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CCMH – NETWORK PROVIDER TRAINING

CCMHP CONTACT INFORMATION

Care Management Unit

Website: https://cchealth.org/mentalhealth/network-provider
Email: CMUProvider.Services@cchealth.org (DO NOT EMAIL ANY PHI)
Phone: (925) 372-4400 Fax: (925) 372-4410

Option 1: CMU Clinician of the Day – Authorizations, eligibility, special requests
Option 2: Initial Authorizations
Option 4: CMU Claims Department
Option 6: CMU Provider Services – availability, supplies, address updates, new providers

U.S. Mail: 30 Douglas Drive, Ste. 234, Martinez, CA 94553

Mental Health Access Line
Phone: 1 (888) 678-7277
Beneficiary screenings for mental health, psychiatry, and AOD services, and information about other programs

Therapeutic Behavioral Services (TBS) Referrals
Contact CMU Clinician of the Day

Mental Health Administration – Behavioral Health Provider Services
Site Reviews, Informing Materials (Beneficiary Guides, Beneficiary Rights Info)
Phone: (925) 608-6790 Email: Provider.Services@cchealth.org

Provider Portal Support – contact our IT department
Phone: (925) 957-7272 Email: BHS.Support@cchealth.org

Docustream Support – contact the Docustream staff
Contact: Chuck Adams & Sterling Hodrick
Email: Chuck@docustream.com Email: Sterling@docustream.com

Mental Health CFS Liasons
The Mental Health Liaisons can help providers navigate through the Child and Family Services department.
Program Manager: Charlene Bianchi, MFT
Central County: Lisa Colvin, MFT (925) 521-5727
East County: Herb Chew, PhD (925) 521-5724
West County: Anthony Coate, MFT (925) 521-5725

12/2019
Contra Costa Behavioral Health

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

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

The Behavioral Health Access Line is the gateway to Contra Costa County’s Behavioral Health system of care, welcoming consumers to integrated services for mental health, substance use, and homelessness. It is the main point of entry into the county’s Mental Health Clinics and Substance Use Disorder treatment programs. It is also the Mental Health Plan Authorization Line for Contra Costa Medi-Cal beneficiaries seeking Specialty Mental Health services with the Provider Network.

The Behavioral Health Access Team is comprised of an interdisciplinary group of licensed mental health clinicians (MFTs, LCSWs, PsyDs, PhDs), Substance Use Counselors, Community Support Workers, and administrative support staff. The team works collaboratively to link consumers to appropriate services via a comprehensive telephonic screening and triage process.

Although the Access Line is available to consumers who have Medi-Cal insurance or may be Medi-Cal eligible, it is also a behavioral health resource line for Contra Costa County residents, providing information, referral, and crisis triage/support to all callers. The line offers 24-hour availability and assistance in all languages via staff or interpreters.

Program Philosophy, Mission, & Vision

As the “front door” to integrated services, all individuals and families with substance use, mental health, and homeless issues are welcome to call and receive help through the Behavioral Health Access Line. The Access Team embraces a person-centered and complex-capable approach, ensuring that co-occurring issues are addressed by building them into the screening/triage process itself. As a call center and community resource line that values efficiency and respect, Access responds to a diversity of needs and makes every effort to exhaust all known resources in assisting callers.

The program’s mission is to be a welcoming and responsive entry point into our system of integrated behavioral health services, while connecting consumers to community resources that promote wellness, recovery, and resiliency.
CARE MANAGEMENT UNIT
OVERVIEW + CLINICAL PAPERWORK REQUIREMENTS

- BHS ACCESS LINE – CLIENT ENTRY
- CMU WORKFLOW
- SAMPLE INITIAL AUTHORIZATION LETTER
- SAMPLE CLIENT REGISTRATION
- SAMPLE NETWORK PROVIDER INTAKE FORM
  - CHILD
  - ADULT
- SAMPLE RE-AUTHORIZATION LETTER
- SAMPLE NETWORK PROVIDER ANNUAL UPDATE FORM
  - CHILD
  - ADULT
- SAMPLE CHANGE OF TREATMENT FORM
- STANDARD CMU AUTHORIZATION TEMPLATES
- SAMPLE DISCHARGE FORM
- CMU DEFINITIONS + DUE DATES
- COLOR CODED TIMELINE/GUIDELINES
CCMH – NETWORK PROVIDER TRAINING

CARE MANAGEMENT UNIT WORKFLOW OVERVIEW

CLIENT CALLS ACCESS LINE FOR REFERRALS

- Acuity Screening (Mild-Mod-Sev Screening)
- Up to 3 VERBAL Referrals Given to Consumer
- Provider Requests (via Portal or Phone) an Initial Authorization
  - Provide DOB, CIN, Date of 1<sup>st</sup> Appt Offered/1<sup>st</sup> Appt Accepted and date client contacted you.
  - 2 Month Authorization Period
  - Includes 8 units/hours of 99205 (Assessment)

ADMISSION

- 1<sup>st</sup> Date of Service (Face to Face Visit)
  - NP Begins Assessment (Can Bill up to 6 ea. 99205 Face to Face + 2 for Clinical Paperwork)
  - See “Due Dates for Client Paperwork to Request Authorization”
- Signatures on Tx Plan from Both Client AND Therapist. *Check Box if Unable to Obtain Signature.*
- Submit Claims after Registration form submitted.

SEND INTAKE TO CMU

- Within 30 Days of 1<sup>st</sup> Date of Service (Up to 60 Days Allowed, **HIGHLY Encourage 30**)
  - Receive *Up to* a Year-Long Authorization
  - Children (20 & Under) – Includes Weekly Sessions and Collateral Sessions
  - Adults (21+) - Only 1 Modality Authorized (Individual OR Family)
- Authorization Letters Mailed to Provider and Consumer
  - Remains in Place as Long as Medi-Cal Eligible & Meets Medical Necessity.
  - *CHECK AEVS LINE OR PROVIDER PORTAL MONTHLY.*

ANNUAL UPDATES TO CMU

- See “Due Dates for Client Paperwork to Request Authorization”
  - Annuals to be Dated no Earlier Than 30 Days Prior to Expiration of Previous Authorization
  - Annuals to be Dated NO LATER Than the Expiration Date of Previous Authorization
CMU MASTER WORKFLOW

1. MENTAL HEALTH ACCESS LINE
   a. Entry point for clients to receive services
   b. Clients call and are screened by an Access Line Clinician
   c. Clients are screened for acuity (mild-moderate or moderate-severe)
   d. Client Medi-Cal eligibility for services is verified
   e. Clients given up to 3 verbal referrals but are told to only make an appointment with one provider.

2. CLIENT CONTACTS NETWORK PROVIDER FOR APPOINTMENT
   a. Provider receives call from new prospective client. Ask if they spoke to someone on the Contra Costa County Mental Health Access line, who discussed their request for therapy, and gave them your name.
   b. If no, ask them to call the Access line to be screened (1-888-678-7277)
   c. If yes, ask if they have contacted or made appointments with any other providers. We can only issue an authorization to one provider at a time.
   d. If not, obtain the correct spelling of their name (as it appears on their Medi-Cal Card), birth date, CIN if possible
   e. Schedule an appointment.

3. PROVIDER REQUESTS AN INITIAL AUTHORIZATION
   a. Request an “Initial Authorization” as soon as possible. The client’s eligibility will be confirmed at this time. This protects you against seeing clients who have lost eligibility, particularly if their referral to you was made in the prior month.
   b. Call 925-372-4400, select Option 2 to make an initial authorization request. Be prepared to provide the demographic information indicated above. Be prepared to give the date the client first contacted you, the appointment date, and also the date of the first appointment that was offered. These may be the same. You will be given a referral number and the client’s MRN.
   c. Or, make the same request through Provider Portal. Click the small triangle next to “New Msg,” then choose “CRM”, then “Behavioral Health Portal Communication” as the topic, and “Behavioral Health Initial Authorization” as the Sub-Topic. Provide the requested demographic information. When the referral is entered, you will be notified through your In Basket. The client should appear on your client list the following day. You can obtain the MRN through Provider Portal.
   d. In either case, you will also receive a hard copy letter in the mail. The CMU term for this authorization is “Initial Authorization.”
   e. If you receive a call from a returning client who has not been recently screened by the Access line, you may still request an initial authorization by providing updated information regarding client’s current presenting problem and/or functional impairments. If you see the client before obtaining a new initial authorization, you will do so at your own risk, as current eligibility for services will not have been confirmed.
4. **CLIENT BEGINS MEETING WITH PROVIDER**
   a. Meet with the client. If they no-show, you do NOT need to inform CMU. No-shows are not billable.
   b. Complete the “**Network Provider Client Registration and Admission**” form
      i. Recommend having client complete a printed copy at first session
      ii. Network Provider submits form to CMU prior to submitting any claims
      iii. Choose “**BHS Registration Form**” Subtopic if submitting via Provider Portal
   c. Begin checking eligibility during the first few days of every month. Eligibility often changes from month to month. Refer to your AEVS line instructions. Once you have a Provider Portal account set up, you can check eligibility online using the Caseload Eligibility Report.
   d. Complete and submit the “**Network Provider Intake Form**” within 30 days to CMU. Use the 5-page intake form dated 10-2018. Please refer to the “Due Dates for Client Paperwork” memo.
      i. Admission Date = first date you met with client = first date you will bill for
      ii. Use Page 5 for narrative that exceeds the space provided elsewhere on the form
         1. Not necessary to submit page 5 if blank
         2. Type “Page intentionally left blank” and file in chart.
      iii. Bill only assessment code (99205) up to and including your signature date on the intake.
         1. Partial units may be billed for assessment activities such as phone calls that last less than an hour. Bill in .25 increments.
         2. Providers may bill a maximum of 2 units of 99205 for completing the clinical documentation portion of the intake. **Bill only based on time actually spent.**
         3. Providers must have a progress note to match every service billed.
         4. Enter the date of the progress note that documents billing for writing up the intake in the space at the top of page one.
      iv. Signature date should match your progress note documenting that you completed the intake.
      v. Signature date of > 60 days = gap in authorization.
   e. You may mail the entire intake to Care Management Unit, 30 Douglas Dr., Suite 234 Martinez, CA 94553
   f. You may fax the entire intake to 925-372-4410.
g. If submitting via Provider Portal
   i. Attach a full scan of the intake showing your wet signature and date of signature, as well as the client signature or the checked box stating you will obtain it.
   ii. Alternatively, attach an electronic copy of the full intake, and to the same message, attach a scan of just the signature page with your wet signature and date, etc.
   iii. Alternatively, you can separately mail or fax the signature page.

h. Please do not submit multiple copies of the same intake unless asked to do so.

i. Choose the subtopic “BHS Reauthorization Request” when submitting intakes.

j. DO NOT SUBMIT CLINICAL PAPERWORK TO DOCUSTREAM, ONLY CLAIMS!

k. When we are processing your paperwork, you may receive a deferral letter requesting corrections, clarifications, or missing information. Please respond within seven calendar days. When your intake is approved, you will receive a letter in the mail with the referral number and details regarding the procedure codes and quantities authorized. You will also receive a notification in Provider Portal, if you use it.

l. Please refer to the “Standard Authorization Templates” handout in the training packet.

m. The CMU term for the authorization you receive based on your intake is a “Reauthorization”

5. CLAIMS SUBMISSION PROCESS
   a. You can submit claims that are covered by your initial authorization once you submit the “Registration and Admission” form. Claims are submitted through Docustream.
   b. Once you are notified that your intake has been processed, and received your authorization letter, you can submit your ongoing claims through Docustream.
   c. If you have a Windows operating system, you can register for DocuHealthLink in order to submit claims electronically.
   d. If you have a Mac, you must submit claims on paper via US mail.
   e. Please follow the claims FAQ’s in the training packet.

6. TERMINATING SERVICES WITHIN 60 DAYS OF EPISODE OPENING
   a. If a client does not meet medical and/or service necessity, you must terminate services as soon as you determine this. Please contact CMU by phone or Provider Portal immediately for consultation.
      i. The client is entitled to an assessment and you can bill for it.
      ii. In this scenario, you cannot bill for any CPT codes other than 99205 Assessment.
      iii. You do not need to complete the intake, but you need to document your justification in your notes and notify CMU by submitting a “Network Provider Discharge Form”.

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CMU Master Workflow (continued)

b. If you close a client prior to the 60-day mark, for this or any other reason, DO NOT submit the full intake.
   i. In this case, submit only Registration plus the Discharge form.
   ii. You must include a covered diagnosis on your claim form if you are billing for any CPT codes other than 99205 (unless you are closing due to not meeting medical & service necessity).
   iii. Submit your claims to DocuStream at the same time, if you had an initial authorization.
   iv. We must see your wet signature, and the date, on the Discharge form. If submitting through Provider Portal, you must scan the Discharge form so that we can see these.
   v. Please use the subtopic “BHS Open/Close” when submitting the paperwork.
   vi. If you billed for working on the intake, file it in your chart to demonstrate the work you did.

7. REQUESTING ATYPICAL/SPECIAL/CHANGE OF AUTHORIZATION
   a. If you know at the time that you are preparing an intake or annual that you want to request an atypical authorization, please make your request CLEAR in the strategies section and provide the justification for it. (examples are continued weekly sessions for adults in an annual update, or additional units of collateral for child cases with treatment team meetings)
   b. For a request to change a previous authorization, please consult with CMU. If directed, use the “Change of Treatment Authorization” form.
      i. Please review the prompts provided on the form to ensure the necessary information is provided
      ii. If an update to the Partnership Plan is required per the prompt on the form, use the space provided on the form to update your treatment goals.
      iii. If submitting a scan through Provider Portal, please choose the subtopic “BHS Other”
   c. For requests for only 1-2 additional units, call or message CMU through Provider Portal.

8. UPDATING YOUR AVAILABILITY WITH CMU
   a. Call, email, or send a message through Provider Portal to CMU at any time to put a hold on new referrals.
      i. Use the subtopic “BHS Provider Services” if sending a message
      ii. Send an email to “CMUProvider.Services@cchealth.org”
      iii. Choose option “6” for Provider Services if calling.
      iv. There may be residual phone calls from clients who were given a verbal referral prior to the hold. Our expectation is that you will continue to return calls in a timely manner to advise that you are unavailable.
   b. Call, email, or send a message through Provider Portal to CMU at any time to re-open your availability for referrals.
   c. Please keep your voicemail clear on a daily basis.
CMU Master Workflow (Continued)

9. **CONTACTING CMU**
   a. General questions for the Clinician of the Day: 925-372-4400, Option 1
      i. Regarding authorizations, current referrals, informal appeals, etc.
      ii. Regarding clinical questions
   b. Requesting initial authorizations: 925-372-4400, Option 2
   c. Responding to requests for information from Provider Services, contacting CMU regarding changes in address, etc: 925-372-4400, Option 6
   d. Questions about claims: 925-372-4400, Option 4
   e. Email: CMUProvider.Services@cchealth.org DO NOT TRANSMIT CLIENT PHI VIA EMAIL.
   f. Please update CMU immediately regarding any changes to your Place of Service (POS) and contact information.
   g. For referrals to other services or other providers, call Access at 1-888-678-7277
   h. Please refer clients to call the Access line, not CMU, with questions.

*****PLEASE READ EMAILS FROM CMU PROMPTLY AND THOROUGHLY*****

CMU Web Page:
https://cchealth.org/mentalhealth/network-provider

(Note: Always go to the “Network Provider Resources” Tab)
SAMPLE INITIAL AUTHORIZATION LETTER

NETWORK PROVIDER - AUTHORIZATION LETTER

MICHELLE TEST  
123 CENTER AVE  
MARTINEZ CA 94553  

Referral #: 2006613  
Member ID: 11111111Z  
Primary: BHS M/C FULL SCOPE MEDI-CAL  
Secondary:  
Phone: (925)566-4880  
DOB: 01/01/1999  
CIN: 91234567A  
MRN: 300199259

January 10, 2019

Dear Michelle Test:

The following service(s) has/have been APPROVED:

**Auth #:** 2006613  
**Auth Start Date:** 10/17/2018  
**Auth Expiration Date:** 12/17/2018

You have been referred to:  
Best Therapist  
3478 BUSKIRK AVENUE #1000  
PLEASANT HILL CA 94523-4378  
Phone: 925-555-1212

For the following service(s):

<table>
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<tr>
<th>Code</th>
<th>Procedure Name</th>
<th>Requested Quantity</th>
<th>Approved Quantity</th>
</tr>
</thead>
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<tr>
<td>99205</td>
<td>PR OFFICE OUTPATIENT NEW 60 MINUTES</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>90834</td>
<td>PR PSYCHOTHERAPY W/PATIENT 45 MINUTES</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>90887</td>
<td>PR CONSULTATION WITH FAMILY</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>90847</td>
<td>PR FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>90846</td>
<td>PR FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS</td>
<td>2</td>
<td>2</td>
</tr>
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</table>
(SAMPLE INITIAL AUTHORIZATION LETTER) - Continued

PLEASE NOTE: This Authorization remains in place as long as full-scope Medi-Cal eligibility does not change, and you (the beneficiary) continue to meet medical and service necessity. You (the beneficiary) must have active eligibility at the time you receive services.

The authorized services described in the letter are for an initial time period only. They will be extended once your provider's request for continued authorization is received and approved, up to a maximum of twelve months total. You will receive an updated letter at that time.

Your provider will be able to answer any questions you may have about authorizations and continued services.

 PROVIDERS: All services require pre-authorization, and claims may be denied if pre-authorization is not obtained. Please resubmit your claim to Docustream for payment: Contra Costa Mental Health Plan, PO Box 2178, San Leandro, CA 94577
 If you are enrolled in Provider Portal, you have 24-7 Web access to consumer information, including eligibility, authorization, referral history and claim status. You may also check the consumer's eligibility by calling the State Medi-Cal Automatic Eligibility Verification System (AEVS) phone-line @ 1-800-456-2387 by the third day of each month.

Sincerely,
Authorization Unit

c:  Best Therapist
    Phone: 925-555-1212
    THERAPIST, BEST
    3478 BUSKIRK AVE STE 1000
    PLEASANT HILL CA 94523
    Fax: 925-555-1212
### Client Registration and Admission

#### (Sample)

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
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</thead>
<tbody>
<tr>
<td>Client’s Current Last Name</td>
</tr>
<tr>
<td>Jones</td>
</tr>
</tbody>
</table>

#### CLIENT IDENTIFICATION

- Date of Birth: 07/31/2005
- SS#: 111-11-1111
- Medi-Cal Card Number (CIN): 999999999E

#### ADDRESS

- Street: 13 Loop Circle
- City: Antioch
- State: CA
- Zip-Code+4: 94509+1234

#### TELEPHONE

- Telephone Number: (925) 555-1212
- Telephone Type: Cell

#### DEMOGRAPHICS

- Gender: Female
- Marital Status: Single
- # Dependents Under 18: 0
- # Dependents Over 18: 0

#### Residential Living Arrangement

- Adult Residential Facility
- Alcohol Abuse Facility
- Community Treatment Facility
- Crisis Residential Facility
- Drug Abuse Facility
- Foster Family Home
- General Hospital
- Group Home (Level 1-12 Child)
- Group Quarters

#### Occupation Type

- Executive/Manager
- Farming/Forestry
- Production/Labor
- Sales/Service
- Unemployed
- Unknown/Not Reported

#### Employment Status

- Disabled
- Full time, 35 hours or more per week (comp)
- Full time, 35 hours or more per week (non comp)
- Full-time training
- Homemaker, Not Seeking Work
- Homemaker, Seeking Work
- Part time, less than 35 hours per week (comp)
- Part time, less than 35 hours per week (non comp)
- Resident / Inmate of institution
- Retired

#### Veteran’s Status

- Yes

#### Hispanic Origin

- Cuban
- Hispanic
- Mexican/Mexican American
- Not Hispanic
- Other Hispanic/Latino
- Puerto Rican
- Unknown/Not Reported

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12/2019
<table>
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<td>☐ Korean</td>
<td>☐ Mixed Race</td>
<td>☐ Other Pacific Islander</td>
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<tr>
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<td>☐ Filipino</td>
<td>☐ Laotian</td>
<td>☐ Native Hawaiian</td>
<td>☐ Other Southeast Asian</td>
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<td>☐ Mexican American</td>
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<td>☐ Other Chinese</td>
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<tr>
<td>☐ Hebrew</td>
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<tr>
<td></td>
<td>☐ Vietnamese</td>
</tr>
<tr>
<td></td>
<td>☐ Unknown/Not Reported</td>
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</tbody>
</table>

**EDUCATION**

Type: ☒ Highest Grade Completed: 7th
☐ None ☐ Decline to State

**EMERGENCY OR MESSAGE CONTACT**

<table>
<thead>
<tr>
<th>Relation to Consumer: Foster Mother</th>
<th>Contact Type: ☒ Emergency Contact ☐ Message</th>
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<tbody>
<tr>
<td>Current Last Name Long</td>
<td>Telephone Number: ☒ Cell ☐ Home ☐ Message ☐ Pager ☐ Work</td>
</tr>
<tr>
<td>Linda</td>
<td>(925) 555-1212</td>
</tr>
</tbody>
</table>

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

| Facility/Place of Service – Location (City): Antioch |
| Group Name: (if applicable) |
| Admission Date: (first billable service) 10/1/2018 |
| ICD-10 Code: R69 |
| DSM5 Description: Diagnosis Deferred |

**Legal/Court Status**

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

**Substance Use?** ☐ Yes ☐ No ☒ Unknown
SU ICD-10 Code: ____________________________

Amazing Therapist, LCSW #12345

**Provider Printed Name/License**

Signature Date

Amazing Therapist (Wet Signature) 10/1/2018

12/2019
CCMH – NETWORK PROVIDER TRAINING

INTAKE FORM (ADULT SAMPLE)

[MANDATORY: Progress note(s) justifying billing for completing intake is/are dated 01/12/2018]

Therapist, Amazing
Provider Last Name, First Name (and Group name, if applicable)
Gomez

Maria
First Name

Location where client will receive services.

Gomez
Beneficiary Last Name
05/06/1969
Birth Date

99999999E
CIN (Medi-Cal Card #)

Provider List Offered.

999999999
MRN (Medical Record #)

Therapist, Amazing
Beneficiary Guide Given during the first face-to-face visit.

Antioch
City

555 Circular Court
Current Street Address

94509
Zip Code

Antioch
Same

925-555-1212
Phone Number

555 Circular Court
Current Street Address

Jose Gomez
Beneficiary Last Name
First Name

Middle Name
Gen (Sr., Jr.)

Emergency Contact

Relationship

Contact Address (Street, City, State, Zip)

Contact Phone

SEXUAL ORIENTATION:

☑️ Heterosexual / Straight
☑️ Lesbian
☐ Gay
☑️ Bisexual
☐ Queer
☐ Questioning

☐ Unknown
☐ Declined to State
☐ Other:

Special Considerations (include cultural diversity, physical, and linguistic considerations):

Client is Spanish speaking and prefers communicating in Spanish. The current political situation is adding to her stress. This will be monitored ongoing. Due to numerous back surgeries, client cannot sit for long periods of time. Client will be encouraged to move around during session as needed.

Admission Date: 12/01/2017
(Date of first office face-to-face session)

DSM-V CODE: DSM-V NAME: Must write full diagnosis narrative, no abbreviations
(P) 296.32 Major Depressive Disorder, Recurrent Episode, Moderate F33.1

Substance Use Issue: □ Yes ☒ No

DSM-V Code:

ICD-10 CODE:

(S) (Note Add’l DX in Presenting Problem)

CURRENT PRESENTING PROBLEM
(Must document symptoms and functional impairments that meet the criteria for the above DSM V included diagnosis. Include life stressors or experiences that are bringing the client to treatment at this time.)

Intake was completed, using an interpreter, in Spanish, as this is the client's preferred language. Client presented as having no energy to get out of bed most days. Client reported an increase in isolation due to low energy. Client experiences reduced appetite and increased insomnia. Reports feeling “like ending it” at least once every day. At this time client does not have an active plan or intent. Client presents as well-dressed, reports it is important to her to look good so that others will not think she is depressed. Client talked about several traumatic events in her life that have impacted her but that she has not healed from or talked about. Client was shot multiple times years ago in a street robbery. Due to client’s symptoms, she is at risk of losing her job.

12/2019
## PART A – CLINICAL ASSESSMENT

### Beneficiary:
**Gomez, Maria**

### Provider:
**Therapist, Amazing**

#### SAFETY RISK:
- □ None Identified
- □ Inability to Care for Self
- □ Not Currently Acute Physical Abuse
- □ Danger to Self
- □ Not Currently Sexual Abuse
- □ Danger to Others
- □ Not Currently Domestic Violence
- □ Neglect
- □ Not Currently Duty to Warn
- □ Weapons Confiscated

#### REPORT FILED:
- □ CPS
- □ APS

Provide additional detail for any box checked above:

*At this point, client is presenting with ideations. Will continue to monitor during sessions.*

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

*Client has felt depressed for many years. Has tried medication, but did not feel it helped and did not like side effects. Client denies any past hospitalizations and outpatient treatments.*

#### RELEVANT FAMILY/PSYCHO SOCIAL HISTORY INCLUDING MENTAL ILLNESS, SUBSTANCE ABUSE, ABUSE/NEGLECT (physical, sexual, emotional, etc), AND/OR SUICIDE (suicide attempt/unexplained death); include any education/school history:

*Client's mother may have had depression. Client witnessed DV against mother by father. Client denies any family history of substance abuse and abuse/neglect as a child. Client denies any family history of suicide. Client has lived in US for approximately 20 years.*

### This Section for YOUTH ONLY

<table>
<thead>
<tr>
<th>LIVES WITH:</th>
<th>First Name of others in home (children &amp; adults)</th>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Family of Origin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended Family/Relative Caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### COMPLETE DEVELOPMENTAL HISTORY: Did consumer meet developmental milestones? Were there environmental stressors? Include prenatal and perinatal events, including trauma during pregnancy.

Pregnancy Trauma: □ Yes □ No □ Unknown

#### MEDICAL HISTORY:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Last Physical:</th>
<th>Last Dental:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Pepper</td>
<td>6/2017</td>
<td>2/2017</td>
</tr>
</tbody>
</table>

- □ 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 conditions, as reported by client):

*Client reported she has had numerous surgeries, most of which were because she was shot in the back during the street robbery. She also had a hysterectomy due to uterine cancer, followed by chemotherapy. Client reported digestive issues.*

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

*Client reports PCP prescribed psych meds for depression 6 years ago. Could not recall the name. Client stopped taking meds when she had suicidal ideations.*

#### CURRENT PSYCHIATRIC & NON-PSYCHIATRIC PRESCRIPTION & O.T.C. MEDICATIONS:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage/Frequency</th>
<th>Prescribed by</th>
<th>Date 1st</th>
<th>Date Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>None reported</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RX Compliant: □ Yes □ No □ Unknown

*Client did not like the side effects of medication.*

### 12/2019
**Beneficiary:** Gomez, Maria  
**Provider:** Therapist, Amazing

### PART A – CLINICAL ASSESSMENT (Continued)

#### SUBSTANCE USE

<table>
<thead>
<tr>
<th>TYPE OF SUBSTANCE</th>
<th>Prenatal Exposure (Check if Yes)</th>
<th>Past Use</th>
<th>Age at First Use (If ever used)</th>
<th>CURRENT SUBSTANCE USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None/Denies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mild</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>ALCOHOL</td>
<td></td>
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<tr>
<td>AMPHETAMINES (Speed/Uppers, Crank, Ritalin)</td>
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<tr>
<td>COCAINE / CRACK</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPIATES (Heroin, Opium, Methadone)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<tr>
<td>MARIJUANA / HASHISH</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TOBACCO / NICOTINE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAFFEINE (Energy Drinks, Sodas, Coffee, Etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OVER THE COUNTER/OTHER SUBSTANCE:**

- [ ] None
- [X] Denies

#### CURRENT SUBSTANCE USE

- [ ] Client - perceived Problem?
  - [ ] Mild
  - [X] Moderate
  - [ ] Severe

- [X] None

#### MENTAL STATUS: (Check and/or describe if abnormal or impaired)

<table>
<thead>
<tr>
<th>Appearance/Grooming:</th>
<th>[ ] Unremarkable</th>
<th>[ ] Remarkable for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior/Relatedness:</td>
<td>[ ] Unremarkable</td>
<td>Motor Agitated Hostile</td>
</tr>
<tr>
<td>Speech:</td>
<td>[ ] Unremarkable</td>
<td>Labile Irritable/Angry</td>
</tr>
<tr>
<td>Mood/Affect:</td>
<td>[X] Unremarkable</td>
<td>[ ] Depressed</td>
</tr>
<tr>
<td>Thought Processes:</td>
<td>[ ] Unremarkable</td>
<td>Concrete</td>
</tr>
<tr>
<td>Thought Content:</td>
<td>[ ] Unremarkable</td>
<td>Suicidal Ideation</td>
</tr>
<tr>
<td>Perceptual Content:</td>
<td>[ ] Unremarkable</td>
<td>Hallucinations</td>
</tr>
<tr>
<td>Fund of Knowledge:</td>
<td>[ ] Unremarkable</td>
<td>Impaired</td>
</tr>
<tr>
<td>Memory:</td>
<td>[ ] Intact</td>
<td></td>
</tr>
<tr>
<td>Intellect:</td>
<td>[ ] Unremarkable</td>
<td>Remarkable for:</td>
</tr>
<tr>
<td>Insight/Judgment:</td>
<td>[ ] Unremarkable</td>
<td>Remarkable for:</td>
</tr>
</tbody>
</table>

**Additional Observations/Comments:**

- Client spoke about traumatic events in a detached manner.

#### FUNCTIONAL IMPAIRMENTS:

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Relations</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Performance/Employment</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Care</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food/Shelter</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/Peer Relations</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments (Describe if Severe):**

- Other: [ ]

#### TARGETED SYMPTOMS:

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Mod</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognition/Memory/Thought</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention/Impulsivity</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socialization/Communication</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Symptoms</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Phobia/Panic Attack</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affect Regulation</td>
<td>[X]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments (Describe if Severe):**

- Other: [ ]

### NOTE: Check off boxes in BOTH columns. MUST have at least one Impairment & Intervention.

**Impairment Criteria** (must have at least 1 of the following):

- [ ] A Significant impairment in an important area of life functioning.
- [ ] B Probability of significant deterioration in an important area of life functioning.
- [ ] C (Under 21) Without treatment will not progress developmentally as individually appropriate.
- [ ] D Does not meet criteria. **(Cannot be authorized)***

**Intervention Criteria** (must have at least one proposed intervention):

- [ ] A Significantly diminish impairment.
- [ ] B Prevent significant deterioration in an important area of life functioning.
- [ ] C (Under 21) Probably allow the child to progress developmentally as individually appropriate.
- [ ] D Condition would not be responsive to physical health care-based treatment. **(Must be checked to authorize)**
**Beneficiary:** Gomez, Maria

<table>
<thead>
<tr>
<th>Beneficiary and/or Family Strengths that will be incorporated into treatment.</th>
<th>Client actively participates in treatment, attends regularly.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Life Goals:</strong> What does the Beneficiary (and/or beneficiary's parents/family/guardian) hope to work toward? Please use quotes.</td>
<td>“I would like to feel better and have more energy.”</td>
</tr>
</tbody>
</table>
| **Treatment Goals:** Must be specific, observable and/or quantifiable goals (with timeframes) that link to diagnosis with the goal of decreasing their impairments or symptoms. Treatment plans should be updated when there are significant changes in symptoms, functioning, or life events. | **Client will work on creating life goals in order to have more sense of something to look forward to (future orientation) (6 months).**  
**Client will process traumatic events in her life such that she is able to sleep seven hours per night at least 4-5 nights per week (12 months).**  
**Client will self-report utilizing CBT skills to change thoughts and actions to cope with depression at least 3-4 days per week (12 months).** |

**Requested Treatment Plan Duration:** 12 Months (max of 12 mos)

<table>
<thead>
<tr>
<th>Strategies to Achieve Goals: Specify actions to be taken by client/family and provider to achieve the above goals. Specify modality needed for interpreter.</th>
<th>Client will attend weekly therapy. Client will complete any assignments given. CBT and journaling. Authorization for 90837 code will be needed for individual therapy sessions.</th>
</tr>
</thead>
</table>

| PARTIES INVOLVED |  
|---|---|
| Beneficiary |  
| Family |  
| Clinicians |  
| Social Workers |  
| Interpreter |  
| Others: |  

| FOR PRESCRIBERS ONLY |  
|---|---|
| [ ] Current medication consents on file |  
| [ ] JV-223 form on file for CCC Foster Children and Juvenile Dependents |  

<table>
<thead>
<tr>
<th>Beneficiary Signature for Part B Treatment Plan:</th>
<th>(For Beneficiary 12 yrs. and older.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] TBS Referral Made.</td>
<td>Date of Referral:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Signature:</th>
<th>(Required if Beneficiary is 11 yrs. or younger.)</th>
</tr>
</thead>
</table>

| If Child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked: |  
|---|---|
| [ ] CFS worker has signed above as legal guardian |  
| [ ] CFS SW verbally agreed to Partnership Plan and Provider faxed a copy to SW for signature & return on: |  

<table>
<thead>
<tr>
<th>☑️ Unable to obtain signature prior to submission. Document reason in progress note.</th>
<th>Date of progress note: 1/12/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Continued efforts to obtain signature should be documented in every progress note until signature is obtained. Failure to obtain signature will result in disallowances in the event of an audit.</td>
<td></td>
</tr>
</tbody>
</table>

| Copy of Partnership Plan offered to Beneficiary/Guardian (MANDATORY): |  
|---|---|
| [ ] Accepted | [ ] Declined |
| Date: |  

<table>
<thead>
<tr>
<th>Provider: Amazing Therapist (Print)</th>
<th>A. Therapist (Wet Signature) LCSW 12345 1/12/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Signature certifies that the above information is accurate and all required documentation is on file.</td>
<td></td>
</tr>
<tr>
<td>Provider Data: Phone 925-555-5555 Ext. Fax (as on file) 925-555-5553</td>
<td></td>
</tr>
</tbody>
</table>

12/2019
Beneficiary:  Gomez, Maria  
Provider:  Therapist, Amazing

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

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**CCMH – NETWORK PROVIDER TRAINING**

**INTAKE FORM (CHILD SAMPLE)**

*MANDATORY:* Progress note(s) justifying billing for completing intake is/are dated 10/31/18

<table>
<thead>
<tr>
<th>Therapist, Amazing</th>
<th>Antioch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones</td>
<td>Hallie</td>
</tr>
<tr>
<td>Beneficiary Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Jones</td>
<td>Hallie</td>
</tr>
<tr>
<td>07/31/2005</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td>CIN (Medi-Cal Card #)</td>
</tr>
<tr>
<td>Gender: ☐ Male ☒ Female ☐ Nonbinary</td>
<td>Transgender: ☐ Male to Female ☐ Female to Male ☐ Other: ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>333 Loop Circle</th>
<th>Antioch</th>
<th>94509</th>
<th>925-555-1212</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Street Address</td>
<td>City</td>
<td>Zip Code</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Linda Long</td>
<td>Foster Parent</td>
<td>333 Loop Cir. Antioch, CA 94509</td>
<td>925-555-1212</td>
</tr>
<tr>
<td>Emergency Contact</td>
<td>Relationship</td>
<td>Contact Address (Street, City, State, Zip)</td>
<td>Contact Phone</td>
</tr>
</tbody>
</table>

**Special Considerations** (include cultural diversity, physical, and linguistic considerations):
Client is African-American. Therapist is white. These differences will be addressed as appropriate during tx.

<table>
<thead>
<tr>
<th>Admission Date:</th>
<th>10/01/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Date of first office face-to-face session)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>DSM-V CODE:</th>
<th>DSM-V NAME:</th>
<th>ICD-10 CODE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(P)</td>
<td>296.22</td>
<td>F32.1</td>
</tr>
<tr>
<td>(S)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Substance Use Issue:** ☐ Yes ☒ No

<table>
<thead>
<tr>
<th>DSM-V Code:</th>
<th>ICD-10 Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Nota Add’l DX in Presenting Problem)

**CURRENT PRESENTING PROBLEM**
(Must document symptoms and functional impairments that meet the criteria for the above DSM V included diagnosis. Include life stressors or experiences that are bringing the client to treatment at this time.)

**Hallie cycles between irritable/angry and sad most days for most of the day. She yells and curses at others when she is angry or hurt. She misses school frequently and had poor grades this past year as a result. Her self-esteem and self-confidence are low. Her thinking is negative. She has little hope for a better life in the future.**

**Hallie has been in and out of foster care most of her life due to mother’s long history of arrests. Mother was recently arrested again and sentenced to two years in jail. There is no immediate family to take care of Hallie, therefore, she has been placed in foster care.**
PART A – CLINICAL ASSESSMENT

Beneficiary: Jones, Hallie

Provider: Therapist, Amazing

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

REPORT FILED:
- CPS
- APS
- Duty to Warn
- Weapons Confiscated

Mental Health History (Including past diagnoses, suicide attempts, violence, hospitalizations and other outpatient treatments & responses):

Due to Hallie’s various foster care placements, it was difficult to obtain historical information. She states she had therapy in the past, but "all I did was play." No history of SI/hospitalizations.

Relevant Family/Psychosocial History Including Mental Illness, Substance Abuse, Abuse/Neglect (physical, sexual, emotional, etc), AND/OR Suicide (suicide attempt/unexplained death); Include any education/school history:

Hallie has been placed in foster care several times. Her current placement is due to her bio mother being arrested again.

Client describes having tried alcohol a few times in the past, but "didn’t like it."

This Section for YOUTH ONLY

Lives With:
- Immediate Family of Origin
- Foster Family
- Extended Family/Relative Caregiver
- Other:

First Name of others in home (children & adults) | Age | Relationship
--- | --- | ---
Linda | 50 | Foster Mother
Viola | 8 | Foster sister
Antoinette | 9 | Foster sister
Honore | 14 | Bio sister

Complete Developmental History: Did consumer meet developmental milestones? Were there environmental stressors? Include prenatal and perinatal events, including trauma during pregnancy.

Obtaining patient history was difficult due to current foster placement. Client stated she does not have any health problems other than being overweight. She states she attended kindergarten on time, remembers going to preschool, but not much about what she did there. Appears on track developmentally at current time.

Pregnancy Trauma: Yes No Unknown

Medical History:
- Last Physical: 6/2018
- Last Dental: 2/2017
- Weight:

Primary Care Provider: Dr. Smith

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

Allergies (Mandatory):
- Peanuts
- No Known Allergies

Include severity of symptoms for allergies: With exposure, will develop a rash. No severe reactions at this point.

Relevant Health History (including surgeries or significant medical conditions, as reported by client):
None Reported

Psychiatric Medication History (Include relevant responses, side effects and compliance):
Dr. Smith prescribed Zoloft. This is the first time client reports she has taken any anti-depressant. She says it helps "a little."

Current Psychiatric & Non-Psychiatric Prescription & O.T.C. Medications:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage/Frequency</th>
<th>Prescribed by</th>
<th>Date 1st</th>
<th>Date Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zoloft</td>
<td>50mg/day</td>
<td>Dr. Smith</td>
<td>08/01/2018</td>
<td>Oct 2018</td>
</tr>
</tbody>
</table>

RX Compliant: Yes No Unknown Explain:
### SUBSTANCE USE

<table>
<thead>
<tr>
<th>TYPE OF SUBSTANCE</th>
<th>Prenatal Exposure (Check if Yes)</th>
<th>Past Use</th>
<th>Age at First Use (If ever used)</th>
<th>CURRENT SUBSTANCE USE</th>
<th>IF Current Use</th>
<th>In Recovery</th>
<th>Client-perceived Problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL</td>
<td></td>
<td></td>
<td></td>
<td>None/ Denies</td>
<td>Current Use</td>
<td>Mild</td>
<td>Mod</td>
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<td>AMPHETAMINES (Speed/Uppers, Crank, Ritalin)</td>
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<td></td>
<td></td>
<td>None/ Denies</td>
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<td>Mod</td>
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<td></td>
<td></td>
<td>None/ Denies</td>
<td>Current Use</td>
<td>Mild</td>
<td>Mod</td>
</tr>
<tr>
<td>CAFFEINE (Energy Drinks, Sodas, Coffee, Etc.)</td>
<td></td>
<td></td>
<td></td>
<td>None/ Denies</td>
<td>Current Use</td>
<td>Mild</td>
<td>Mod</td>
</tr>
</tbody>
</table>

### MENTAL STATUS:

- **Appearance/Grooming:** Unremarkable | Remarkable for: ____________
- **Behavior/Relatedness:** Unremarkable | Motor Agitated | Hostile | Inattentive | Suspicious/Guarded | Other: ____________
- **Speech:** Unremarkable | Expressed for: ____________
- **Mood/Affect:** Unremarkable | Depressed | Irritable/Angry | Disturbed | Disorganized | Odd/Idiosyncratic |
- **Thought Processes:** Unremarkable | Blocking | Deficient Content | Loosening of Assoc | Homicidal Ideation | Paranoid Ideation |
- **Thought Content:** Unremarkable | Racing Thoughts | Hallucinations | Delusions | Flashbacks | Ideas of Reference |
- **Fund of Knowledge:** Unremarkable | Remarkable for: ____________
- **Intellect:** Intact | Impaired | ____________
- **Insight/Judgment:** Unremarkable | Remarkable for: ____________

### FUNCTIONAL IMPAIRMENTS:

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
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<tbody>
<tr>
<td>Family Relations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Performance/Employment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food/Shelter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social/Peer Relations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td></td>
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</table>

**Comments (Describe if Severe):** ____________

### TARGETED SYMPTOMS:

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<th>Mod</th>
<th>Severe</th>
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</thead>
<tbody>
<tr>
<td>Cognition/Memory/Thought</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention/Impulsivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socialization/Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressive Symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Phobia/Panic Attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affect Regulation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments (Describe if Severe):** ____________

### NOTE:

- **Check off boxes in BOTH columns. MUST have at least one Impairment & Intervention.**
- **Impairment Criteria (must have at least 1 of the following):**
  - Significant impairment in an important area of life functioning.
  - Probability of significant deterioration in an important area of life functioning.
  - (Under 21) Without treatment will not progress developmentally as individually appropriate.
  - Does not meet criteria. *(Cannot be authorized)*
- **Intervention Criteria (must have at least one proposed intervention):**
  - Significantly diminish impairment.
  - Prevent significant deterioration in an important area of life functioning.
  - (Under 21) Probably allow the child to progress developmentally as individually appropriate.
  - Condition would not be responsive to physical health care-based treatment. *(Must be checked to authorize)*

**Beneficiary:** Jones, Hallie

**Provider:** Therapist, Amazing

**Date:** 12/2019
PART B – PARTNERSHIP PLAN FOR WELLNESS

Beneficiary: Jones, Hallie

**Beneficiary and/or Family Strengths** that will be incorporated into treatment.

*Hallie participates in therapy and says she wants to feel better and behave differently. She loves art and often draws.*

**Life Goals:** What does the Beneficiary (and/or beneficiary’s parents/family/guardian) hope to work toward? Please use quotes.

*Hallie would like to be happier and to do well in school. She wishes her mother would get her life together so she and her sister could grow up with their mother.*

**Treatment Goals:** Must be specific, observable and/or quantifiable goals (with timeframes) that link to diagnosis with the goal of decreasing their impairments or symptoms. Treatment plans should be updated when there are significant changes in symptoms, functioning, or life events.

*Verbal lashing out (cursing, yelling at others) will reduce from 10x per day to 5x per day by self and parent report within 6 months.*

*Hallie will identify and express feelings underlying depression and anger appropriately 8 out of 10 times, by parent report within 6 months.*

*Increase in self-esteem and self-efficacy as shown by going to school daily and consistently turning in work on time, within 12 months by parent/teacher report.*

*Hallie will improve self-care behaviors as seen by consistently getting 8 hours of sleep, eating nutritious foods and getting 30 minutes of exercise per day (as directed by her doctor) within 12 months.*

Requested Treatment Plan Duration: **12 Months** (max of 12 mos)

**Strategies to Achieve Goals:** Specify actions to be taken by client/family and provider to achieve the above goals. Specify modality needed for interpreter.

*Hallie will attend therapy weekly and learn CBT techniques to address distorted thinking. Will use modeling, mirroring, role play, and psychoeducation to help client develop better self-soothing and communication skills. Will provide collateral to foster parent and teachers to support understanding of client’s symptoms and treatment.*

\[\begin{array}{|c|}
\hline
\text{Modality & Frequency Requested by clinician completing this form:}
\hline
\text{Modality} & \text{Requested Frequency} \\
\hline
\text{Individual Therapy} & \text{Weekly} \\
\text{Group Therapy} & \text{2x/Month} \\
\text{Family Therapy} & \text{2x MONTH} \\
\hline
\text{Other:} & \text{Other:} \\
\hline
\text{Monthly} & \text{2x/Month (adult)} \\
\text{Other:} & \text{Other:} \\
\hline
\text{Other Modalities:} & \text{Collateral} \\
\hline
\text{Therapy w/Meds} & \text{(child)} \\
\hline
\end{array}\]

**PARTIES INVOLVED**

- Beneficiary
- Family
- Clinicians
- Social Workers
- Interpreter
- Others: 

\[\square \text{TBS Referral Made.} \quad \text{Date of Referral:} \]

**FOR PRESCRIBERS ONLY**

- \[\square \text{Current medication consents on file} \]
- \[\square \text{JV-223 form on file for CCC Foster Children and Juvenile Dependents} \]

Beneficiary Signature for Part B Treatment Plan: 

*Hallie Jones (Wet Signature)  
Date: 11/2/2018* 

(For Beneficiary 12 yrs. and older.)

Parent/Guardian Signature: 

(Required if Beneficiary is 11 yrs. or younger.)

**If Child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked:**

\[\square \text{CFS worker has signed above as legal guardian} \]
\[\square \text{CFS SW verbally agreed to Partnership Plan} \quad \text{Provider faxed a copy to SW for signature & return on:} \]

**If unable to obtain signature prior to submission. Document reason in progress note:** 

**Date of progress note:**

**Note:** Continued efforts to obtain signature should be documented in every progress note until signature is obtained. Failure to obtain signature will result in disallowances in the event of an audit.

**Copy of Partnership Plan offered to Beneficiary/Guardian (MANDATORY):**

\[\square \text{Accepted} \quad \square \text{Declined} \quad \text{Date: 11/2/2018} \]

Provider: **Amazing Therapist**

\[\text{(Print)} \quad \text{(Wet Signature)} \quad \text{(License/Regist. #)} \quad \text{(License/Regist. #)} \quad \text{Date: 10/31/2018}\]

Provider’s Signature certifies that the above information is accurate and all required documentation is on file.
Beneficiary:  

Jones, Hallie

Provider:  

Therapist, Amazing

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

This space intentionally left blank.
SAMPLE RE-AUTHORIZATION LETTER
NETWORK PROVIDER - AUTHORIZATION LETTER

MICHELLE TEST
123 CENTER AVE
MARTINEZ CA 94553

October 17, 2018

Dear Michelle Test:

The following service(s) has/have been APPROVED:

Auth #: 2006644    Auth Start Date: 10/17/2018    Auth Expiration Date: 12/17/2018

You have been referred to:
Best Therapist
3478 BUSKIRK AVENUE #1000
PLEASANT HILL CA 94523-4378
Phone: 925-555-1212

For the following service(s):

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure Name</th>
<th>Requested Quantity</th>
<th>Approved Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>PR PSYCHOTHERAPY W/PATIENT 30 MINUTES</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>90846</td>
<td>PR FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 50 MINS</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>90847</td>
<td>PR FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50 MINS</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>90887</td>
<td>PR CONSULTATION WITH FAMILY</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>90834</td>
<td>PR PSYCHOTHERAPY W/PATIENT 45 MINUTES</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>99205</td>
<td>PR OFFICE OUTPATIENT NEW 60 MINUTES</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>
(SAMPLE RE-AUTHORIZATION LETTER) - Continued

PLEASE NOTE: This Authorization remains in place as long as full-scope Medi-Cal eligibility does not change, and you (the beneficiary) continue to meet medical and service necessity. You (the beneficiary) must have active eligibility at the time you receive services.

PROVIDERS: All services require pre-authorization, and claims may be denied if pre-authorization is not obtained. Please resubmit your claim to Docustream for payment: Contra Costa Mental Health Plan, PO Box 2178, San Leandro, CA 94577
If you are enrolled in Provider Portal, you have 24-7 Web access to consumer information, including eligibility, authorization, referral history and claim status. You may also check the consumer’s eligibility by calling the State Medi-Cal Automatic Eligibility Verification System (AEVS) phone-line @ 1-800-456-2387 by the third day of each month.

**For adults only: If authorized for 39 units of therapy, the authorization is for weekly sessions for the first six months, and then every other week for the remaining 6 months.

Sincerely,
Authorization Unit

c:  Best Therapist
Phone: 925-555-1212
THERAPIST, BEST
3478 BUSKIRK AVE STE 1000
PLEASANT HILL CA 94523
Fax: 925-555-1212
**Provider Last Name, First Name** (and Group name, if applicable)  | **Location where client will receive services.**  
---|---  
Minuchin, Salvador | Pittsburg  

**Beneficiary Name (Last, First, Middle)**  | **Current Phone Number**  
---|---  
Khan, Shah | 925-555-1212  

**Current Street Address**  | **City**  | **Zip Code**  
---|---|---  
1 Street Lane | Bay Point | 94565  

**Birth Date**  | **CIN (Medi-Cal ID #)**  | **MRN (Medical Record #)**  
---|---|---  
8/15/1985 | 99999999E | 012345678  

**Emergency Contact**  | **Relationship**  | **Current Address**  | **Phone Number**  
---|---|---|---  
Nasreen Khan | Wife | 1 Street Lane | 925-555-1212  

**Sexual Orientation:**  
- ☒ Heterosexual / Straight  
- ☐ Lesbian  
- ☐ Gay  
- ☐ Bisexual  
- ☐ Queer  
- ☐ Questioning  
- ☐ Unknown  
- ☐ Declined to State  
- ☐ Other:  

**Special Considerations** (include cultural diversity, physical, and linguistic considerations):  
Client is Pakistani-American. Cultural perceptions regarding therapy have been addressed ongoing.

| **DSM-V CODE:** | **DSM-V NAME:** | **ICD-10 CODE:**  
---|---|---  
(P) | 296.32 | Major depressive disorder, Recurrent episode, Moderate | F33.1  
(S) | 309.81 | Post-Traumatic Stress Disorder | F43.10  

**Substance Use Issue:**  
- ☐ Yes  
- ☒ No  

**CURRENT PRESENTING PROBLEM**  
(Must document symptoms/functional impairments that meet the criteria for the DSM V included diagnosis. Include life stressors and other relevant factors. Document client progress or provide clinical justification for lack of progress. If appropriate, include how treatment will be adjusted to achieve progress. Also note any changes in Substance Use which impact mental health treatment & daily functioning.)  

Client continues to report feeling depressed the majority of the time. Over the past year, client’s sleeping patterns have improved and interest in activities have increased. However, client continues to exhibit increased irritability and anger management issues, mostly precipitated by job stress and tension with his wife. He is working on finding a balance between work and home stressors. Client’s wife recently called the police when he became violent, he was arrested and went to court. Client stated he had blacked out. A contributing factor was that he had been off his psychotropic meds for a month, unable to get appt with his psychiatrist. Client has PTSD from childhood abuse experiences, which is an area of focus for ongoing treatment.

**SAFETY RISK:**  
- ☐ None Identified  
- ☐ Not Currently Acute  
- ☐ Danger to Self  
- ☒ Danger to Others  
- ☒ Domestic Violence  

**REPORT FILED:**  
- ☐ CPS  
- ☐ APS  
- ☐ Duty to Warn  
- ☐ Weapons Confiscated  

Provide additional detail for any box checked above:  
Client has become violent with his wife when under stress and out of medication.

---

12/2019
Beneficiary Name: Khan, Shah
Provider Name: Salvador Minuchin

Psychiatric Admissions in last year? □ Yes ☑ No
Number of admissions in last year: 

Receiving other outpatient MH Services? □ Yes ☑ No
Describe: 

For YOUTH ONLY Lives with: ☑ Family of Origin ☑ Independent ☑ Relative Caregiver ☑ Foster Family ☑ Other

MEDICAL HISTORY
Primary Care Provider: CCHP
Last Physical Exam: 05/15/2018
Last Dental Exam: 06/06/2018
☐ If client has no PCP, then referral information has been provided (CCCHS Clinic @1-800-495-8885 or Private PCP)

Current Medical Conditions ☑ No Change ☑ Update (Describe):
Client has been diagnosed as pre-diabetic

Allergies MANDATORY (Medication/Food) ☑ None ☑ Yes (Describe type of allergy and reaction/severity): Client has been diagnosed as pre-diabetic

Current Medications (Prescribed and over the counter)

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Target Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abilify</td>
<td>15 mg</td>
<td>Daily</td>
<td>Mood</td>
</tr>
<tr>
<td>Zoloft</td>
<td>200 mg</td>
<td>Daily</td>
<td>Depression, Anxiety</td>
</tr>
</tbody>
</table>

MENTAL STATUS: (Check and/or describe if abnormal or impaired)

Appearance/Grooming: ☑ Unremarkable ☑ Remarkable for:

Behavior/Relatedness: ☑ Unremarkable ☑ Motor Agitated ☑ Hostile
☐ Motor Retarded ☑ Suspicious/Guarded ☑ Other: 

Speech: ☑ Unremarkable ☑ Remarkable for:

Mood/Affect: ☑ Unremarkable ☑ Depressed ☑ Other: 
☐ Labile ☑ Elated/Expansive ☑ Anxious

Thought Processes: ☑ Unremarkable ☑ Concrete ☑ Other: 
☐ Blocking ☑ Circumstantial ☑ Tangential
☐ Paucity of Content ☑ Tangential
☐ Flight of Ideas ☑ Obsessive
☐ Racing Thoughts ☑ Other:

Thought Content: ☑ Unremarkable ☑ Suicidal Ideation ☑ Other: 

Perceptual Content: ☑ Unremarkable ☑ Hallucinations ☑ Other: 
☐ Depersonalization ☑ Delusions ☑ Flashbacks
☐ Derealization ☑ Dissociation ☑ Reference

Fund of Knowledge: ☑ Unremarkable ☑ Remarkable for:

Orientation: ☑ Unremarkable ☑ Remarkable for:

Memory: ☑ Intact ☑ Impaired

Intellect: ☑ Unremarkable ☑ Remarkable for:

Insight/Judgment: ☑ Unremarkable ☑ Remarkable for: hindered by impulsivity

Additional Observations/Comments:

NOTE: Check off boxes in BOTH columns. MUST have at least one Impairment & Intervention.

Impairment Criteria (must have at least one of the following): AND Intervention Criteria (must have at least one proposed intervention):

☑ A Significant impairment in an important area of life functioning.
☐ B Probability of significant deterioration in an important area of life functioning.
☐ C (Under 21) Without treatment will not progress developmentally as individually appropriate.
☐ D Does not meet criteria. (Cannot be authorized)

☑ A Significantly diminish impairment.
☐ B Prevent significant deterioration in an important area of life functioning.
☐ C (Under 21) Probably allow the child to progress developmentally as individually appropriate.
☐ D Condition would not be responsive to physical health care-based treatment. (Must be checked to authorize)
### Beneficiary Name:
Khan, Shah

### Provider Name:
Salvador Minuchin

### PARTNERSHIP PLAN FOR WELLNESS

#### Beneficiary and/or Family Strengths that will be incorporated into treatment.

*Caring, nice person, reliable, honest, faithful*

#### Life Goals: What does the Beneficiary and/or beneficiary's parents/family/guardian hope to work toward?

*Please use quotes.*

“I would like to own property, have a business doing construction, have kids, and stay married.”

#### Treatment Goals: Must be specific, observable and/or quantifiable goals (with timeframes) that link to diagnosis with the goal of decreasing their impairments or symptoms. Treatment plans should be updated when there are significant changes in symptoms, functioning, or life events.

- **Anxiety:** Enhance ability to effectively handle the full variety of life’s anxieties both at home and on the job. Practice self-soothing skills. In six months, be able to implement skills consistently 5 out of 7 days.
- **Develop a safety plan to avoid violence, demonstrate knowledge of action steps to avoid violence and use them when necessary. Client will have no incidents of physical violence in the next 12 months.**
- **Verbalize angry feelings in constructive ways that enhance daily functioning, at least once per day, within the next 12 months.**
- **Begin disclosing and processing childhood abuse experiences in therapy sessions within the next six months.**

#### Requested Treatment Plan Duration:
**12** Months (max of 12 mos)

#### Strategies to Achieve Goals: Specify actions to be taken by client/family and provider to achieve the above goals.

- Continue to use CBT approach to determine triggers for angry feelings and coping strategies to manage those feelings. Teach relaxation techniques to help client manage anxiety, coaching to find work/home balance. Add EMDR to deal with past trauma.

#### PARTIES INVOLVED

- **Beneficiary**
- **Family**
- **Clinicians**
- **Social Workers**
- **Interpreter**
- **Others:**

#### FOR PRESCRIBERS ONLY

- Current medication consents on file
- JV-223 form on file for CCC Foster Children and Juvenile Dependents

#### Beneficiary Signature for Treatment Plan:  
**Mary Smith** (Wet Signature)  
(For Beneficiary 12 yrs. and older.)  
Date: **7/25/2018**

#### Parent/Guardian Signature:
(Required if Beneficiary is 11 yrs. or younger.)

#### If Child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked:

- CFS worker has signed above as legal guardian
- CFS SW verbally agreed to Partnership Plan and on:  
  Provider faxed a copy to SW for signature & return

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

**Salvador Minuchin**  
(Print)  
(Wet)  
(License/Regist.)  
Date: **7/18/2018**

**S. Minuchin**  
(Signature)  

**Date of progress note:**

Note: Continued efforts to obtain signature should be documented in every progress note until signature is obtained.

**Date of progress note:**

**Copy of Partnership Plan offered to Beneficiary/Guardian (MANDATORY):**

- X Accepted  
- Declined  
- **Date:** **7/25/2018**

**Provider Data:**

- **Phone:** 925-555-1212  
- **Fax (as on file with CMU):** 925-555-1213
Beneficiary:  Khan, Shah  
Provider:  Salvador Minuchin  

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

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ANNUAL UPDATE FORM
(Child Sample)

Mandatory: Progress note(s) justifying billing for completing annual is/are dated 5/25/2018

Provider Last Name, First Name (and Group name, if applicable) Location where client will receive services.
White, Katherine Antioch
Beneficiary Name (Last, First, Middle) Current Phone Number
Smith, Joseph 925-555-1212
Current Street Address City Zip Code
99 Jump Street Antioch 94555
Birth Date CIN (Medi-Cal ID #) MRN (Medical Record #)
03/15/2008 99999999D 999999999
Emergency Contact Relationship Current Address Phone Number
Mary Smith Mother 99 Jump Street 925-555-1212

Sexual Orientation: [ ] Heterosexual / Straight [ ] Lesbian [ ] Gay [ ] Bisexual [ ] Queer
[ ] Questioning [ ] Unknown [ ] Declined to State [ ] Other:

Special Considerations (include cultural diversity, physical, and linguistic considerations):
Client is legally blind in one eye. Printed material for client needs to use larger font.

DSM-V Code: DSM-V Name: Must write full diagnosis narrative, no abbreviations ICD-10 Code:
(P) 313.81 Oppositional Defiant Disorder F91.3

Substance Use Issue: [ ] Yes [X] No

DSM-V Code: ICD-10 Code:
(Note Add’l DX in Presenting Problem)

Current Presenting Problem
(Must document symptoms/functional impairments that meet the criteria for the DSM V included diagnosis. Include life stressors and other relevant factors. Document client progress or provide clinical justification for lack of progress. If appropriate, include how treatment will be adjusted to achieve progress. Also note any changes in Substance Use which impact mental health treatment & daily functioning.)

Joseph has made progress academically, but continues to have significant issues at home. Joseph engages in sibling rivalry. Along with a low tolerance for frustration, Joseph displays impulsivity which results in physical aggression and angry outbursts. He has difficulty cooperating with others and does not tolerate losses well. He often cheats at games or becomes angry and physically aggressive when frustrated with them. Parents have to repeat instructions on boundaries often and multiple times to gain compliance.

During one anger outburst, Joseph threatened to grab a kitchen knife to harm himself. Parents were able to intervene and he was admitted into PES for 2 days.

Safety Risk: [ ] None Identified [X] Not Currently Inability to Care for Self Acute Physical Abuse
[ ] Danger to Self [ ] Danger to Others [ ] Domestic Violence
[ ] Sexual Abuse [ ] Neglect

Report Filed: [ ] CPS [ ] APS [ ] Duty to Warn [ ] Weapons Confiscated
Provide additional detail for any box checked above: Client was hospitalized in the past year. Since discharge, client has not exhibited any suicidal ideations. Will continue to monitor.
### Beneficiary Information

**Beneficiary Name:** Joseph Smith  
**Provider Name:** Katherine White

- **Psychiatric Admissions in last year?** Yes  
- **Number of admissions in last year:** 1 (03/01/2018)
- **Receiving other outpatient MH Services?** Yes

### Medical History

**Primary Care Provider:** Dr. Marcos  
**Last Physical Exam:** 3/01/2018  
**Last Dental Exam:** 4/5/2018

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

### Current Medical Conditions

- **No Change**
- **Update (Describe):**

### Allergies

- **Mandatory:** (Medication/Food) None
- **Describe:**

### Current Medications

**Name:** None Reported

### Mental Status

**Appearance/Grooming:** Unremarkable

<table>
<thead>
<tr>
<th>Behavior/Relatedness</th>
<th>Motor Agitated</th>
<th>Hostile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Retarded</td>
<td>Inattentive</td>
<td>Avoidant</td>
</tr>
</tbody>
</table>

**Speech:** Unremarkable

<table>
<thead>
<tr>
<th>Mood/Affect</th>
<th>Depressed</th>
<th>Irritable/Angry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labile</td>
<td>Suspicious/Guarded</td>
<td>Other:</td>
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</table>

**Thought Processes:** Unremarkable

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<thead>
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<th>Thought Content</th>
<th>Suicidal Ideation</th>
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</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td>Homicidal Ideation</td>
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</tbody>
</table>

**Perceptual Content:** Unremarkable

<table>
<thead>
<tr>
<th>Fund of Knowledge</th>
<th>Hallucinations</th>
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</thead>
<tbody>
<tr>
<td>Depersonalization</td>
<td>Delusions</td>
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</tbody>
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**Orientation:** Unremarkable

<table>
<thead>
<tr>
<th>Memory</th>
<th>Hallucinations</th>
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</thead>
<tbody>
<tr>
<td>Impaired</td>
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**Intellect:** Unremarkable

<table>
<thead>
<tr>
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<th>Hallucinations</th>
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</thead>
<tbody>
<tr>
<td>Impaired</td>
<td>Delusions</td>
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</tbody>
</table>

**Additional Observations/Comments:**

### Impairment Criteria

**Intervention Criteria** (must have at least one proposed intervention):

<table>
<thead>
<tr>
<th>Impairment Criteria</th>
<th>Intervention Criteria</th>
</tr>
</thead>
</table>
| □A                  | □A  
| □B                  | □B  
| □C                  | □C  
| □D                  | □D

- **□A** Significant impairment in an important area of life functioning.
- **□B** Probability of significant deterioration in an important area of life functioning.
- **□C** (Under 21) Without treatment will not progress developmentally as individually appropriate.
- **□D** Does not meet criteria. *(Cannot be authorized)*

**□A** Significantly diminish impairment.

- **□B** Prevent significant deterioration in an important area of life functioning.
- **□C** (Under 21) Probably allow the child to progress developmentally as individually appropriate.

**□D** Condition would not be responsive to physical health care-based treatment. *(Must be checked to authorize)*

12/2019
**Beneficiary and/or Family Strengths**
Joseph is intelligent and very verbal. His family is supportive and actively works toward implementation of skills and tools learned in therapy.

**Life Goals**
Please use quotes. “I don’t want to get in trouble anymore.”
“We would like Joseph to learn how to handle his anger better.”

**Treatment Goals**
1. Reduce physical aggression toward others from 5x to 2x per week within 6 months. Reduce outbursts from 5x to 3x per week by parent report within 6 months.
2. Joseph will comply with parental requests and accept boundaries with one reminder within 12 months.

**Requested Treatment Plan Duration:** 12 Months (max of 12 mos)

**Strategies to Achieve Goals**
Play and art therapy to process emotions underlying behaviors. Alternative behaviors will be taught and practiced through modeling, role play, positive reinforcement and feedback

**PARTIES INVOLVED**
Beneficiary
Family
Clinicians
Social Workers
Interpreter
Others:

**TBS Referral Made**
Date of Referral:

**FOR PRESCRIBERS ONLY**
Current medication consents on file
JV-223 form on file for CCC Foster Children and Juvenile Dependents

**Beneficiary Signature for Treatment Plan:** (For Beneficiary 12 yrs. and older.)
Date:

**Parent/Guardian Signature:**
Mary Smith (Wet Signature)
Date: 6/1/2018
(Required if Beneficiary is 11 yrs. or younger.)

**If Child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked:**
- CFS worker has signed above as legal guardian
- CFS SW verbally agreed to Partnership Plan and on: Provider faxed a copy to SW for signature & return

**Unable to obtain signature prior to submission. Document reason in progress note.**
Date of progress note:

**Copy of Partnership Plan offered to Beneficiary/Guardian (MANDATORY):**
- Accepted
- Declined

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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Phone</th>
<th>Fax (as on file with CMU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine White</td>
<td>925-555-5555</td>
<td>925-555-5554</td>
</tr>
</tbody>
</table>

Provider Data: 5/25/2018 (Signature)
License/Regist. 5/25/2018 (License/Regist.)
**CCMH – NETWORK PROVIDER TRAINING**

**Network Provider**

**CHANGE OF TREATMENT AUTHORIZATION**

Request & Partnership Plan Update For Outpatient Services

(SAMPLE)

<table>
<thead>
<tr>
<th>Listena, Vera Gooda</th>
<th>Clienta, Jo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Last Name, First Name (and Group name, if applicable)</td>
<td>Beneficiary Last Name, First Name</td>
</tr>
<tr>
<td>01/19/1985</td>
<td>9999999A</td>
</tr>
<tr>
<td>Birth Date</td>
<td>CIN # (Medi-Cal Card #)</td>
</tr>
<tr>
<td>43333333</td>
<td>Medical Record # (MRN)</td>
</tr>
</tbody>
</table>

Please provide specifics of the change in frequency, quantity, duration, or modality that you are requesting.

**I am requesting weekly individual therapy for the next 6 months**

Date that change is requested to start: **6/1/2018**

<table>
<thead>
<tr>
<th>Current Primary DSM5 Medi-Cal included Diagnosis</th>
<th>DSM-V Name*</th>
<th>Major depressive disorder, Recurrent episode, With psychotic features</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.34</td>
<td></td>
<td></td>
<td>F33.3</td>
</tr>
</tbody>
</table>

* Must write full diagnosis narrative, no abbreviations

Briefly provide the clinical justification for the request. Describe the current presenting problem, including details of any changes in client symptoms, functioning, and/or life circumstances since completion of the most recent Intake or Annual update. Document any current safety risks, recent psychiatric hospitalizations, medication changes, and other resources available to support the client. Clients are expected to benefit from Medi-Cal Mental Health Services, therefore, please document any reasons for client failure to make progress, or regression in functioning. Describe how granting this request will help stabilize the client’s current functioning, prevent hospitalization, incarceration or a higher level of care.

Vera was released from the psychiatric inpatient unit in Martinez in mid May of 2018. She was hospitalized for approx 7 days due to inability to engage in her ADL’s due to deep depression, and experiencing persecutory/commanding auditory hallucinations (voices telling her to end her life by overdosing on her medication because she is worthless). She is currently a patient of Dr. Khan at the West Co Adult Mental Clinic. Weekly therapy will help stabilize the client in order to avoid future hospitalizations.

Significant Changes in the beneficiary’s condition require updates to client’s Partnership Plan. If there is a safety risk, it must be addressed in the Partnership Plan. If an update to the treatment goals and/or strategies is needed, please complete the section below:

Updated Goal(s): Client will adhere to safety plan and follow steps to prevent a crisis and/or once in crisis will follow steps to address crisis.

Updated Strategies: Develop a clear safety plan that defines possible crisis situations, identifies triggers that may signal escalation to a crisis, identifies how to address triggers before they lead to a crisis, and then provides details, including programs/individuals/phone numbers, of how to address crisis.

Provider Name: **Listena, Vera Gooda**

Provider Signature: **VG Listena (Wet Signature)**

Date: **11/9/2018**

Provider License/Designation: **LMFT**

License/Registration #: **11111**

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

Beneficiary Signature: ____________________________ Date: __________________

☑️ Unable to obtain signature prior to submission. Document reason in progress note. Date of Progress note: **11/9/2018**
Client felt she had made progress on her tx goals and decided to end therapy. Referred to Access Line for future services.

**ICD-10 Code:** 296.32  **DSM5 Description:** Major Depressive Disorder, recurrent episode, moderate

A. Therapist (Wet Signature)  **Therapist, Amazing**  11/30/18

**Signature/License**

**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:**
## TYPICAL CMU AUTHORIZATION TEMPLATES FOR NETWORK PROVIDERS
### LCSW, LMFT, Psy.D., & Ph.D

### Child is under age 21

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CHILD REAUTH</th>
<th>CHILD REAUTH GROUP</th>
<th>CHILD ANNUAL</th>
<th>CHILD ANNUAL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>90834</td>
<td>Individual Therapy - Standard Session</td>
<td>52</td>
<td>12</td>
<td>52</td>
<td>12</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Therapy - 30 minutes</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>90847</td>
<td>Family Therapy w/ client present</td>
<td>52</td>
<td>0</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td>90846</td>
<td>Family Therapy w/o client present</td>
<td>52</td>
<td>0</td>
<td>52</td>
<td>0</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>0</td>
<td>52</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>90887</td>
<td>Collateral</td>
<td>60</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>99205</td>
<td>Assessment*</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*A maximum of two units of assessment are allowed for completing the clinical documentation portion of the intake. One unit of 99205 from the reauthorization template is to be saved for the event that an annual update will be requested. Up to six units of 99205 may be billed for the purpose of gathering assessment information.*

### Adult is age 21 and over

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>ADULT REAUTH</th>
<th>ADULT REAUTH GROUP</th>
<th>ADULT ANNUAL</th>
<th>ADULT ANNUAL GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>90834</td>
<td>Individual Therapy - Standard Session</td>
<td>39*</td>
<td>12</td>
<td>26**</td>
<td>12</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Therapy - 30 minutes</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>90847</td>
<td>Family Therapy w/ client present</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90846</td>
<td>Family Therapy w/o client present</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90853</td>
<td>Group Psychotherapy</td>
<td>0</td>
<td>52</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>90887</td>
<td>Collateral</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>99205</td>
<td>Assessment*</td>
<td>9</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* Typical adult is authorized for therapy every week for the first 6 months, and every other week for the 2nd 6 months. **Typical adult annual individual therapy authorization is every other week.
## CPT Codes for MFTs and LCSWs

### New CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Procedure Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Outpatient Assessment Visit NEW PATIENT</td>
<td>60 min</td>
</tr>
<tr>
<td>90834</td>
<td>Individual Psychotherapy -- 38-52 minutes STANDARD SESSION</td>
<td>45 + progress note writing = 60 min</td>
</tr>
<tr>
<td>90832</td>
<td>Individual Psychotherapy -- 16-37 minutes (30 minutes)</td>
<td>30 min</td>
</tr>
<tr>
<td>90837</td>
<td>Individual Psychotherapy -- 53+ minutes <strong>REQUIRES PREAUTHORIZATION</strong></td>
<td>53+ min</td>
</tr>
<tr>
<td>90853</td>
<td>Group Therapy - per person/per visit</td>
<td>90 min</td>
</tr>
<tr>
<td>90887</td>
<td>Collateral</td>
<td>10 min</td>
</tr>
<tr>
<td>90847</td>
<td>Family Therapy-with client present*</td>
<td>60 min</td>
</tr>
<tr>
<td>90846</td>
<td>Family Therapy-without client present*</td>
<td>60 min</td>
</tr>
</tbody>
</table>

*Up to two units of therapy can be billed for children in a seven-day period. This could be one unit of 90834 and one unit of either family therapy code, or it could be one unit of 90846 and one unit of 90847*
## TYPICAL CMU AUTHORIZATION TEMPLATES

MDs & Psychiatric Nurse Practitioners

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>CHILD REAUTH</th>
<th>CHILD ANNUAL</th>
<th>ADULT REAUTH</th>
<th>ADULT ANNUAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psychiatric assessment w/o Medical Services</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric assessment w/ Medical Services</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>99213</td>
<td>E &amp; M – 15 Min</td>
<td>24 (2/mo.)</td>
<td>24 (2/mo.)</td>
<td>24 (2/mo.)</td>
<td>24 (2/mo.)</td>
</tr>
<tr>
<td>99214</td>
<td>E &amp; M – 25 Min</td>
<td>18 (1.5/mo.)</td>
<td>18 (1.5/mo.)</td>
<td>18 (1.5/mo.)</td>
<td>18 (1.5/mo.)</td>
</tr>
<tr>
<td>99215</td>
<td>E &amp; M – 40 Min</td>
<td>12 (1/mo.)</td>
<td>12 (1/mo.)</td>
<td>12 (1/mo.)</td>
<td>12 (1/mo.)</td>
</tr>
<tr>
<td>90833</td>
<td>Individual Psychotherapy w/ Meds – 30 Min</td>
<td>12 (1/mo.)</td>
<td>12 (1/mo.)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90836</td>
<td>Individual Psychotherapy w/ Meds – 45 Min</td>
<td>12 (1/mo.)</td>
<td>12 (1/mo.)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90887</td>
<td>Collateral</td>
<td>30 (2.5/mo.)</td>
<td>30 (2.5/mo.)</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>CPT CODES FOR MD'S</td>
<td>PROCEDURE DESCRIPTION</td>
<td>DURATION</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------</td>
<td>----------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric Diagnostic Evaluation w/o medical services</td>
<td>60 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric Diagnostic Evaluation with medical services</td>
<td>60 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy PT &amp;/Family With E&amp;M Services - 45 min</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHILDREN ONLY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy PT &amp;/Family With E&amp;M Services - 30 min</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHILDREN ONLY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90887</td>
<td>Collateral</td>
<td>10 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90833 +E&amp;M</td>
<td>Individual Psychotherapy w/meds (use E&amp;M code with Add-On Psychotherapy code)</td>
<td>Varies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90836 + E&amp;M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>E &amp;M -Office Outpatient Visit 15 mins</td>
<td>15 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>E &amp;M -Office Outpatient Visit 25 mins</td>
<td>25 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99215</td>
<td>E &amp;M -Office Outpatient Visit 40 mins</td>
<td>40 min</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PAPERWORK DUE DATE GUIDELINES

**Admission Date:** This is the date of the client’s first session and will determine the authorization period for the first and future annual cycles, if services continue to be justified.

**Client Registration and Admission Form:** This must be submitted prior to submitting 1st claims. It is due within seven days of the first session (Admission Date) and annually thereafter.

**Intake Form:** This must be completed, signed, and dated by provider within 60 days of opening. If closing by the 60-day mark, only submit the Registration with Discharge form and any claims.

**Late Intakes:** For an intake that is dated after the 60-day mark, there will be a gap in authorization between the 60-day mark and the date the provider signed the intake.

**Annual Updates:** The client’s authorization will expire the day before the anniversary of the admission date. To request continued services, complete the annual update within the 30 days prior to the prior authorization expiration date.

**Late Annual Updates:** Services between the expiration of the previous authorization, and the provider’s signature date on the updated treatment plan, will not be covered.

**Client signatures:** The client (or legal guardian) should sign the intake as soon as possible. The signature must be dated. As long as the client signature is not obtained, the provider must document the reason in every note.

**DUE DATES FOR OUTPATIENT CLAIMS AND APPEALS OF DEFERRALS/DENIALS**

**Due dates for claims:** Claims must be submitted within 60 days of the date of the service being claimed, 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:** Authorizations do not guarantee Medi-Cal eligibility. Providers must check clients’ eligibility at the beginning of every month to prevent denial of claims due to the client no longer being eligible. This also applies to clients who have been recently referred for services.

Please see the next page for a graphic representation of the due date cycle.
Intake MUST BE completed, signed and DATED by the provider no later than the date of this cycle in order to avoid a gap in authorization.

30 days prior to the start of each authorization cycle:
- 4/1/16
- 6/1/16
- 3/1/17
- 3/31/17

Next authorization cycle:
- 4/1/18
- 6/1/18
- 3/1/19
- 3/31/19

CARE MANAGEMENT UNIT
GUIDELINES FOR PAPERWORK DUE DATES

- First authorization
- Session
- Date of first client session
- 60 days before
- Authorization expires
- Update the intake date
- Annual update

COVERED services are NOT update after the expiration date of the authorization and before the next authorization period. Services provided after the expiration date must be updated within 30 days of the last session to avoid gap in authorization. Authorization forms dated after the last session must be completed and signed by the provider no later than the date of this cycle.
OVERVIEW OF CLAIMS SUBMISSION

- CLAIMS SUBMISSION FAQS
- HOW TO INSTALL ADOBE ACROBAT READER
- HOW TO REGISTER & DOWNLOAD DOCUHEALTHLINK
- HOW TO SET-UP PROVIDER MASTER
- HOW TO SET-UP CLIENT MASTER
- HOW TO SUBMIT A TEST CLAIM
- HOW TO SUBMIT A LIVE CLAIM
- HOW TO PRINT CLAIMS FOR MAILING
- SAMPLE CLAIM FORMS
- CPT CODES & DEFINITION OF COLLATERAL
- CLAIMS TERMINOLOGY & EXAMPLES
- SAMPLE REMITTANCE ADVICE (MAILED & PORTAL VERSIONS)
The “Network Provider Client Registration & Admission” form must be received by CMU prior to paying claims for a new client.

Claims must be submitted through our third-party vendor, DocuStream.

- Be sure your version of Adobe Reader DC is up-to-date.
  - Follow instructions for “Installing Adobe Acrobat Reader” in training packet
  - Follow “Instructions for Windows 10” if applicable
  - If you have not received an electronic copy of the CMS-1500 PDF form, please request that one be emailed to you.
- If you have a Windows operating system, you can sign up for DocuHealthLink and submit your claims electronically.
  - See the handout on “How to Register for DocuHealthLink” for instructions on how to set up an account.
  - See the following handouts in the training packet to set up your practice master, client master, and individual claims
    - “How to Set-Up PROVIDER MASTER CLAIM”
    - “How to Set-Up CLIENT MASTER CLAIM”
    - “How to Submit a Live Claim to DocuHealthLink”
  - For claims submitted via DocuHealthLink, you will get an email response from DocuHealthLink within 24–48 hours notifying you if the claim has been accepted or rejected.
  - Be sure to choose “Contra Costa Behavioral Health” as the “Payer”
  - Claim rejection is the term for claims that could not be accepted by DocuHealthLink for a variety of reasons, such as incorrectly entered identifying information for the client
    - If your claim is rejected by DocuHealthLink, you will receive an email providing the reason. If you know how to resolve the problem, you can resubmit your claim immediately. You do not need to file an informal appeal.
    - “No member match” is most common rejection reason. Verify that CIN, MRN, date of birth, and spelling of client’s name are all exact before contacting CMU.
- If you have a Mac, or do not want to sign up for DocuHealthLink, you must print out and mail your claims to Contra Costa Mental Health Plan, PO Box 2178, San Leandro, CA 94577
  - See the following handouts in the training packet to set up your practice master, client master, and individual claims
    - “How to Set-Up PROVIDER MASTER CLAIM”
    - “How to Set-Up CLIENT MASTER CLAIM”
    - “How to Submit a Live Claim to DocuHealthLink”
CLAIMS SUBMISSION FAQ’s
Continued

- Submit your printed claims via mail
  - Purchase pre-printed forms at an office supply store.
  - The template does not print the full claim form, only the data you’ve entered. See the sample in the packet of how the template prints.
  - Place your pre-printed CMS-1500 form in your printer and use the template to print on the form.
  - If you have difficulty aligning the data to the spaces on the form, please see the document “How to Print CMD1500 Form Data on Official CMS-1500 Forms”

- Claims submitted by mail will be deferred if they are unable to be uploaded into the Tapestry system.
  - If you receive a deferral letter, correct the error as noted, and resubmit to DocuHealthLink. You do not need to contact CMU.

- If a mailed claim is accepted, you will not receive an email confirming acceptance.

- An accepted claim will be processed by Tapestry (Contra Costa County) to determine whether it will be approved, pended, or denied.
  - If your claim is approved, you will receive a check, followed separately by a remittance advice letter. We do not have the option for direct deposit of checks. If everything is in order to pay your claim (clean claim, referrals in place, etc.), you should expect a check within about 30 days.
  - If your claim is pended, you will not receive a notification. If you are signed up for Provider Portal, you will be able to check status online.
  - If your claim is denied, you will receive a letter in the mail, giving the reason.

- DO NOT fax claims unless specifically requested to do so. They will not be accepted.

Tips regarding completing the CMS-1500 form
- See the sample claim form in the training packet with handwritten tips for completing it
- View the e-Learnings on completing the CMS-1500 form if you haven’t already (via your Contra Costa County Learning Management System account)
- Mailed claims must be typed or computer printed.
- You can indicate “Signature on File,” or the abbreviation “SOF,” in boxes 12 and 13, where it calls for the client’s signature.
  - You can have the client sign a blank claim form and keep it in the chart, OR
  - Include language in your informed consent document that covers the statements in boxes 12 and 13 on the CMS-1500 form
  - It is HIGHLY ENCOURAGED to have the client sign this paperwork in the FIRST session, in case they do not return.
  - The signature date you enter in box 12 on all of your claims is the date your client signed either the blank claim form or your informed consent document
Please reference the CPT codes handout for approved CPT codes for billing Contra Costa County Behavioral Health Services. Do not bill codes that are not on this list.

- We have provided the Title 9 description for 90887 collateral for your reference.
- 90837 for individual therapy requires preauthorization. Claims for 90837 code will be denied without preauthorization. The standard individual therapy code is 90834.
- Do NOT enter any data in Box 14 unless your client has a special form of Medi-Cal related to pregnancy only. You would be notified of this on your provider letter. Call CMU for consultation.

- Place of Service Codes (Box 24B):
  - Use “11” for all services
  - On your progress note, document the actual location of the service.

- Modifier Codes (Box 24D)
  - 59 for services billed on the same day, even if different CPT codes
    - Enter on second and subsequent lines of service for the same day
  - 76 for repeat procedure on the same day with the same CPT code
    - Most often will apply to 99205 and 90887 codes
    - Enter on the second and subsequent lines of service.

The ICD-10 code(s) must be indicated on the CMS-1500 form, in box 24.

- Enter a “0” in the “ICD Ind” space in box 24.
- Please reference the official included diagnosis DSM-V to ICD-10 crosswalk dated March 2017.
- You must only use codes on the included diagnosis list for Medi-Cal.
- DSM-V and ICD-10 codes are BOTH required on intakes/annuals.
- Do NOT use a non-included diagnosis as the secondary diagnosis. It will not crosswalk to ICD-10 included codes.
- Do not include ICD-10 codes that there is no “Diagnosis Pointer” for in at least one line in box 24 E.

You can submit claims at any time. You do not have to wait for a certain time of the month.

- If you realize you made a mistake on a claim, which caused it to be rejected, you can resubmit it immediately
- If your claim was accepted and you realize you made a mistake, please contact CMU for guidance
- If you realize you submitted a duplicate claim, please do not submit an informal appeal for the denied duplicate claim. Check your records to make sure whether or not it was already paid.
- DO submit claims no later than 60 days from the date of service. Late claims may be denied.

Informal appeals can be submitted for denied claims

- Denial letters will be sent via US Mail, even if you are signed up for Provider Portal
- Informal appeals can be submitted via the In-Basket feature of Provider Portal.
- They can also be mailed or faxed to CMU.
• DO NOT submit appeals to DocuHealthLink.
• Hold corrected claim resubmissions until CMU has approved an Informal Appeal. Once the response to appeal has been determined, you will be instructed whether to resubmit to DocuHealthLink, or if CMU will “rapid enter” the claim for payment.
• If your claims denied because you submitted them before your intake paperwork was authorized, you will need to resubmit them via mail, fax or provider portal. Claims that have the same dates and CPT code as a previous claim will deny as duplicates (this is a bug in our system).

When calling regarding claims issues, please have the following information:
• How did you submit your claim? (mail or electronically)
• Did you receive a rejection email from DocuHealthLink? If so, what was the reason given?
  ▪ If “No member match,” please review your claim closely to confirm that the spelling of the client name, the CIN, the MRN, and date of birth are all exactly correct.
• Did you receive a deferral letter from CMU? If so, what was the reason given?
• Did you receive a denial letter from CMU? If so, what was the reason given?
• Did you get a “Remittance Advice”? If so, what were the denial codes?

DO NOT submit an informal appeal if:
• Your claim was rejected, rather than denied.
• Claims were rejected due to a data entry error on your claim
• Please consult with CMU if you have any questions.

DO submit an informal appeal if clinical review or human intervention is required.
• Your authorization needs to be corrected
• Your claim denied for no referrals, but you know that you have them
• You are asking for a one-time exception
• The client lost eligibility but regained it retroactively, your authorization had been truncated due to the loss of eligibility, and it needs to be extended.
• You had a claim with the same dates and CPT codes denied previously.

Informal appeals must be received within 30 days of the date of the denial letter.

DO consult your Remittance Advice, which will come in the same envelope as the denial letter. This will give more detail regarding the reason for denial and may save you time in calling CMU or submitting an unnecessary appeal.

DO log on to your Contra Costa County Learning Management System account to view tutorials on how to complete the CMS-1500 claim form.
  ▪ Go to http://tinyurl.com/yembjd4u
  ▪ If you have forgotten your log in information, please contact CMU.
INSTRUCTIONS FOR USING ADOBE READER WITH WINDOWS 10

1. First step is to download Adobe Reader from the internet. Navigate to Google and search for ‘Adobe Reader’.

2. Click Install Now:

3. Locate the downloaded file and double click it to initialize the installation.

4. The installation will download and install Adobe Reader to your computer:

5. Click ‘Finish’ to close the installation window
6. Now we need to make sure Adobe Reader is set as your Default PDF Viewer.

7. Navigate to the Contra Costa Behavioral Health PDF and right click. Select ‘Open with’ and then click ‘Choose another app’.

8. Look for Adobe Acrobat Reader DC in the list that appears on your screen, you may need to look in the ‘Other Options’ section of this window. Once you have found the correct program, select it. Ensure that ‘Always use this app to open .pdf files’ is checked.
HOW TO REGISTER AND DOWNLOAD DOCUHEALTHLINK

1. Go to www.docuhealthlink.com and click on the REGISTER tab in the upper right-hand corner
2. Choose a username and password and provide your contact information
   o Shortly after, you will receive a confirmation email stating that your account is in a “PENDING” status
3. After 1-2 days, you should receive a second email from DocuHealthLink
   o This email should state that your account has approved and has been assigned a Client ID
4. Go back to www.docuhealthlink.com and click “LOG IN” link at top right of the web page
5. On your Home Page, you will see your Client ID:

   cmathew's Home
   User account is activated!

   User Client ID
   ClientID: XPALQW

   Click Here To View Report Details
   Click Here To View Report List

6. Underneath your Client ID, you will see “INSTALLER DOWNLOADS” links provided
   o Choose the file for your Windows Operating system, either 32-bit or 64-bit

   **Installer Downloads**
   
   **Docuhealthlink 32-bit v1.2.0.1**
   File Size: 76.6 MB
   Docuhealthlink for Windows 32-bit

   **Docuhealthlink 64-bit v1.2.0.1**
   File Size: 77.0 MB
   Docuhealthlink for Windows 64-bit

7. When prompted, allow the file to begin downloading by clicking “RUN”
   o **NOTE: It may take a few minutes for the download to complete**
8. During the installation you will be prompted to enter your Client ID, which is on your Home Page
9. Follow the prompts to complete the installation and create a shortcut for your desktop
   o The shortcut will be titled “DocuHLTransmit”
SETTING UP CLAIM FORMS

CCMH – NETWORK PROVIDER TRAINING

CCMH – CARE MANAGEMENT UNIT

WHAT'S NEXT? How to Set-Up Provider Master (CMS-1500)

HOW TO SET UP PROVIDER MASTER

Before you begin:
- Did you receive a copy of the CMS1500DS1_MASTER.pdf in your email?
  - YES = Great! Continue to PART A.
  - NO = Send an Email to CMUProvider.Services@hsd.cccounty.us and request a copy

PART A: Locate your email copy of the CMS1500DS1_MASTER.pdf form

  o Download the PDF to your computer (Select the download option or drag and drop file onto your desktop)
  o Open CMS1500DS1_MASTER.pdf in Adobe Reader DC

    Box 24j: Enter the rendering Provider NPI. Note, you must enter on EACH service line billed
    o TIP - you can enter the NPI on each line for ease of future billing

    Box 25: Enter the same Tax ID number you submitted on your W-9 to CMU

    Box 27: Accept Assignment - Check the “YES” box

    Box 31: enter the rendering provider- LASTNAME, FIRSTNAME; and DATE

    o If you mail your claims, you must sign the form here

    Box 32: Enter the Service Location – this cannot be a P.O. Box

    o The Service Location or Place of Service (POS) is where you saw your client

    o For multiple locations, you will need a PROVIDER MASTER for each separate location

    Box 32a: Enter the 10-digit NPI for this Service Location

    Box 33: Enter the Billing Provider Information on 3 lines

    **THIS SHOULD MATCH WHAT YOU SUBMITTED ON YOUR W-9 FORM TO CMU**

    Box 33a: Enter the 10 digit NPI for the Vendor we pay

    o For solo practitioners, ALL NPI #’s should be the same

PART B: With the CMS1500DS1_MASTER.pdf still open follow these next steps

  o From your Desktop, right-click the background - from the drop-down menu choose “New” and “New Folder”
  o Give your folder a name (Ex: “Contra Costa County Claims Templates”)
  o Go back to your CMS1500DS1_MASTER.pdf in Adobe Reader DC
  o At the top of the window, select “File”
  o From the drop-down menu, choose “Save As”
  o Choose your new folder as the location and rename the file “CMS1500_PROVIDERMASTER.pdf”
  o Click SAVE – this saves a copy with ONLY your practice information for future billing 😊
CCMH – NETWORK PROVIDER TRAINING

CCMHP – CARE MANAGEMENT UNIT

HOW TO SET UP CLIENT MASTER

PART A: Locate the folder where you keep your PROVIDER MASTER

- Right-click on the folder icon - from the drop-down menu choose “New” and “New Folder”
  - Give this folder a name to identify your client ➔ Example - “DOE, JANE - CLAIMS”
- Open your “CMS1500_PROVIDERMASTER.pdf”
- At the top of the window, select “File,” then choose “Save As,” saving to the folder you just created
- Rename the template with your client’s name or an identifier of your choosing

PART B: With the form still open, fill in the following boxes with your client’s information

Box 1: check the box for Medicaid
Box 1a: enter the client Medi-Cal ID Number (CIN #)
Box 2: enter the client’s LAST NAME, FIRST NAME
  - TIP – use the name on your client’s Medi-Cal card or their Authorization Letter
Box 3: enter the client DOB (mm|dd|yyyy) AND check the correct box for sex
Box 4: enter “SAME “ for the Insured’s Name
Box 5: enter the client’s home address, including City, State, and Zip code
Box 12: enter “SIGNATURE ON FILE” and the date the client signed your release of information form
Box 13: enter “SIGNATURE ON FILE” indicating the date the client/guardian signed their consent form, or a blank claim form, authorizing payment to you the provider
Box 14: This is for females with Pregnancy-Related Medi-Cal. Complete ONLY if instructed on your auth letter
  - Enter the date of their last menstrual period (LMP) and qualifier 484
Box 21: enter client’s ICD-10 diagnosis code(s) and the indicator “0” in the box to the right

PART C: Fill out the billing information for services rendered

Box 24a: enter the “FROM” date of service (mm|dd|yy) – DO NOT enter a “TO” date
Box 24b: enter the Place of Service: 11 = office or phone (for services that take place outside the office, such as a collateral visit at the school, use POS 11 and document where the procedure took place on your progress note)
Box 24d: enter the CPT Code.
- If you are billing for 2 services (CPT codes) on same Date-of-Service:
  - For 2 distinct service codes (i.e. 99205 & 90887), enter Modifier code 59 for second service and subsequent services
  - For 2 identical service codes (i.e. 90887 & 90887), enter Modifier code 76 for second service and subsequent services
Box 24e: enter the applicable pointers to the diagnosis codes entered in Box 21 (A, B, C...)
Box 24f: enter the total charge for the line of service using NNN.NN including the decimal point.
  - (i.e. multiply the number of units x the rate per unit)
Box 24g: enter the total number of units for that service line
More than one office? Be sure that you use the correct PRACTICE MASTER for each corresponding location
Box 26: Enter your client’s MRN #, including ALL LEADING ZEROS ➔ Example – “000123456”

PART D:

- Check your work! ☑ then SAVE your document and submit via DocuHealthLink
- Or PRINT and mail your claims to Contra Costa Mental Health Plan, PO Box 2178, San Leandro CA 94577

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CM 5/9/18

12/2019
SUBMITTING A TEST CLAIM

HOW TO SUBMIT A TEST-CLAIM

1. Prepare a claim using the fillable CMS-1500 form as you would for any client
   - TIP – Be sure to use actual patient info, and double check your work as to avoid a Test Claim rejection
2. With the claim still open, go to “File” and choose “Print” – a print box will pop-up on the screen
3. Use the drop-down menu and choose DocuHealthLink Printer
4. Click “Print” at the bottom of the box
   - NOTE: This action will NOT print your claim, it sends your claim to a queue until you are ready to submit
   - Go to your Desktop and open the “DocuHLTransmit” shortcut - This will open a new window where you can review your claims before submitting

5. Under “Claim Info” Select Payer by using the drop down menu and choosing Contra Costa Behavioral Health
6. Select your claim type by clicking “CMS 1500” and then SAVE on the right
7. At the top left of the window click on “Test” and then choose “Submit as Test” from the drop-down menu
   - NOTE - This will send your claim to DocuStream, but the data will NOT be submitted for payment
8. Once you submit your Test Claim, send an email to with the Subject Line as “Test Claim Submitted”
   - SEND TO: DocuHealthLink@docustream.com
9. Within 1-2 days you will receive a response email stating that your Test Claim was processed
   - If successful, you will be notified that you are OK to submit Live Claims for payment

HOW TO SUBMIT A LIVE CLAIM

OM 5/9/18
CCMH – NETWORK PROVIDER TRAINING

CCMHP – CARE MANAGEMENT UNIT

1. Prepare a claim using the fillable CMS-1500 and “Save” your copy
   - TIP – Be sure to double check your work as to avoid a REJECTED claim from DocuStream

2. With an open claim, go to “File” and “Print” - Use the drop-down menu to choose “DocuHealthLink Printer”

3. Click “Print” at the bottom of the box
   - NOTE: This action will NOT print your claim
   - It sends the claim into a queue until you are ready to submit

4. Open the “DocuHLTransmit” shortcut you created earlier
   - This will open a new window where you can review, add, or delete claims in queue before submitting

5. From the queue on the right, click a single claim or use Shift-click or Ctrl-click to select multiple claims

6. Underneath “Claim Info” select Payer by using the drop down and choose “Contra Costa Behavioral Health”

7. Select “Claim Type” by clicking “CMS-1500” and then SAVE - This queues your claim for final upload
   - NOTE: Only claims with “Payer” and “Type” selected will be uploaded. The rest will remain in the queue

8. When you are ready to Submit your claims, click Upload in the bottom-right corner
   - Within 1 business day you will receive an email that your claim has been either accepted or rejected.
   - Accepted? Continue submitting claims Rejected? Go back, check your claim and try again ☹
   - Still need help? CMU Provider Services: 925-372-4400 or CMUProviderServices@hsd.ccounty.us

CM 5/9/18

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12/2019
APPENDIX A - HOW TO PRINT CLAIM DATA ON CMS-1500 FORMS [Windows Example]

- When printing from Adobe Acrobat, the Print dialog box opens as shown below
- On the right, under Comments & Forms, be sure to select “Form Fields Only” option
- On the left, under Page Sizing & Handling, select the “Actual Size” option
- In the bottom right corner you will then see a preview of what will print on an actual CMS 1500 form
  - TIP – this preview only shows the data entered on your template forms
- Click “Print” when you are ready to print your data onto the CMS-1500 form
**SAMPLE COMPLETED CLAIM FORM**

**Medi-Cal D.O.B.**

**CIN (6#s, 1Alpha letter)**

**Always check**

**Medi-Cal Name**

**Always self**

**Date client signs blank claim form**

**Client signs blank claim form**

**Box 14 is for Pregnancy Related Medi-Cal only. Date is 1st date of last menstrual cycle. Always use 484 qualifier.**

**Always 0, ICD10**

**Rate x # of units**

**Must match W9**

**Client’s MRN**

**You do the math**

**Address on W9**

**Type full name**

**SERVICE LOCATION/PRACTICE NAME**

**PAY TO NAME**

**NPI for Place of Svs.**

**NPI for Vendor we pay**
Claim Detail
1 message

general@docustream.com <general@docustream.com>  Thu, Jun 14, 2018 at 5:24 PM
Reply-To: docuhealthlink@docustream.com
To:
Cc: claimdetails@docustream.com

Processed claim information below:

Batch: 181645098_003_003, Insurer: CCMH, Total Claims: 3, Total Accepted Claims: 0, Total Rejected Claims: 3,
ClientID: 9KQKPZ

<table>
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<tr>
<th>DS Reference</th>
<th>InsuredID</th>
<th>Date of Service</th>
<th>Total Amount</th>
<th>Status</th>
<th>Rejected Reason</th>
</tr>
</thead>
<tbody>
<tr>
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<td>91908442G</td>
<td>061318</td>
<td>$70.20</td>
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</tr>
<tr>
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<td>051418</td>
<td>$70.20</td>
<td>Rejected</td>
<td>NO</td>
</tr>
</tbody>
</table>

If you have any questions or comments please email docuhealthlink@docustream.com
DEFERRAL OF CLAIM PROCESSING

DATE: ____________________________  RE:  ☒ A. Beneficiary Last Name, First Name

TO: _______________________________  ☒ B. See Attached

PLEASE COMPLETE A **NEW CLAIM** WITH REQUIRED INFO AND MAIL TO: CONTRA COSTA COUNTY MENTAL HEALTH PLAN PO BOX 2178, SAN LEANDRO, CA 94577

The attached Claim(s) has been **REJECTED** for the following reason(s):

**BENEFICIARY (CLIENT) INFORMATION IS INCORRECT OR INCOMPLETE**

- [ ] Beneficiary Name is Missing, Incomplete or Illegible. (Box #2)
- [ ] CIN # is Missing, Incorrect, Incomplete or Illegible. (Box #1a)
  - **Note:** Info MUST be documented correctly for Medi-Cal verification
- [ ] Date-of-Birth is Missing, Incorrect, Incomplete or Illegible. (Box #3)
- [ ] CIN # **AND** Date-of-Birth provided does **NOT** match the Beneficiary Name

**CLAIM INFORMATION IS INCORRECT OR INCOMPLETE:**

- [ ] Missing, Incomplete or Illegible Diagnosis *(must use ICD-10)* (Box #21)
- [ ] CPT Code is Missing or Illegible (Box #24d)
  - Beneficiary MRN (Medical Record Number) is Missing, Incorrect, Incomplete or Illegible.
  - Please include the leading Zeros (00) as the MRN must be a 9 digit number.
  - See attached example. (Box #26)

**PROVIDER INFO IS MISSING OR INCOMPLETE:**

- [ ] Federal Tax ID (or Social Security #) for Vendor we are paying is Missing or Incorrect. (Box #25)
- [ ] NPI Number is Missing or Incorrect. (Box 24j, 32a & 33a) **NPI Number must be in all 3 boxes.**
  - Box 24j – NPI Number for Person Providing Services
  - Box 32a – NPI Number for Place of Service
  - Box 33a – NPI Number for Vendor we are Paying

- ☒ Please correct high-lighted areas and resubmit new claim.

Revised 8.8.18
ADVERSE ACTION NOTIFICATION - DENIAL

DATE: 09/05/19
TO: NOT FOR PUBLIC RELEASE
FAX#: No fax number available
FROM: Care Management Unit (CMU)
SUBJECT: Denial re: Claim #10564616 for:

NOT FOR PUBLIC RELEASE  MRN: NOT FOR PUBLIC RELEASE  CIN: NOT FOR PUBLIC RELEASE

The attached Claim(s) has been denied. See attached Claim for the reason.

TO MAKE AN INFORMAL APPEAL:

1. Submit this denial letter, claim and a cover letter with the reason for appeal to CCMHP via Provider Portal message, using the "Informal Appeal" subtopic.
2. If you are not enrolled in Provider Portal, submit via mail to CMU or via Fax at (925) 372-4410 (note “INFORMAL APPEAL” on subject line).

Total Pages: _____ (including this cover page)

CONFIDENTIAL: This message is confidential and intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential or exempt from disclosure under applicable Federal State Law. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this message in error, please telephone the originator of this message immediately.
Check Number: 31

Happy, Therapist (Practice #12121)  
30 Douglas Dr. Suite 234  
Martinez, CA 94553

<table>
<thead>
<tr>
<th>Member Number</th>
<th>Patient Name</th>
<th>Treatment</th>
<th>Date</th>
<th>Reference Tariff Code</th>
<th>Charged</th>
<th>Paid</th>
<th>SOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>10860000101</td>
<td>TJHTEST.RULECHECKERTWO</td>
<td>09/16/2019</td>
<td>90806</td>
<td></td>
<td>100.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

**SUBTOTAL**  
**TOTALS**  
0.00

Explanation of Benefits

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>DUPLICATE CLAIM DENIED</td>
</tr>
</tbody>
</table>
SAMPLE OF PRINTED REMITTANCE ADVISE
Below is a snapshot & key to reading your RA

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

CODICE(S) DESCRIPTION

[DW] 1-Duplicate claim/service, generated by EDI claim load
[C] 2-Contracted Rate Payment
[CD] 3-Claim Denied
DEFINITION OF COLLATERAL

A service activity/contact with a significant support person in a client’s life (parents, legal guardians, relatives, etc.) with intent of improving or maintaining the mental health status of the client. May include providing consultation and collaboration to assist in areas such as: better utilization of services, overcoming obstacles, improvement in functioning.

- For example, calling a family member and getting an update on client, treatment planning, etc.
- Collateral service may also include family counseling or therapy which is provided on behalf of the individual.
- The beneficiary may or may not be present for these activities (CCR Title 9: 180.206).
- Calling and scheduling appointments, checking on SSI status, book keeping, faxing information, merely leaving a message (vs. making contact) are all clerical tasks and are not billable.
- Do not use collateral for coordination/collaborating with other providers within the same clinic.
- Requires prior authorization; for adults, Progress Note must be submitted with claim.
OVERVIEW OF PROVIDER PORTAL

- **FREQUENTLY ASKED QUESTIONS**

- **SAMPLE ATTACHMENT A**
What is Provider Portal?
- It is a secure website that you can log into to manage your county Medi-Cal clients and to communicate with CMU
- Provider Portal can be accessed using any operating system or web browser
- You log in just as you would any other type of account, such as a bank.
- Provider Portal will allow you to check client eligibility, acuity level, authorization status, claims status.
- All claim information will be uploaded to Provider Portal whether submitted by mail or electronically.
- You can also communicate with CMU via provider portal, 24/7. You can send messages using the “In Basket” feature.
- You can upload documents for review, such as intakes, annual updates, informal appeals, etc.
- You will be able to access limited additional information about clients, such as their PCP and other members of the client’s care team.

Will signing up for Provider Portal make me a HIPAA-covered entity?
- Providers are already HIPAA-covered entities by virtue of the fact that information about clients is communicated electronically by the county and by Medi-Cal.

How does Provider Portal protect privacy?
- You must log in to a secure website in order to access client information.
- Information is protected during communications between the website and your computer because the website uses HTTPS, which encrypts the information.
- You will receive information about installing a “security certificate” on your computer. You can install the same certificate on more than one computer.
- You will receive an email informing you of a new notification in Portal, but you will have to actually log in to Portal to view the information.

Who can sign up for Provider Portal?
- All CCCMHP Network Providers and qualified office staff.
- You must submit a User Agreement and attachment to designate users who are to be given access.

How can I sign up?
- You can provide your email and we will email the necessary documents
- You must complete a five-page user agreement and an Attachment A
- You will receive two separate emails with Portal login info once your account is set up. These will go to the email address you provide on Attachment A.

What if I don’t want to sign up for Provider Portal?
- You can submit documentation via mail or fax to CMU.
- Claims must be submitted through Docustream/DocuHealthLink, either electronically or by mail, to the San Leandro PO Box.
What if I signed up for Provider Portal and don’t want to use it?
- We encourage you to use it if you signed up.
- If you don’t want to use it, or have problems with it, you can submit paperwork via mail or fax. We will deactivate inactive accounts.
- You must notify CMU in writing if you want to withdraw and no longer have access to client info in Portal. You must submit a letter with your signature.

How will I document my own signature and client signature on intakes/annuals?
- We have to be able to see your signature and the date of the signature to determine timeliness.
  - You must attach a scanned intake to your In-Basket message when you request reauthorization or annual authorization.
  - Alternatively, you can submit the electronic version of your intake/annual, and scan only the signature page and submit it on the same In Basket message.
  - If you don’t have scanning ability, submit by mail or fax.
- For client signatures, if you did not obtain the client signature prior to submitting, you can check the box on the signature page, and document continued efforts to obtain the signature in your progress notes.

How long will clients stay on my client list in Provider Portal, once I have stopped seeing them?
- They will stay on your caseload list for 90 days after the last activity (referral or claim), regardless of whether or not you have submitted an episode closing form.
- If you want to have a client removed from your list, or you want to have a client added that dropped off inadvertently, please contact CMU via Provider Portal or phone call.
- **Do not send emails that include client information.**
PROVIDER PORTAL USER AGREEMENT INSTRUCTIONS FOR COMPLETION

Page 1:

1. Line 1: “Dated_____________________________” Fill out today’s date
2. Line 2: Martinez, CA 94553 and ___________________” Fill out your name
3. Line 3: “Having an address at ___________________(Outside Entity)” Fill out your practice site’s location.

Example:

THIS ccLink Provider Portal ACCESS AGREEMENT (“Agreement”), dated ___September 28, (year)___, is entered into by and between CONTRA COSTA HEALTH SERVICES (CCHS) with an address at 2500 Alhambra Avenue, Martinez, CA 94553 and ________Chris Therapist, LCSW____ having an address at _____1320 Arnold Drive, Suite 242, Martinez, CA 94553 (“Outside Entity”).

Page 5:

Please add your signature, printed name and title under the “OUTSIDE ENTITY” (Provider) section of the agreement.

Example:

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be signed as of the date and year first set forth above.

CONTRA COSTA HEALTH SERVICES

By: __CCHS Representative Signature________
Name: __CCHS Representative Printed Name__
Title: ___President__________________________

OUTSIDE ENTITY (Provider)

By: ____Chris Therapist, LCSW Signature____
Name: ____Chris Therapist, LCSW Printed Name____
Title: ___LCSW, Network Provider____
CCMH – NETWORK PROVIDER TRAINING

Exhibit A

Authorized Users

*Please fax completed agreement and form to CCHS Provider Services at (925) 372-4410

**Please Type or Print Legibly

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<thead>
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<th>Practice Name:</th>
<th>Chris Solo Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>1330 Arnold Street 123 Martinez 94553</td>
</tr>
<tr>
<td></td>
<td>Street Suite City Zip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Point of Contact:</th>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chris Solo Practitioner</td>
<td>925/000-0000</td>
<td>925/000-0000</td>
<td><a href="mailto:Christherapist@gmail.com">Christherapist@gmail.com</a></td>
</tr>
</tbody>
</table>

*Please indicate your tax ID in the cells provided below. For billers—Please indicate the tax ID number(s) of the groups you are contracted with to bill.

| Tax ID# 999-99-9999 |

List each individual to be assigned privileges to ccLink Provider Portal in the table below.

When choosing Role, please pick one of these four choices: Provider, Nurse, Office Staff, or Manager

**Note:** Office staff role does not permit access to clinical information.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Role</th>
<th>Phone</th>
<th>Email</th>
<th>Add User?</th>
<th>Delete User?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo Practitioner</td>
<td>Chris</td>
<td>T</td>
<td>Provider</td>
<td>925/123-4567</td>
<td><a href="mailto:Christherapist@gmail.com">Christherapist@gmail.com</a></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Group/Org Staff</td>
<td>Samuel</td>
<td>T</td>
<td>Office Staff</td>
<td>925/000-0000</td>
<td><a href="mailto:Sam@groupname.com">Sam@groupname.com</a></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Thank you 😊