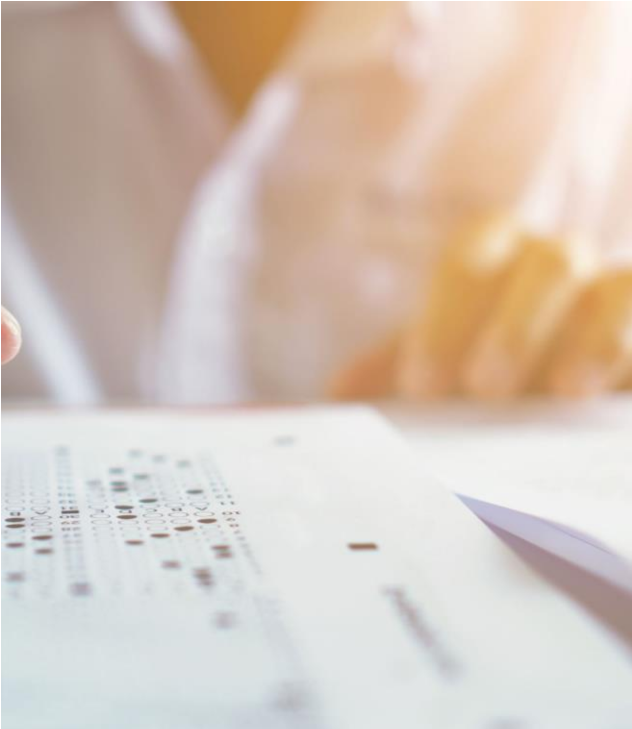
CPT Code	Description	Units allowed per day	Allowable Modifiers	May not be billed with:	Notes
90785	INTERACTIVE COMPLEXITY, PER OCCURRENCE	1	93, 95	90839,90840,T1013	
90791	PSYCHIATRIC DIAGNOSTIC EVALUATION 15 MINUTES	1	59, 93, 95	90792, 90832-90834, 90836-90838, 90847, 90853, 96116	
90792	PSYCHIATRIC DIAGNOSTIC EVALUATION 15 MINUTES	1	59, 93, 95	90791, 90832-90834, 90836-90838, 90847, 90853, 96116	
90833	PSYCHOTHERAPY, 30 MINUTES W/ PATIENT WHEN PERFORMED W/ E&M SERVICE	1	59, 93, 95	90791, 90792, 90836, 90838, 90839, 90840	Must be billed w/ an E&M code (99202-99205 or 99212-99215)
90836	PSYCHOTHERAPY, 45 MINUTES W/ PATIENT WHEN PERFORMED W/ E&M SERVICE	1	59, 93, 95	90791, 90792, 90833, 90838, 90839, 90840	Must be billed w/ an E&M code (99202-99205 or 99212-99215)
90838	PSYCHOTHERAPY, 60 MINUTES W/ PATIENT WHEN PERFORMED W/ E&M SERVICE	1	59, 93, 95	90791, 90792, 90833, 90836, 90839, 90840	Must be billed w/ an E&M code (99202-99205 or 99212-99215)
90839	PSYCHOTHERAPY FOR CRISIS, FIRST 30-74 MINUTES	1	None	90791, 90792, 90832, 90834, 90837, 90847, 90853	Must be performed in person
90840	PSYCHOTHERAPY FOR CRISIS, EACH ADDTL 30 MINUTES	13	None	90791, 90792, 90832, 90834, 90837, 90847, 90853	Must be billed with 90839. Must be performed in person
90885	REVIEW OF HOSPITAL RECORDS	1	59, 95	90791, 90792, 90839, 90840	

MD Codes

CPT Code	Description	Units allowed per day	Allowable Modifiers	May not be billed with:	Notes
99202	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 15-29 MINUTES	1	59, 95	99212-99215	
99203	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 30-44 MINUTES	1	59, 95	99212-99215	
99204	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 45-59 MINUTES	1	59, 95	99212-99215	
99205	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 60-74 MINUTES	1	59, 95	99212-99215	
99212	OFFICE OR OTHER OUTPATIENT VISIT OF ESTABLISHED PATIENT 10-19 MIN	1	59, 95	99202-99205	
99213	OFFICE OR OTHER OUTPATIENT VISIT OF ESTABLISHED PATIENT 20-29 MIN	1	59, 95	99202-99205	
99214	OFFICE OR OTHER OUTPATIENT VISIT OF ESTABLISHED PATIENT 30-39 MIN	1	59, 95	99202-99205	
99215	OFFICE OR OTHER OUTPATIENT VISIT OF ESTABLISHED PATIENT 40-54 MIN	1	59, 95	99202-99205	
G2212	PROLONGED OFFICE OR OTHER OUTPATIENT SERVICE BEYOND THE MAXIMUM TIME, EACH ADDTL 15 MIN	14	SC	H2011, H2021	May only be billed with assessment/therapy/ psychiatric codes
H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES	32	SC	G2212	Use when crisis intervention was provided via phone or video appointment
H2021	COMMUNITY BASED WRAP AROUND SERVICES, 15 MIN (COLLATERAL)	96	SC	G2212	
T1013	SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES, 15 MIN	variable	SC	90785 & 90885	Bill the number of units needed to cover the service provided.

MD Codes

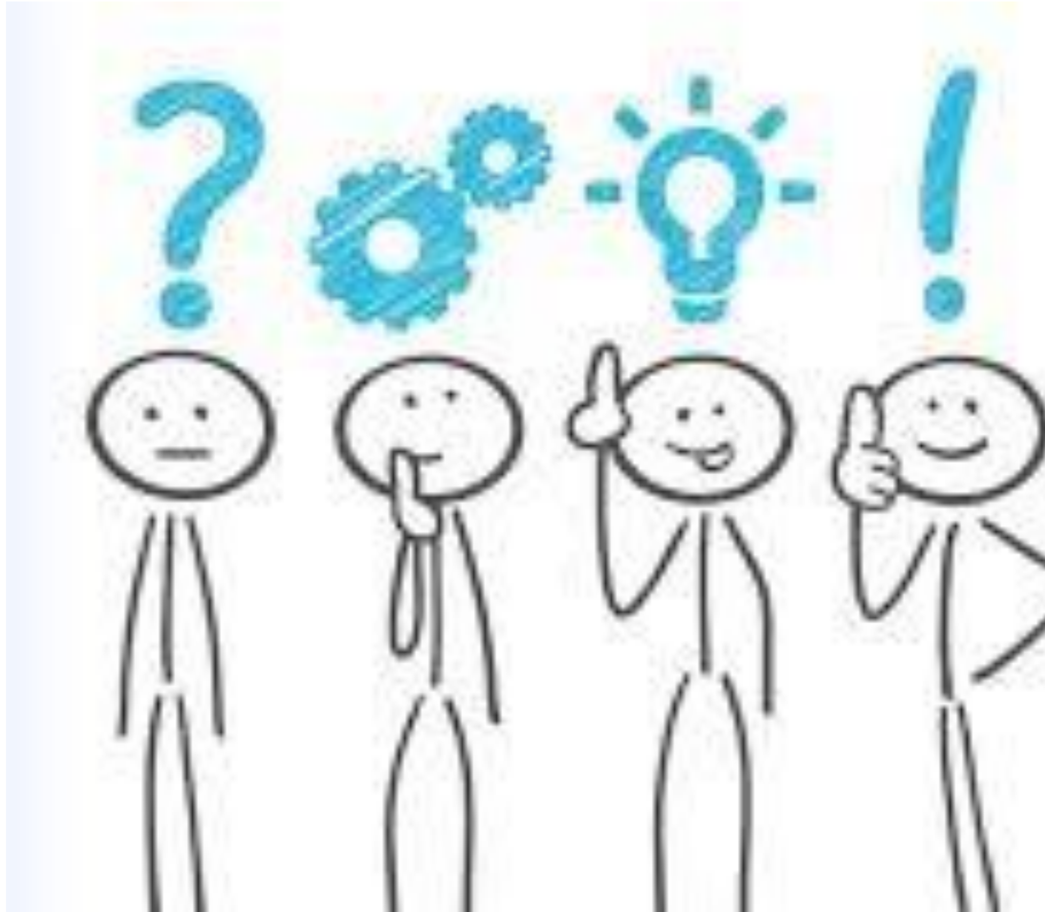
Note on Collateral



- Collateral services can STILL BE BILLED under Payment Reform. They simply no longer utilize a distinct service code called “Collateral”.
- Collateral can be a component of many mental health services. When documenting a collateral contact, providers should select the service code that most closely fits the service provided and it should be clear in the progress note that the service was provided to a collateral contact.
- Possible collateral codes:
  - 90791 – Meeting with caregiver/significant support person/other treatment providers to gather information to inform an assessment/re-assessment.
  - H0032 – Meeting with caregiver/significant support person/other treatment providers to develop a member plan.
  - H2021 – Consultation with other treatment providers in an exchange of information.

CPT Code Tip Sheet

- **Providers will receive a “Tip Sheet” which will go over the definitions/guidelines for CPT codes and modifiers.**



Claims / CPT Code Questions?

PROVIDER PORTAL

PROVIDER PORTAL

- Web-Based Access to Real-Time member Information
  - member List
  - Eligibility
  - Attachment of Forms to Customer Relationship Management (CRM) Messages
  - Claims Status
  - CRM and In-basket Messaging

Provider Portal Registration Process

- Provider Completes ccLink Provider Portal Access Agreement – PRINT LEGIBLY
- Include Attachment A:
  - Portal Access User Request
  - Solo Providers = Provider
  - Group\Org Providers = All Staff\Office Admin Accessing Provider Portal on Behalf of Provider
- Primary user will receive two emails when account is set up.

PROVIDER PORTAL DEMO

Claim Status

Information about the status of the claim will be provided as the claim changes status in processing.

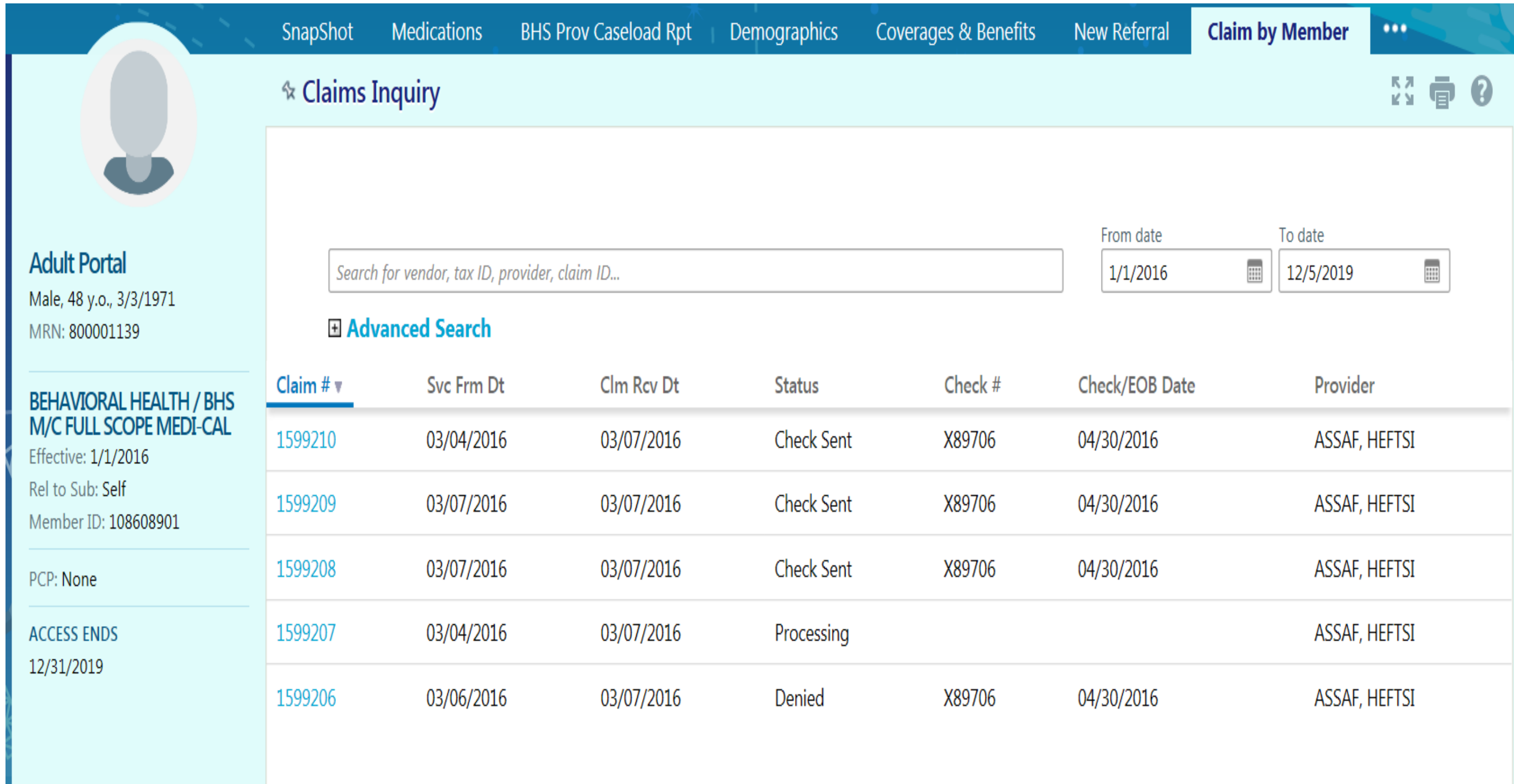
Claims Unit Processing

- Approved
- Pending
- Denied

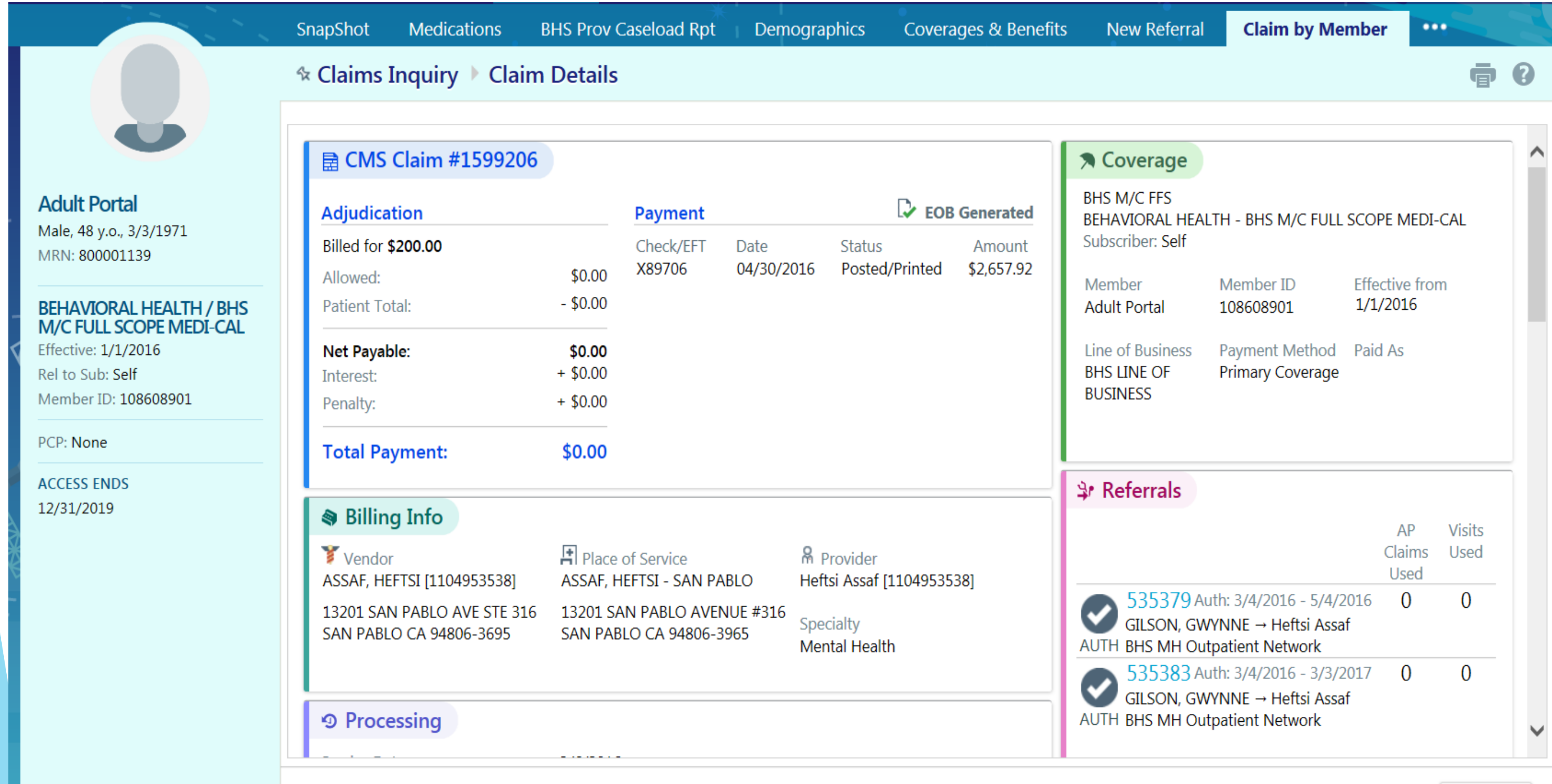
Auditors Office Check Cycle

- Processed
- Check Sent

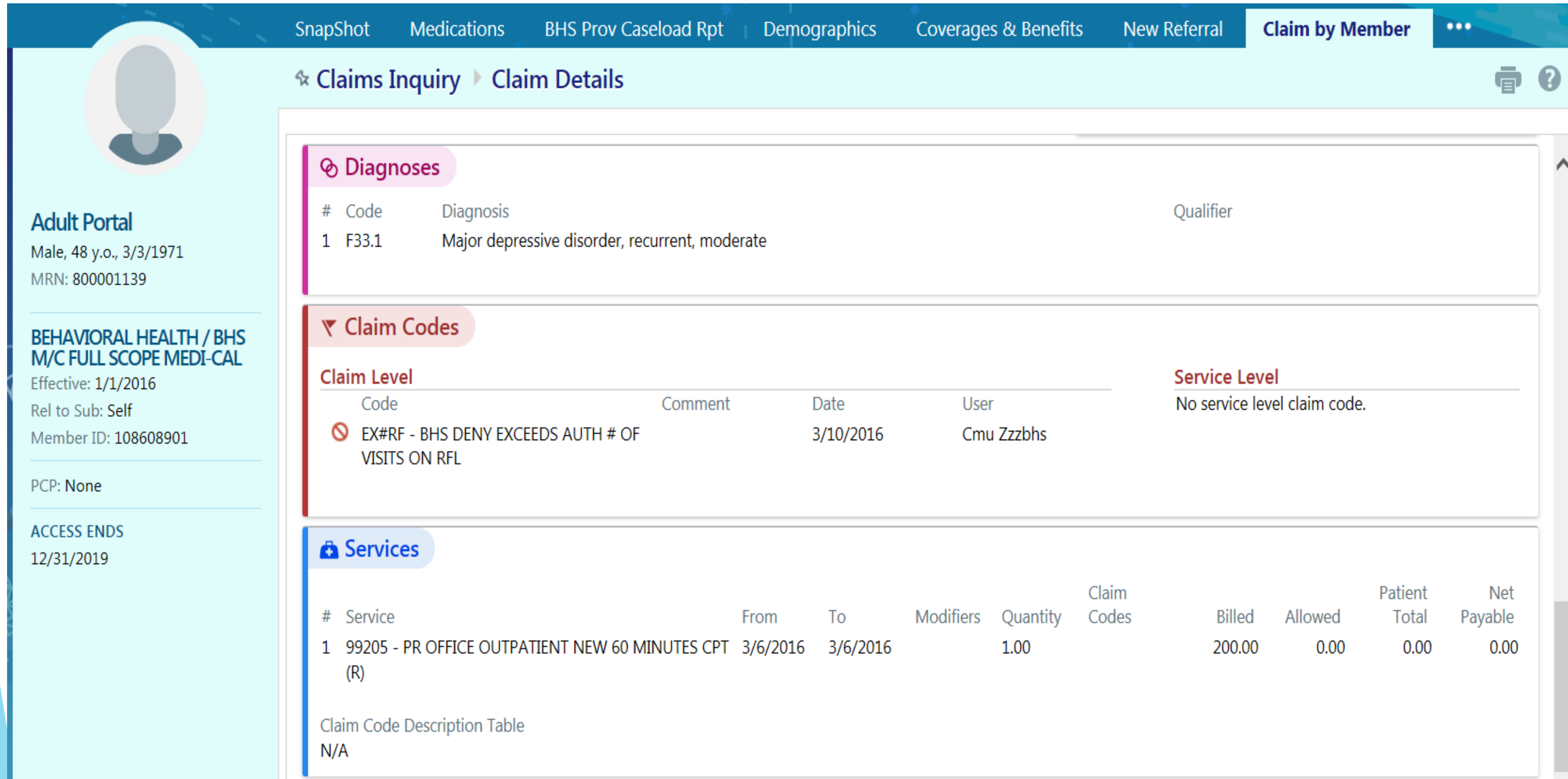
CLAIM STATUS
Click on Claim # to see detail



CLAIM STATUS (1 of 2)



CLAIM STATUS (2 of 2)



Provider Portal Questions?

Technical Support

Phone: (925) 957-7272

E-Mail: BHS.Support@cchealth.org

Lastly, We're Here for ***YOU***!

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Website:https://www.cchealth.org/health-insurance/information-for-providers/mental-health-network-provider