CONTRA COSTA HEALTH

CMU Updates – FINAL

PRESENTED BY:

BEHAVIORAL HEALTH SERVICES (BHS)

CARE MANAGEMENT UNIT (CMU)

INTRODUCTIONS

Welcome

Purpose of Training

Ensure all network providers are aware of recent and upcoming changes related to CalAIM

Housekeeping\Breaks

- Please put your name in the chat
- Zoom Tips
- Depending on the pace of the training we may take 1 10-minute break

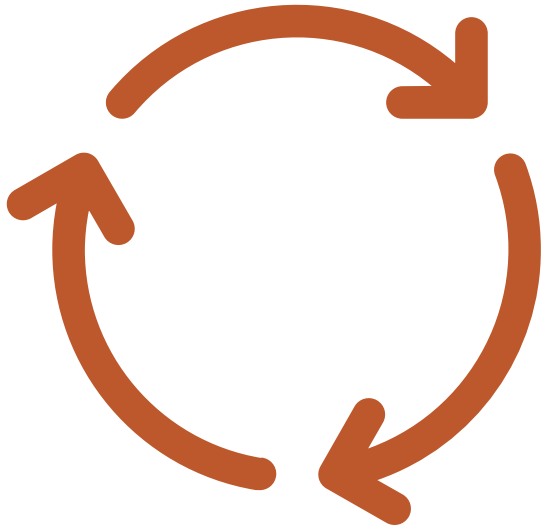
Question Format

- Please put your questions in the “chat”
- We will address questions at the end of each section
- There will be time at the end of the training for additional questions

Presenter Introductions

Agenda

- CMU Structure
- High level overview of CalAIM Updates
- Payment Reform
- CMU Documentation Requirements
- CMU Quality Review
- Questions



Care Management Unit (CMU)

Overview of CMU Lines of Business/Programs

	SPECIALTY MENTAL HEALTH SERVICES (SEVERE)	NON-SPECIALTY MENTAL HEALTH SERVICES (MILD/MODERATE)
Responsibility	• The Contra Costa Mental Health Plan (CCMHP) is responsible for service delivery	• 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 IX criteria	• Adheres to Medi-Cal & CCHP guidelines which are less restrictive than Title IX
Forms	• Registration & Admission Form • Mental Health Assessment Form • Levels of Care Determination Form (future) • Discharge Form	• Registration & Admission Form • Prior Authorization Form • Mental Health Assessment Form • Discharge Form

How will I know my client's acuity?

Provider Portal	Authorization Letter	Consult if Needed
Provider Portal will display the acuity. Mild/Moderate or Moderate/Severe.	Authorization Letters will display the acuity or program. Mild/Moderate Services or Specialty Mental Health Services.	If the acuity displayed does not match what you feel the client's acuity is, call CMU to consult.

How will acuity be assigned?

Acuity will be identified through:

A screening completed by the Access Line

And/or

An assessment from a network provider

CalAIM – California Advancing and Innovating Medi-Cal

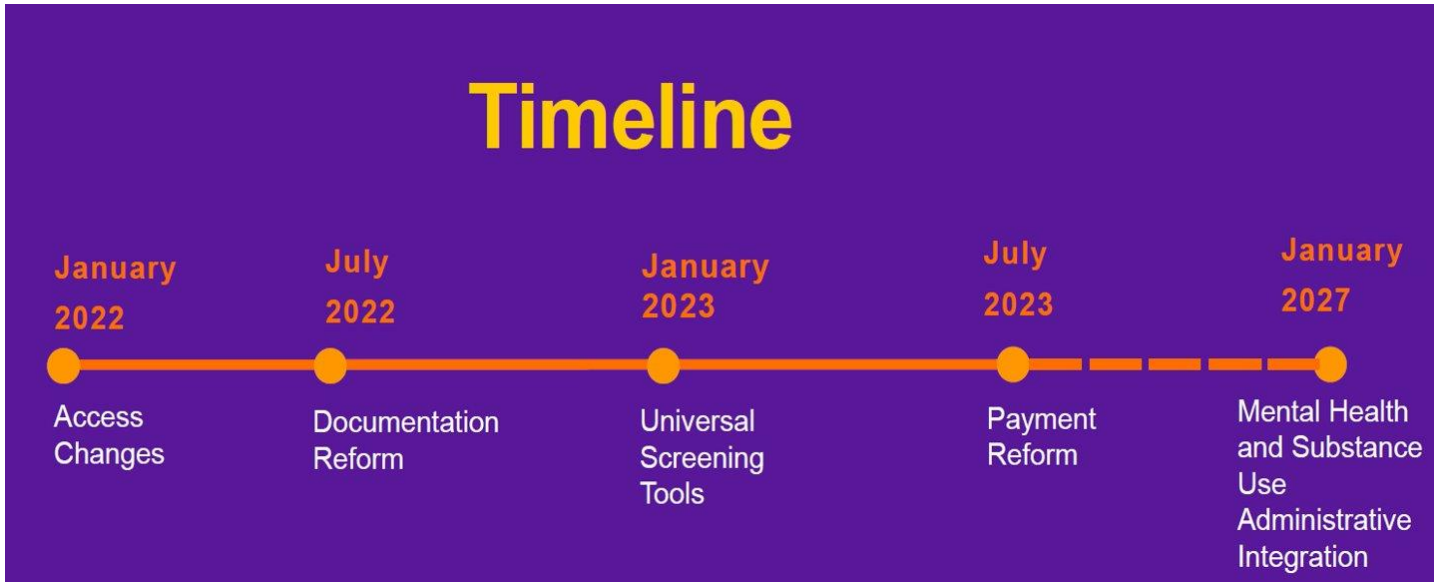
OVERVIEW OF UPDATES

CalAIM Timeline

Goal 1: Implementation of CalAIM Policy Changes

Goal 2: Payment Reform

Goal 3: Data Exchange



Goals of CalAIM

1

Identify and manage comprehensive needs through whole person care approaches and social drivers of health.

2

Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.

3

Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

Effective 1/1/2022 - Treatment may begin prior to completion of an assessment/diagnosis. Also, No Wrong Door introduced. Non-specialty and specialty mental health services can be provided concurrently, if the services are coordinated and not duplicative. Co-Occurring treatment is acceptable if you are practicing within your scope of practice.

Effective 7/1/2022 – Assessment form and Progress Note were updated, and Problem List introduced.

Effective 1/1/2023 – New Access Screening Tool and Transition of Care Tool introduced.

Summary of CalAIM Changes to Date

Z Codes

Z Codes may be used prior to establishing a mental health diagnosis:

Z55-65 – DHCS “Priority” Social Determinants of Health: Persons with potential health hazards related to socioeconomic and psychosocial circumstances.

Z03.89 – Encounter for observation for other suspected diseases and conditions ruled out.

“Other specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services.”

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	*Inadequate drinking-water supply*
Z59.00	*Homelessness unspecified*
Z59.01	*Sheltered homelessness*
Z59.02	*Unsheltered homelessness*
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	*Food insecurity*
Z59.48	*Other specified lack of adequate food*
Z59.7	Insufficient social insurance and welfare support
Z59.811	*Housing instability, housed, with risk of homelessness*
Z59.812	*Housing instability, housed, homelessness in past 12 months*
Z59.819	*Housing instability, housed unspecified*
Z59.89	*Other problems related to housing and economic circumstances*
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Universal Screening Tools & Transition of Care Tool

EFFECTIVE JANUARY 1, 2023

Universal Screening & Transition of Care Tools – New Standardized Screening Tools

January 1, 2023 – New standardized screening tools were implemented for all counties in California.

There are 3 tools:

- Adult Screening Tool (ages 21+)
- Youth Screening Tool (under age 21)
- Youth Screening Tool (adult calling on behalf of an individual under 21)

The Access Line will primarily use the screening tools.

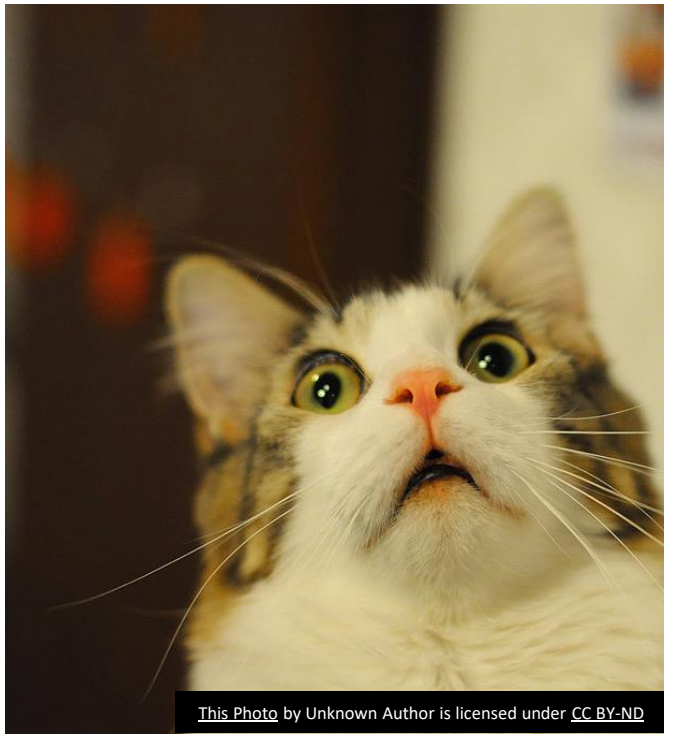
A screening is not required if the individual contacts a provider directly and an assessment is scheduled/completed.

A Screening is NOT always required

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

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

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



What to do when a client 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**
- **Medi-Cal Webpage**
- **Contact CMU – 925-372-4400, option 1**

Provider Portal

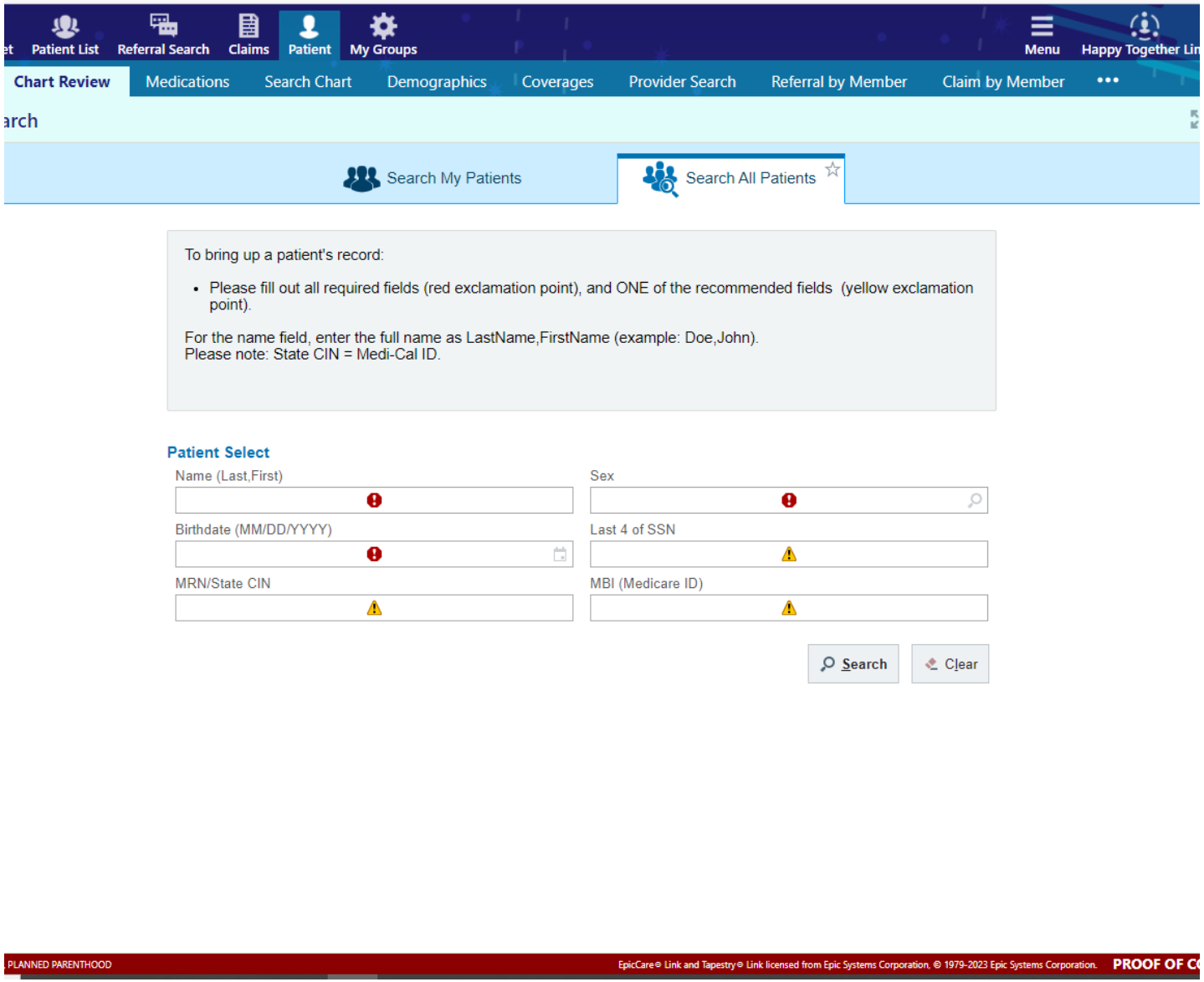
Through “Patient Lookup” you may find an individual using 4 pieces of information:

First Name

Last Name

Date of Birth

CIN (Medi-Cal Number) / Social Security Number



Provider Portal – Cont'd

A CRM may also be sent to CMU requesting verification client is eligible for services.

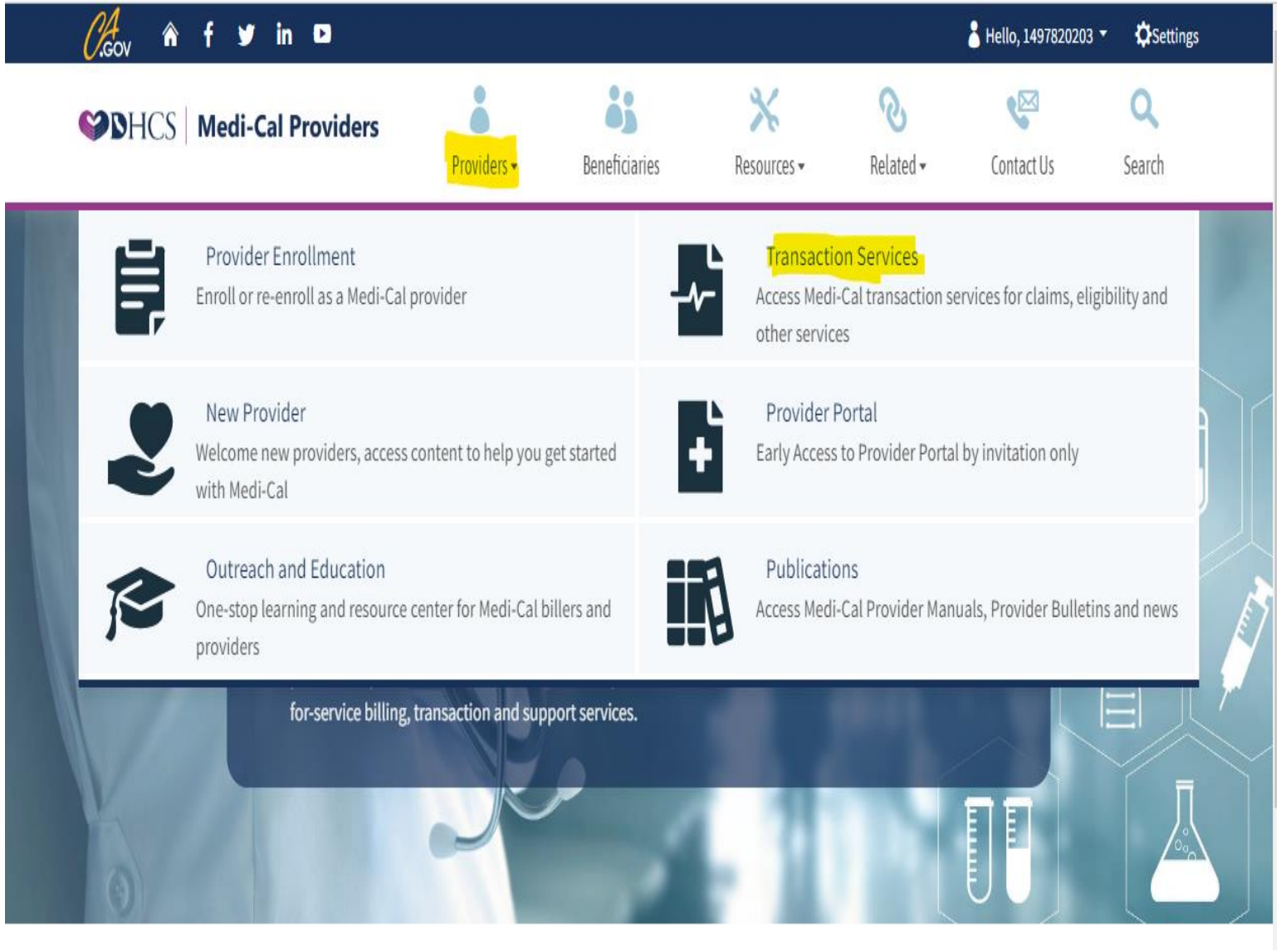
Provide the client's first and last name, DOB, CIN.

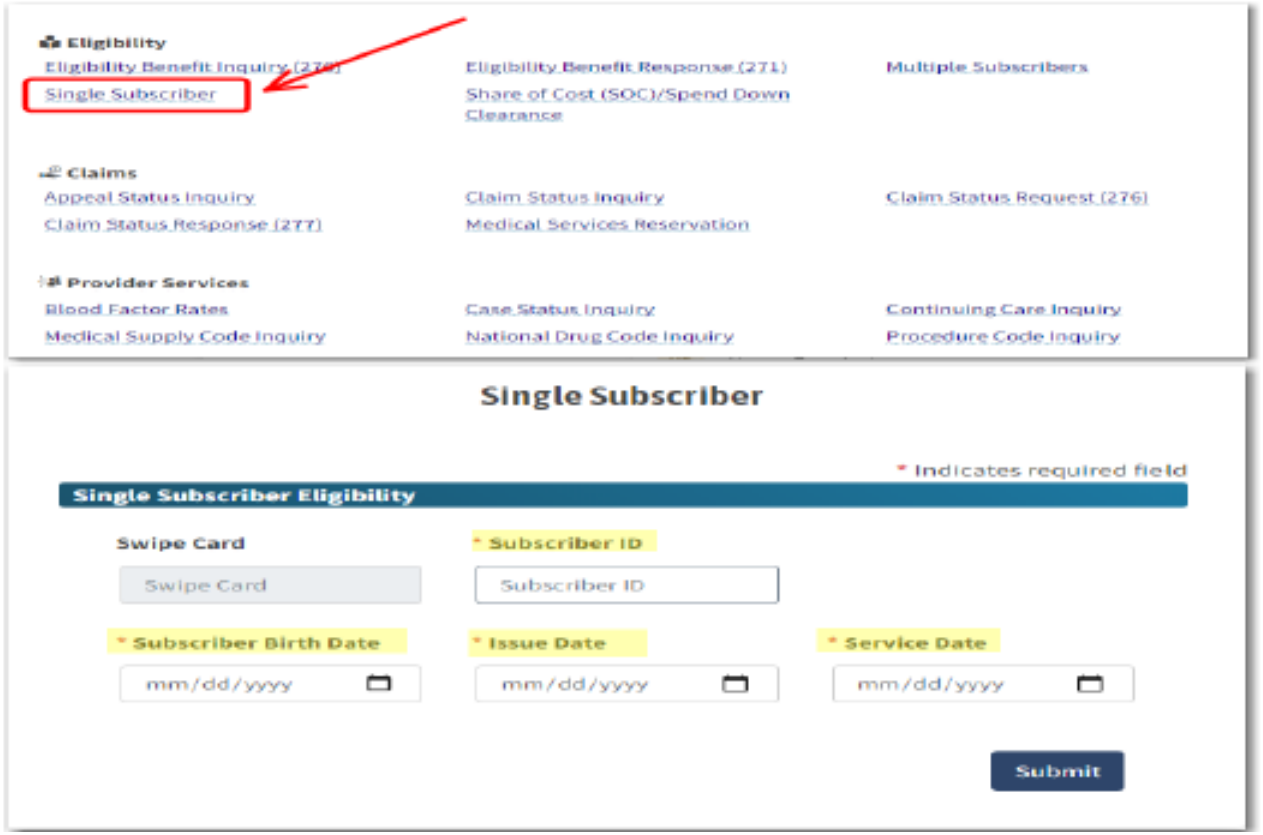
If you can see the client, you may also provide information on the date an initial authorization is needed.

Medi-Cal Webpage

All providers registered with DHCS can request access to the Medi-Cal webpage.
Log on to the State Medi-Cal website: Medi-Cal: Provider Home Page.
Click on “Providers” (top) and then “Transactions Services” on the right-hand column.

Please note: If this is the first time you are using the state website, you will need to complete internet enrollment forms with the State.





- Select "Single Subscriber"
- Enter in required data
  - **Subscriber ID**: SSN or CIN
  - **Subscriber Birth Date**
  - **Issue Date:** Use the current date
  - **Service Date**: Date services are being rendered

The "Eligibility Message" will provide an over-view of coverage including:

- Client name
- County code and aid code
- Type of Medi-Cal
- Medicare Information
- Managed Medi-Cal plan information
- Any OHC ("Other Health Insurance") information

- **Name :** Subscriber first and last name
- **Subscriber ID**
- **Service Date:** This will be the date you entered
- **Issue Date:** This will be the date you entered

- **First Special Aid Code**
- **Third Special Aid Code**
- **HIC Number:** (Medicare #)
- **Trace Number:** Eligibility Verification Confirmation Number

- **Submitted ID:** CIN or SSN used to look client up
- **Subscriber Birth Date**

- **Primary Aid Code**

- **Second Special Aid Code**
- **Subscriber County:** The county the Medi-Cal is assigned to

What to do when a client contacts you directly (Cont'd)

2) Immediately after the 1st session:

- Submit the Registration & Admission Form to CMU.
- Submit your initial assessment information to CMU.
  - If the Clinical Assessment form was not completed, submit the progress note from that first session.
  - Based on the information provided, CMU will assign acuity and issue an initial authorization.*

Providers do not need to call Access/CMU for an initial authorization prior to the first session.

What to do when a client contacts you directly (Cont'd)

3) Complete the Clinical Assessment Form

- Non-specialty Mental Health – submit the Prior Authorization and assessment after the 8th session.
- Specialty Mental Health – submit the assessment within 60 days of the admission date.

Universal Screening & Transition of Care (TOC)Tool –

Transition of Care Tool

The transition of care (TOC) tool is used when:

1) an individual's needs require a new or an additional service

AND

2) the acuity changes from mild/moderate to severe or severe to mild/moderate

Providers will determine whether a client's change in symptoms indicate a change in acuity

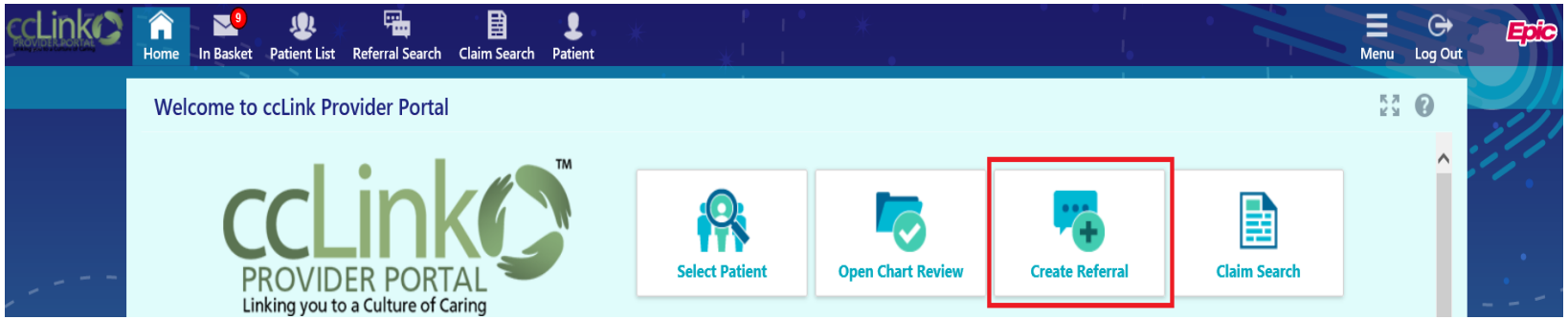
If there is a change in symptoms BUT a new or additional service is not needed, then a TOC is not indicated.	**Contact CMU to report the change in symptoms and a new acuity will be generated based on your information.**

How to submit a TOC Tool

A new feature will be added to the Provider Portal.

Soon (date TBD), there will be a “Referral” tab in your Provider Portal.

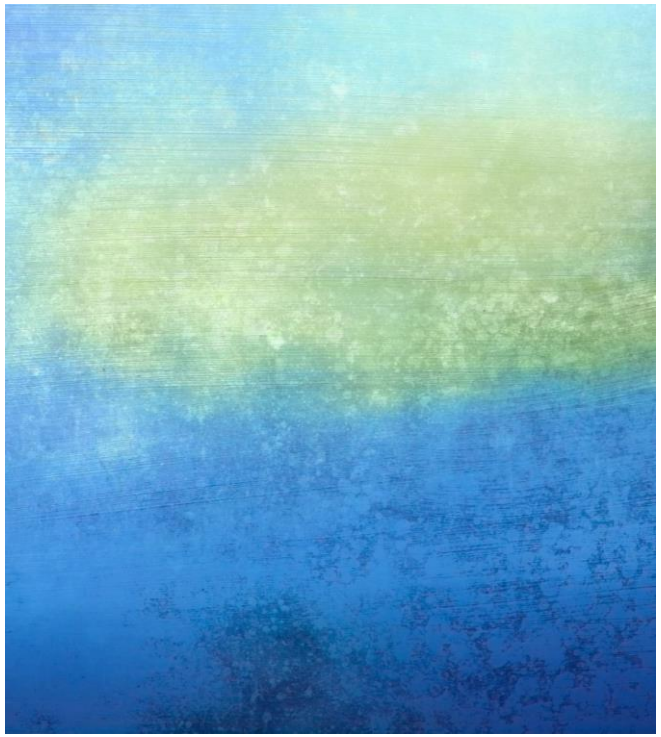
Network providers will be able to submit the TOC tool through this referral function.



How to submit a TOC Tool – cont’d

Until the “Referral” function is enabled in the Provider Portal, you may send in the TOC tool via CRM or Fax.

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 must ensure that the referral loop is closed.


QUESTIONS

Payment Reform

EFFECTIVE JULY 1, 2023

What are the benefits of this transition?

Increased ability to understand the services rendered via data analysis – ability to share data between entities.

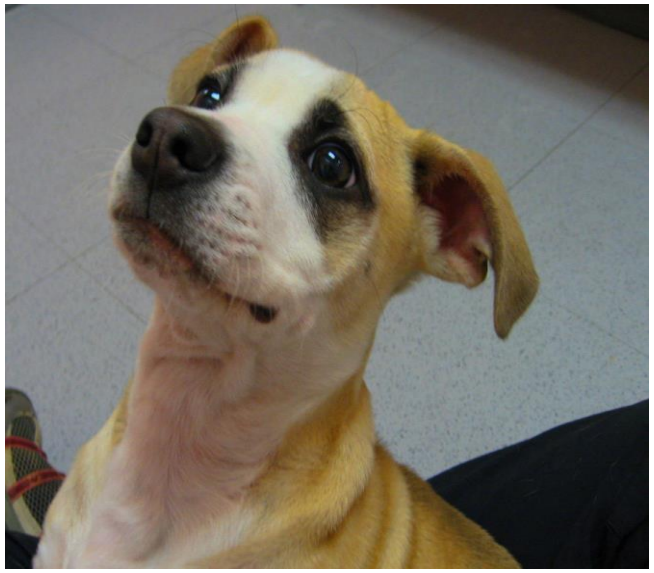
Additional granularity to describe the services provided.

Provides a more accurate reflection of the range of services and needs of beneficiaries served.

Payment Reform CPT Codes –

Upcoming Changes as a result of Payment Reform:

- Some of the current codes are going away and new ones are being introduced.
- Documentation time is not billable.
- There are updated modifiers.



Payment Reform CPT Codes cont'd –

Upcoming Changes as a result of Payment Reform:

- Add-on/Supplemental codes are being introduced.
- No partial units allowed (whole units only).
- CPT codes are linked to measurement of time. You will choose the correct CPT code based on the amount of time spent on the service.
- If you provide 1 hour of service you will bill 1 unit of 90837, not 1.25 units of 90834.

Add-On / Supplemental Codes

"Add-On" and "Supplemental Service" codes will be available.

- **Add-On Codes**: Most therapy codes only allow one unit per service, per day.
  - As needed, CMU will provide "Add-On" codes to allow for more time.
  - Code = G2212
- **Supplemental Service Codes**: The supplemental code for network provider will be used when interpreter services are used during a session. If using an interpreter during sessions, call CMU to request the "Supplemental Service" code be added to the current authorization.
  - Code = T1013

For both Add-On and Supplemental Codes, a primary CPT code must be used.

Changes to current CPT code structure

90791 – Assessment code (15 minutes) will replace 99205 (60 minutes)

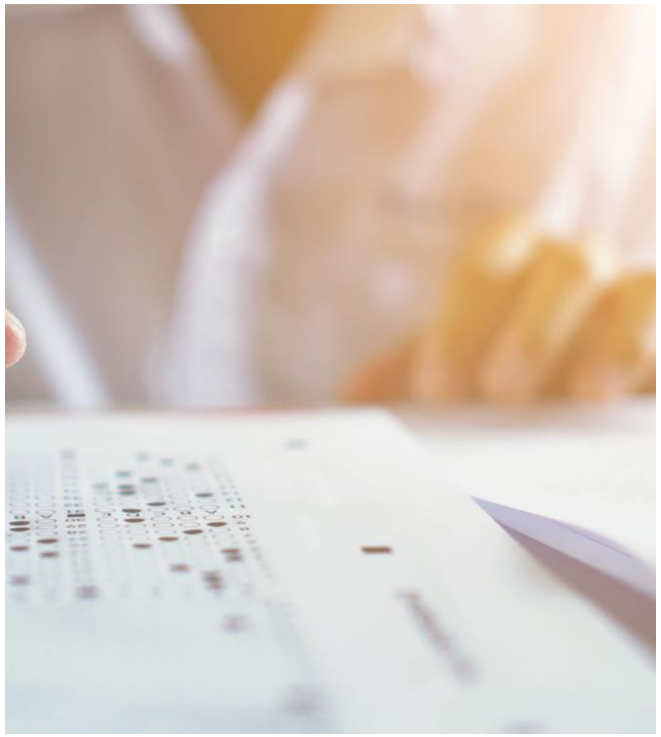
*you will be able to use the “Add on” code G2212 for time exceeding 15 minutes in a day

90846 will not be billable –

will use H0032

90887 will no longer be used for collateral contact* - Collateral will be covered by various H 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 client plan.
- H2021 – Consultation with other treatment providers in an exchange of information.

Changes to current CPT code structure - Therapists

New Codes:

- 90785 – INTERACTIVE COMPLEXITY, PER OCCURRENCE
- 90839 – PSYCHOTHERAPY FOR CRISIS - first 30-74 minutes
- 90840 – PSYCHOTHERAPY FOR CRISIS - each additional 30 minutes
- 90885 – PSYCHIATRIC EVALUATION OF HOSPITAL RECORDS, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes (15 minutes)
- 96110 DEVELOPMENTAL SCREENING, 15 MINUTES (PER INSTRUMENT)
- 96127 BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT, 15 MINUTES
- G2212 – ADD ON CODE, 15 minutes
- H0032 MENTAL HEALTH SERVICE PLAN DEVELOPMENT, 15 MINUTES
- H2011 CRISIS INTERVENTION SERVICE, PER 15 MINUTES
- H2021 COMMUNITY BASED WRAP AROUND SERVICES, 15 MIN (COLLATERAL)
- T1013 SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES, 15 MIN

Changes to current CPT code structure - Psychiatrists

New Codes:

➢90785 –	INTERACTIVE COMPLEXITY, PER OCCURRENCE
➢99202	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 15-29 MINUTES
➢99203	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 30-44 MINUTES
➢99204	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 45-59 MINUTES
➢99205	OFFICE OR OTHER OUTPATIENT VISIT OF NEW PATIENT 60-74 MINUTES
➢90885	PSYCHIATRIC EVALUATION OF HOSPITAL RECORDS, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes (15 minutes)
➢96110	DEVELOPMENTAL SCREENING, 15 MINUTES (PER INSTRUMENT)
➢96127	BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT, 15 MINUTES
➢G2212	ADD ON CODE, 15 minutes
➢H2011	CRISIS INTERVENTION SERVICE, PER 15 MINUTES
➢T1013	SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES, 15 MIN

* Replacement for Collateral is still being reviewed

CPT CODE	PROCEDURE DESCRIPTION	DURATION	Limitations	Max # units per day
90791	“Psychiatric” Diagnostic Evaluation (initial assessment)	15 min	Will use G2212 for any time over 15 minutes	1
90832	Individual Psychotherapy	16-37 min		1
90834	Individual Psychotherapy--- STANDARD SESSION	38-52 min		1
90837	Individual Psychotherapy	53 - 67 min		1
90839	Psychotherapy for Crisis	30-74 min		1
90840	Psychotherapy for Crisis	Additional 30 min		13
90847	Family Therapy-with client present	50 min		1
90853	Group Psychotherapy	15 min	Will use G2212 for any time over 15 minutes	1
H0032	Mental Health Service Plan Development	15 min	Can use this code when meeting with client’s family without the client present	96 (24 hrs.)
H2021	Community Based Wrap Around Services	15 min	Can use this code when communicating with members of the client’s treatment team	96 (24 hrs.)
G2212	Prolonged Office or Other Outpatient Service Beyond the Maximum time	15 min	Will use as an “add-on” code as needed	14 (3.5 hrs.)

Common CPT Codes for LPCC, LCSW, LMFT, PsyD, PhD

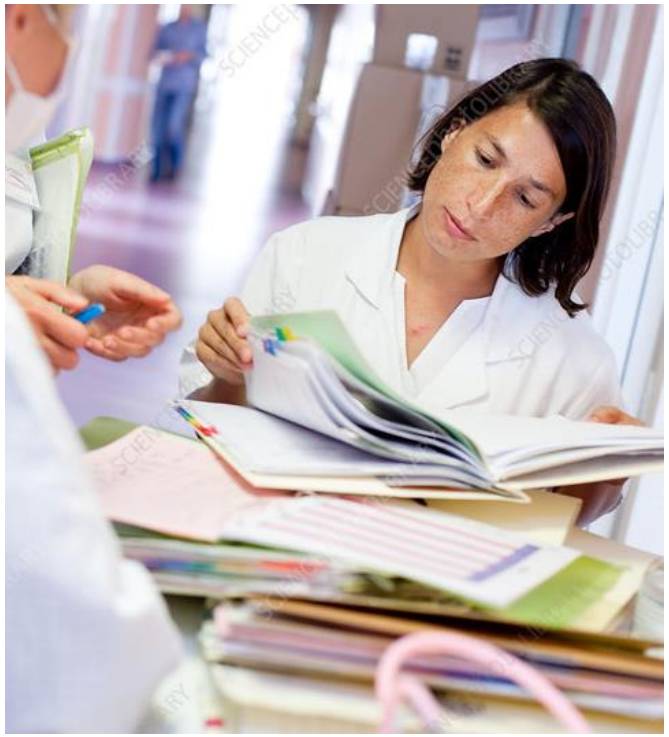
CPT CODES FOR MD'S	PROCEDURE DESCRIPTION	DURATION	LIMITATIONS	Max # units per day
90791	“Psychiatric” Diagnostic Evaluation (initial assessment)	15 min	Will use G2212 for any time over 15 minutes	1
90792	Psychiatric Diagnostic Evaluation with medical services	15 min	Will use G2212 for any time over 15 minutes	1
90833	Psychotherapy PT &/Family With E&M Services	16-37 min		1
90836	Psychotherapy PT &/Family With E&M Services	38-52 min		1
90838	Psychotherapy PT &/Family With E&M Services	53 - 67 min		
99202	E&M – Office or Other Outpatient Visit of NEW Client	15-29 min		1
99203	E&M – Office or Other Outpatient Visit of NEW Client	30-44 min		1
99204	E&M – Office or Other Outpatient Visit of NEW Client	45-59 min		
99205	E&M – Office or Other Outpatient Visit of NEW Client	60-74 min		1
99212	E & M - Office Outpatient Visit of ESTABLISHED Client	10-19 min		1
99213	E & M – Office Outpatient Visit of ESTABLISHED Client	20-29 min		1
99214	E & M – Office Outpatient Visit of ESTABLISHED Client	30-39 min		1
99215	E & M – Office Outpatient Visit of ESTABLISHED Client	40-54 min		1
G2212	Add-On Code	15 min		14

Common CPT Codes for MD, DO, NP

90885 - Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes

- The provider reviews the medical records of the patient pertaining to psychiatric evaluation to help in establishing the diagnosis and treatment plan.

- Can be used when need to review documents for clinical purposes when client is not present.



90839 – Psychotherapy for Crisis 30-74 minutes

Goal: stabilize an immediate crisis within a community or clinical treatment setting

The individual must be present for all or part of the service. Urgent assessment and exploration of an individual in crisis. Includes mental status exam as well as a disposition and treatment includes therapy, mobilization of resources, and implementation of interventions to address the crisis.

Add-on code: 90840, each additional 30 minutes

H0032 –
Mental Health Service Plan Developed by a Non-Physician*

Plan development means a service activity that consists of one or more of the following:

1) Development of client plans

2) Approval of client plans

3) Monitoring of a client's progress

- ❑ Can be used for case conferencing or consultation without MD when appropriate.
- ❑ Can be used for collateral when meeting with caregiver/significant support person to develop a care plan/client plan.

***Can use this code when meeting with a family without the client present.**

90785 - Interactive Complexity

Interactive complexity can be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, and group therapy.

Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure.

Interactive Complexity Continued

Psychiatric procedures may be reported with interactive complexity when at least one of the following is present:			
The need to manage maladaptive communication (high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.	Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.	Evidence or disclosure of a sentinel event and mandated report to third party (abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.	Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician and the other qualified health care professional and a patient who has not developed, or has lost either the expressive language communication skills to explain his/her symptoms and response to treatment or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

Interactive Complexity Continued

DO NOT USE:

- If using evaluation and management codes when no therapy has been rendered
- If there are multiple participants in the session but communication is straight forward
- If client attends sessions individually and there are no sentinel events or language barriers
- If the family member/caregiver's emotions and behaviors do not interfere with the treatment plan

Interactive Complexity Continued

EXAMPLE:

Mother and her young daughter are meeting with the therapist. Mother is emotional and will not allow the child to respond to the therapist's questions. The therapist finds herself in the middle working at managing the mother while still working with the young girl to address her needs. In this situation the provider can use Interactive Complexity but must document to this interactional difficulty.

MODIFIERS –

Modifiers provide a way to report or indicate that a service or procedure that has been performed has been modified by some specific circumstance but not changed in its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed

Modifier Codes

- 59 = services billed on the **same day**, **different codes**
- 76 = repeat procedure on **same day** with **same code**
- 93 = Telehealth services via **phone**
- 95 = Telehealth services via **video**
- HQ = When using G2212 for group therapy

When using multiple modifiers, always have 93/95 first.

Documentation Requirements

EFFECTIVE JULY 1, 2023

CMU Workflow Overview

IMMEDIATELY AFTER 1ST MEETING: SUBMIT CLIENT REGISTRATION & ADMISSION FORM

MILD TO MODERATE

SUBMIT PRIOR AUTHORIZATION REQUEST & CLINICAL ASSESSMENT AFTER 8 SESSIONS. NEW AUTHORIZATION IS GOOD FOR AN ADDITIONAL 8-26 SESSIONS. ALL AUTHORIZATIONS WILL BE FOR 1 YEAR

SEVERE

WITHIN 60 DAYS OF ADMISSION: SUBMIT CLINICAL ASSESSMENT – AUTHORIZATION IS GOOD FOR UP TO 1 YEAR FROM YOUR SIGNATURE DATE

MILD TO MODERATE

SUBMIT PRIOR AUTHORIZATION REQUEST AFTER EACH 8-26 SESSIONS AS CLINICALLY INDICATED.

SEVERE

ANNUALLY WILL COMPLETE A LEVEL OF CARE (LOC) DETERMINATION PROGRESS NOTE.

Update on the Registration form– Starting 7/1/2023

Format of Registration & Admission form slightly altered

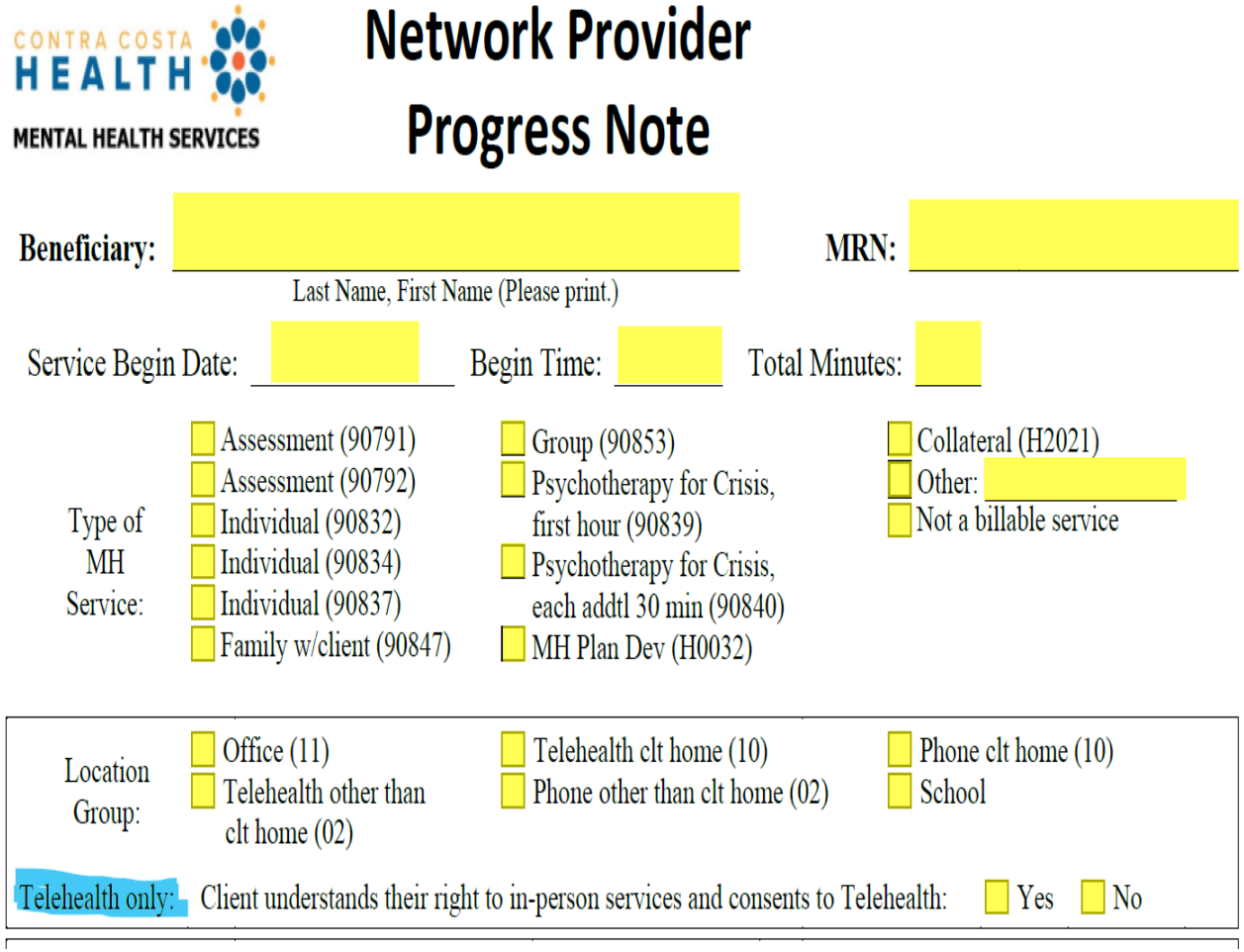
Will now track appointments offered and accepted

***** **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:	

Update on the Progress Note – Starting 7/1/2023

CPT codes and places of service will be added to the form.

For Telehealth only cases, there will be a new verification box.



CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Network Provider Progress Note

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

Claims

EFFECTIVE 7/1/2023

IMPORTANT UPDATES

- The timeline for submitting claims is changing from 60 days to 15 calendar days.
  - Starting **July 1, 2023**, all claims should be submitted within **15 calendar days** of the service being provided, but no later than the 10th day of the following month. Claims received after the 10th day are at risk of not being paid timely. Additionally, claims submitted after 60 days are at risk of being denied.
- To close out the fiscal year:
  - **ALL CLAIMS** for dates **prior to 7/1/2023** will need to be submitted by **Sunday, July 16, 2023.** Claims submitted late are at very high risk of being denied.

CMU Quality Review

Review of Clinical Documentation

At the beginning of treatment providers will submit the Clinical Assessment.

Annually, providers will submit an annual update summary (Levels of Care Determination Form).

CMU will review the Clinical Assessment and annual update summary to ensure clients meet medical necessity and to ensure providers are adhering to the documentation requirements. CMU will provide feedback on any documentation that may be vulnerable in the event of an audit.

As requested, providers will submit progress notes.

Notes may be requested:

- **As part of CMU's review for those over/under the average utilization rate.**
- **For services exceeding 3 years.**
- **When there is a pattern of concerns related to the Clinical Assessment.**

Utilization Review

Standard expectation is services are based on clinical need

On a regular basis, CMU will review the utilization rates for all providers

Those over or under the average utilization rate will be subject to an in-depth review by a CMU clinician

As appropriate, CMU clinician will reach out to providers to discuss current treatment regimen and transition/discharge plan

Questions?

CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

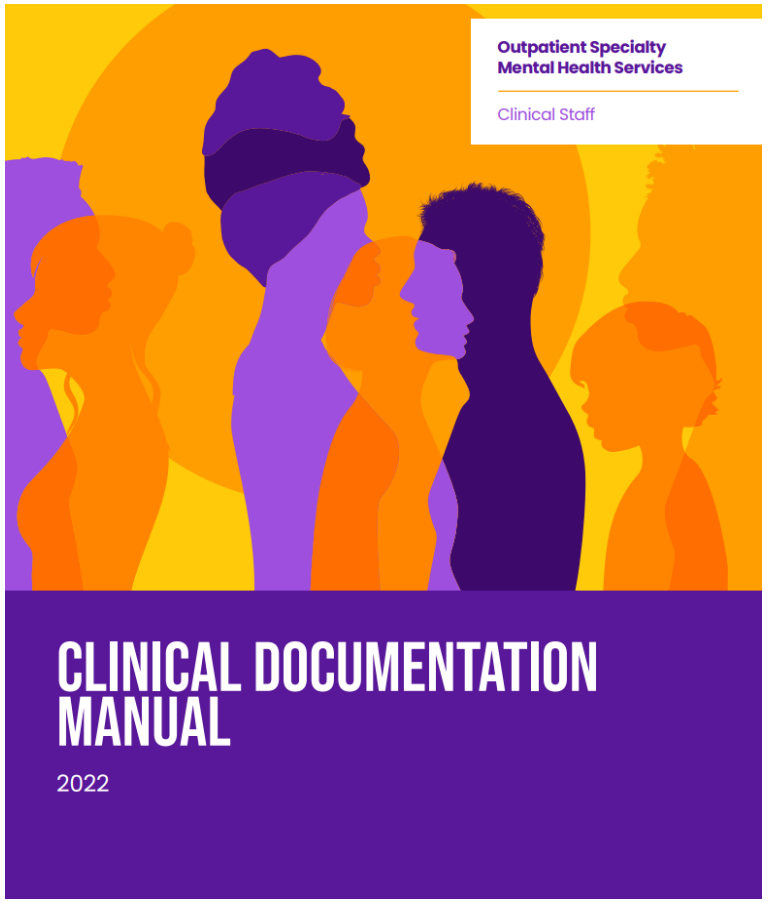
CalMHSA Resources:

https://www.calmhsa.org/calaim-support-for-counties/

CalMHSA Documentation Guides: (available May 2022-new) role specific guides for both MH and SUD that encompass all clinical documentation standards. Will be updated in January 2023 to include CPT codes as part of payment reform.

Department of Health Care Services CalAIM:

https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx



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

Care Management Unit (CMU)
1330 Arnold Drive Suite 143
Martinez CA 94553

Phone: 925 372 4400 Fax: 925 372 4410
Email: cmuprovider.services@cchealth.org

Website: https://cchealth.org/mentalhealth/network-provider/