Contra Costa Mental Health Plan (CCMHP)

NETWORK PROVIDER

CMU Orientation

Front Cover: "Father Abraham"

Before my mental health started to improve, I had no hobbies or things that I liked to do. Now that my mental health is in good standing for the most part, I enjoy doing artwork. The reason I like to draw and paint and what not is that it helps me to sit down and focus and it also makes me feel good to know that I am creating something that brings joy to others as well as it does to myself.

Stephen A. Boyd Jr.
Community Support Worker, Office for Consumer Empowerment

CONTRA COSTA HEALTH SERVICES

BEHAVIORAL HEALTH DIVISION

MISSION STATEMENT

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 use, homelessness and other needs that promote wellness, recovery, and resiliency while respecting the complexity and diversity of the people we serve.

VISION STATEMENT

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

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: 1330 Arnold Drive #143, 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 for contact information

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**

Availity Support – contact the Availity staff
Email: www.availity.com/ediclearinghouse

Mental Health CFS Liasons
Contact CMU Clinician of the Day for contact information

CCMHP PROVIDER NETWORK

The Network is a panel of licensed Providers and Organizations that operates to serve the mental health needs of Contra Costa County residents with "Full-Scope" Medi-Cal coverage. The CCMHP Provider Network consists of individual providers across the county with various clinical specialties, cultural competencies, and language capabilities.

Services are authorized for all Medi-Cal Beneficiaries who meet "Medical Necessity."

The philosophy of the Contra Costa Mental Health Plan is to provide a full range of mental health services to residents of Contra Costa County who receive Medi-Cal benefits. Contra Costa is committed to providing services to beneficiaries based on their individual needs, strengths, choices and involvement in service planning.

CCMHP PROGRAMS

The Care Management Unit (CMU) manages services for both Specialty Mental Health services and Mild-Moderate mental health services. Provider manuals for each of these programs may be found:

Specialty Mental Health services:
https://cchealth.org/mentalhealth/provider/pdf/Provider-Manual.pdf

Mild-Moderate mental health services:
https://cchealth.org/healthplan/pdf/provider/provider-manual.pdf

PURPOSE OF THE NETWORK PROVIDER CMU ORIENTATION MANUAL

This manual has been developed as a resource for Network Providers within the Contra Costa Mental Health Plan (CCMHP), which includes Specialty mental health services and Mild-Moderate mental health services. It seeks to ensure that Network Providers meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services.

As with any manual, updates will need to be made as policies and regulations change. When updates are distributed, please be sure to replace old sections with updated sections.

AFFIRMATIVE STATEMENT

CMU makes utilization management decisions based on the appropriateness of care and service and included coverage. CCHP/BH does not reward providers or staff for issuing denials of coverage. There are no financial incentives for UM decision makers to make decisions that result in underutilization.

TIMELY ACCESS TO SERVICE

Providers offer 24-hour service availability to address urgent conditions. Providers shall return a phone call regarding a non-urgent matter within one business day. Provider shall offer an appointment to a new beneficiary within 10 business days of the beneficiary request.

CCMHP PROVIDER NETWORK

BENEFICIARY INFORMING MATERIALS

Please refer to the respective "Provider Manuals" for required informing materials.

Specialty Mental Health services:
https://cchealth.org/mentalhealth/provider/pdf/Provider-Manual.pdf

Mild-Moderate mental health services:
https://cchealth.org/healthplan/pdf/provider/provider-manual.pdf

AUTHORIZATION FOR MENTAL HEALTH SERVICES AND MEDI-CAL ELIGIBILITY

CCMHP is a mental health plan for Medi-Cal Beneficiaries. CCMHP verifies Medi-Cal eligibility before making the initial referral. Services may only be authorized, and paid, when the beneficiary has "Full Scope" Medi-Cal coverage. Full Scope Medi-Cal means:

- The beneficiary has Contra Costa County (07) Medi-Cal.
- No other primary coverage (i.e., commercial insurance or Medicare (Part B).
- Medi-Cal is not limited (such as "Emergency/Restricted")
- No Share of Cost (Share of Cost is collected by the Provider and met for the month).

There are exceptions to the above, which are known as "alternative benefits." **Please contact the Care Management Unit ("CMU") with any questions about eligibility.**

The Mental Health Access Line (1-888-678-7277) is responsible for providing Beneficiaries with referrals for planned mental health services. Beneficiaries are given a referral to one provider. When the beneficiary calls to schedule the initial appointment, the provider should confirm they were referred by the Access Line. If not, the provider should refer the beneficiary to the Access Line for screening.

Once the Provider has made an appointment with the beneficiary, the Provider MUST do the following to receive an initial referral for services:

- Call CMU, or send a message through Provider Portal
- Specify **date & time of appointment** the beneficiary accepted
- If the scheduled appointment is outside of 10 business days from the first point of contact, specify date of the **first appointment** offered

CMU (925) 372-4400 option 2 is responsible for providing an initial authorization for planned mental health services to Providers with clinical knowledge of the beneficiary, who call, or submit a request through Provider Portal. CMU is also responsible for continued authorization.
All Non-urgent/emergent (crisis) mental health treatment services require authorization prior to service delivery to ensure eligibility and payment.

MEDI-CAL VERIFICATION

Providers are responsible for monitoring their beneficiaries' eligibility throughout the duration of services. It is expected eligibility will be checked at least at the beginning of the month and it is strongly encouraged to check again mid-month.

PROVIDER PORTAL

Through Provider Portal, providers can check eligibility 24/7. Please refer to the CMU Provider Portal Guide to Procedures for details.

AEVS PHONE LINE PROCEDURE

If not using Provider Portal, providers must call the AEVS (Medi-Cal Automated Eligibility Verification System) phone line to verify beneficiary eligibility at the beginning of each month.

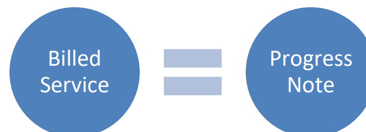
The AEVS phone number is **1-800-456-2387.**

- You will be asked to select English or Spanish as your language
- You will be asked to enter your Provider Identification Number. Individual Providers will be given this number on the CCMHP Welcome Letter
- Select the option for eligibility verification (Option 1)
- You will then be asked for the subscriber's ID number = State CIN.
    - To enter the letter at the end of the CIN, select the "star key," then enter the number on the keypad that corresponds to the letter, then enter 1, 2, or 3, depending on the position of the letter on the number key. For instance, to enter the letter "C", press the star key, then the number 2, then the number 3 (because "C" is the third letter associated with the number 2)
    - Instructions on how to enter the letter are also available when calling the AEVS line.
- Enter birth month/year (01/1965 = 011965)
- Enter service date (06/01/2018 = 06012018)
- Listen for the system to verify the county code as "07" Medi-Cal = Contra Cost Medi-Cal
- Continue listening to the entire message for additional eligibility information, such as Medicare.
- Document the eligibility response verification number.

SERVICE AND REIMBURSEMENT OVERVIEW

GENERAL GUIDELINES

Documentation provides a permanent record of each beneficiary's condition and treatment as clearly and completely as possible. **A progress note is required for each billed service**.



- ✓ **For Specialty Mental Health services -** All paperwork requiring signatures must have a **"wet" signature** (in dark blue or black ink), dated, and license/title indicated. At a minimum, the provider's signature must include the first initial of first name, and full last name.

  ⚠ **Electronic signatures, and digital images of signatures, are not acceptable.**

- ✓ All sections of forms are required. No sections should be left blank. Use "None Reported," "Not Available," etc. to indicate an attempt was made to collect the information.
- ✓ All documentation, including progress notes, must be **legible**.
- ✓ Do not use "White-out," correction tape or scribble over/write over errors. If an error is made, draw a single line through the error, enter corrected information, initial and date the correction.
- ✓ If a Progress Note is not written the same day as the service is provided, the note is considered late. Check the "Late Entry" box on the progress note if applicable.
- ✓ Time spent preparing the Discharge Form is not reimbursable.
- ✓ **For Specialty Mental Health services -** When an interpreter is used, or the session is provided in a non-English language, the clinician must document this on the progress note.
- ✓ **For Specialty Mental Health services -** If a beneficiary has special needs, such as language, visual impairments, etc., each progress note must document how that need was addressed if relevant to that session.

SERVICE DEFINITIONS

<u>MENTAL HEALTH SERVICES</u>

Definition (§1810.227)

"Mental Health Services" means those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

§ 1840.324. Mental Health Services Contact and Site Requirements

Mental Health Services may be **either face-to-face or by** telephone* with the beneficiary or significant support persons and may be provided anywhere in the community.

*During COVID restrictions DHCS is permitting TeleHealth appointments.

Types of Mental Health Service Activities

§ 1810.204. Assessment
CPT Code: 99205

“Assessment” means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes, but is not limited to, one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

Note: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

Additional Guidance:

Assessment is the only service activity that can be billed up to and including the date of the provider’s signature. ***No services*** may be billed ***prior to the first face-to-face session***. The exception is unplanned crisis services.

Services provided under billing code 99205 include appraisal of the individual’s functioning in the community such as living situation, daily activities, social support systems, and health history. They also include screening for substance use/abuse, establishing diagnoses and may include the use of psychological testing procedures. Assessment services must be provided by a licensed practitioner consistent with his/her/their scope of practice. Beneficiaries are entitled to an assessment. 99205 requires authorization prior to service delivery to ensure eligibility and payment.

Types of Mental Health Service Activities (CONT'D)

Specialty Mental Health Assessment services may include:

1) **Gathering information** to gain a complete clinical picture.
2) **Interviewing** the beneficiary and/or significant support person.
3) Administering, scoring and analyzing **psychological tests**.
4) **Formulating** a diagnosis. Completing clinical documentation.
5) **Observing** the beneficiary in a setting such as milieu, school, etc. May be indicated for clinical purposes.

In addition to the actual assessment, there must be a corresponding progress note. In addition to documenting that assessment services were provided on a certain date; the progress note must include:

1) **Why** the Assessment is being completed and

2) **Preliminary findings or observations** of the beneficiary's behaviors during the assessment process.

3) Justification for continuing assessment, if applicable.

<u>In order to obtain service authorization, for Specialty mental health services, CCMHP requires a completed intake or annual update on CCMHP approved forms.</u>

Types of Mental Health Service Activities (CONT'D)

§ 1810.206. Collateral
CPT Code: 90887

"Collateral" means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's plan. **Collateral may include, but is not limited to:**

- Consultation and training of the significant support person to assist in better **utilization of specialty mental health services** by the beneficiary.
- Consultation and training of the significant support person(s) to assist in better understanding of mental illness
- Family counseling with the significant support person(s)

The beneficiary may or may not be present for this service activity.
Requires prior authorization.

Additional Guidance:
Except for *unplanned* crisis services, collateral services may only be billed after the beneficiary's partnership plan has been finalized and must be included in the treatment plan to be billable. The partnership plan is considered active as of the date of the provider's signature.

§ 1810.246.1. Significant Support Person

"Significant support person" means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

Collateral services may include helping significant support persons understand and accept the beneficiary's challenges/barriers and involving them in planning and provision of care. ***Remember, there must be a current release of information in the chart to include these supports.***

Types of Mental Health Service Activities (CONT'D)

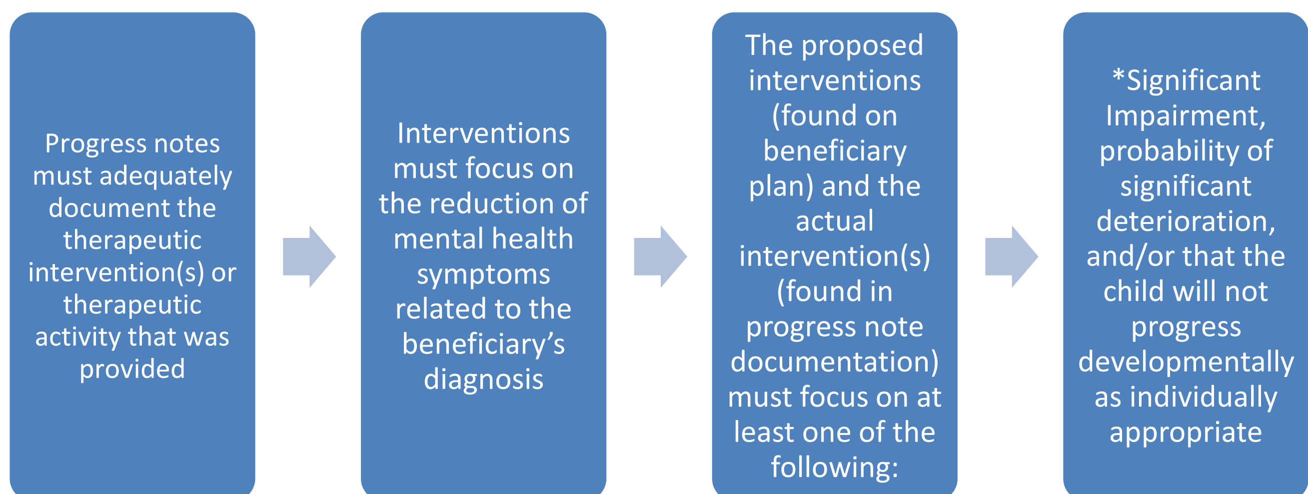
§ 1810.250. Therapy

"Therapy" means a service activity that is a therapeutic intervention that focuses primarily on **symptom reduction** as a means to **improve functional impairments**. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

Additional guidance:

Therapeutic interventions can include the application of strategies incorporating the principles of development, wellness, adjustment to impairment, recovery and resiliency. Therapy should assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors. These interventions and techniques are specifically implemented in the context of a professional clinical relationship.

THERAPEUTIC INTERVENTIONS –



Types of Mental Health Service Activities (CONT'D)

CPT CODES FOR THERAPY

Individual Therapy (90834) must be consistent with beneficiary's stated goals. Services may be provided with an individual face-to-face, by phone, or TeleHealth (during COVID restrictions).

Family Therapy (90846, 90847) is a service activity with one or more family members or significant support persons in the life of the beneficiary with primary focus of symptom reduction of the beneficiary as a means to improve family functioning and to reduce familial conflicts. ***May include consultation and training to assist in better utilization of services and understanding of mental illness.***

- Couples counseling is not an approved modality

Additional Guidance:

In family therapy, the family is brought into the treatment process. The emphasis is on the beneficiary's care, but therapy is aimed at the environment in which the beneficiary lives and interactions of the family.

Family members are defined as:

- Immediate family; husband, wife, spouse, sibling(s), child(ren), grandchild(ren), grandparent(s), mother, father (Includes live-in companions and significant others)
- Primary caregivers who provide care on a voluntary, uncompensated, regular, sustained basis, guardian, or health care proxy
- A family therapy session does not have to include the beneficiary in the session (90846), but documentation needs to state how the session is medically necessary for the beneficiary's mental health treatment

Types of Mental Health Service Activities (CONT'D)

CPT CODES FOR THERAPY (CONT'D)

Group Therapy (90853) is a therapeutic intervention with two or more beneficiaries in a group with a primary focus of symptom reduction as a means to improve social functioning and reduce interpersonal conflicts.

Group Notes Should Document:

- The purpose/focus of the group and interventions/activities are clearly stated on each note (can be same for all group participants).
- There must also be documentation on each progress note justifying the need for more than 1 staff person for the group (can be the same for all group participants).
- Document on each note how beneficiary/family participated in group and beneficiary/family response to group interventions (this must be beneficiary specific and individualized for each group participant).

Types of Mental Health Service Activities (CONT'D)

§1810.225. Medication Support

"Medication Support Services" means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include, but are not limited to:

1) Evaluation of the **need for medication**
2) Evaluation of **clinical effectiveness and side effects**
3) Obtaining of **informed consent**
4) Instruction in the **use, risks and benefits of and alternatives** for medication and
5) **Collateral and plan development** related to the delivery of the service and/or assessment of the beneficiary.

Additional Guidance:

This service is used exclusively by medical staff where it is within their scope of practice to provide such services. ***Within the Provider Network, medication support services may only be provided within their scope of practice by a Physician or a Nurse Practitioner.***

Medication Support Services supports beneficiaries in taking an active role in making choices about their behavioral health care and helps them make specific, deliberate, and informed decisions about their treatment options.

Types of Mental Health Service Activities (CONT'D)

CPT CODES FOR MEDICATION SUPPORT

Initial Psychiatric Assessment (90791/90792) includes, but is not limited to:

- Chief complaint & history of present illness
- Review of systems
- Family, psychosocial, medical and psychiatric history
- Complete mental status exam
- Current medication
- Chart review
- Observation of need for medication due to acuity
- Consultation with clinician, M.D., or nurse regarding medication
- Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, and side effects
- Obtaining informed consent for medications

Medication Management (99213/99214/99215)

Pharmacological management, including prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, and side effects.

Individual Psychotherapy with Meds (90833/90836)

Individual psychotherapy, insight oriented, behavior modifying and/or supportive service with medical evaluation and management service.

Medication Management & Individual Psychotherapy w/ Meds may only be billed on or after the date of the provider's signature on the intake, except for unplanned crisis services.

URGENT/EMERGENT CRISIS SERVICES

Crisis intervention is an ***immediate emergency response*** that is intended to help a beneficiary cope with a crisis (potential danger to self or others, severe reactions that are above the beneficiary's normal baseline). Crisis services are ***limited to stabilization of the presenting emergency***. The crisis must be the beneficiary's crisis, as opposed to another family member's crisis.

- Examples of crisis intervention include services to beneficiaries experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing and shelter) due to a mental disorder.
- Service activities may include, but are not limited to assessment, collateral, and therapy to address the immediate crisis only.
- Crisis intervention activities are usually face-to-face or by telephone with the beneficiary and/or significant support person(s) and may be provided in the office or in the community.

Crisis Intervention Progress Notes Describe:

1) The immediate emergency requiring crisis response
2) Interventions utilized to stabilize the crisis
3) Safety Plan developed
4) The beneficiary's response and the outcomes
5) Follow-up plan and recommendations

Note: If crisis intervention notes cannot be linked to beneficiary's existing Partnership Plan, the progress note must document that the services were "unplanned." Providers should consider whether the beneficiary's plan should be updated as a result of the crisis.

Prior Authorization is not required for crisis, unplanned, or urgent/emergent conditions. **CALL THE CARE MANAGEMENT UNIT WITHIN TWO BUSINESS DAYS FOR AUTHORIZATION.**

NON-BILLABLE SERVICES

Certain procedures and certain service locations block the service from being claimed. Non-billable services may include a wide variety of services which may be useful and beneficial to the beneficiary but are not reimbursable as a Specialty Mental Health service. These services should nevertheless be documented in the beneficiary chart.

The following services are not Medi-Cal reimbursable:

- Network provider's **travel time or mileage**, including when a beneficiary is not at the arranged location for the appointment.
- Completing the Network Provider **Discharge Summary**.
- **Utilization review** or responding to an **audit request**.
- Any service **after the beneficiary is deceased**. Includes "collateral" services to family members of deceased.
- **Preparing documents for court testimony** for the purpose of fulfilling a requirement; whereas when the preparation of documents is directly related and reflects how the intervention impacts the beneficiary's behavioral health treatment and/or progress in treatment, then the service may be billable. **Call CMU to consult**.
- Completing the reports for **mandated reporting** such as a CPS or APS.
- **No service provided**: Missed visit. Waiting for a "no show" or documenting that a beneficiary missed an appointment. **<u>Beneficiaries may not be charged for missed appointments.</u>**
- Services **under 5 minutes**.
- **Leaving a message** on an answering machine or with another individual about the missed visit.
- Purely **clerical activities** (faxing, copying, etc.)
- **Recreation, general play, or generalized social activities** which do not provide a mental health intervention and individualized feedback.
- **Attending a meeting in which non-mental health related topics** affecting a beneficiary are discussed (such as an IEP that does not include discussion of beneficiary's mental health needs).
- **Utilization management**, peer review, or other quality improvement activities.
- **Interpretation/Translation**; however, *therapy or another mental health service* provided in another language may be claimed.

LOCKOUTS

A "lockout" situation means that a service activity is not reimbursable to Medi-Cal because the beneficiary resides in and/or receives mental health services in one of the settings listed below. If a clinical service is rendered, the provider should document in a progress note, even though the service is not billable.

Lockout situations:

Jail **Juvenile Hall** **Institutes for Mental Disease (IMD)** **Mental Health Rehab Center (MHRC)**	No service activities are reimbursable if the beneficiary resides in one of these settings, except prior to admission and after discharge. Document clearly in note.
Psychiatric Inpatient (Not PES)	No service activities are reimbursable if the beneficiary resides in one of these settings except prior to admission and after discharge. Document clearly in note.
Crisis Residential Treatment • Nierika • Hope House	No service activities are reimbursable if the beneficiary resides in one of these settings except prior to admission and after discharge. Document clearly in note. Exception: Medication Support Services (if within scope of practice)

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FORMS

Current versions of all CMU forms may be downloaded from the CMU Network Provider web page (see contact list for web address)

When completing forms:

- Please complete all sections. Do not leave anything blank. If information is not available, note “unknown,” “not available,” etc. “Not applicable” should not be used, with the exception of in sections pertaining to a child beneficiary, when completing paperwork for an adult.

- Names and identifying numbers (CIN) must be exactly as recorded through Medi-Cal, even if incorrect. Please ask the beneficiary to contact Medi-Cal directly to have his/her/their record corrected.

- Provider documentation will be strengthened by attention to the prompts that are provided in many, if not most, of the fields. Please take the time to review these prompts for specific details regarding the information being requested in that section.

NETWORK PROVIDER BENEFICIARY REGISTRATION & ADMISSION FORM

The Registration section is a collection of beneficiary data that is reported to the State of California, Beneficiary and Services Information System to measure the effectiveness of services delivered to beneficiaries. Annual reporting allows the DHCS and CCMHP to collect information on service outcomes over time. Data is reported to the State upon admission, annually, and upon discharge.

The Registration form should be completed and submitted after the **first** face-to-face session. An updated Registration form should be completed no more than 30 days prior to the expiration of the beneficiary's previous authorization and submitted at the same time as an annual update.

Most of the registration may be completed by the beneficiary or with the beneficiary; except for the "Provider Use Only" section on the top right of page one, and at the bottom of page 2.

PROVIDER USE ONLY

Facility/Place of Service – Location (City): Location of Provider's office where sessions will occur. If services may occur at multiple locations, include each location.

Admission Date: This is the first date of service provided to the beneficiary and must be a face-to-face session.

The admission date is a critical date. No services can be entered into the mental health computer system before the admission date.

ICD-10 Code: The ICD-10 code that corresponds to the DSM-5 description that has been indicated, using the CCMHP-issued crosswalk. If no diagnosis has been developed since this is the **first session, the code Z03.89**, Diagnosis Deferred, may be used.

DSM5 Description: The full diagnosis narrative must be written out with no abbreviations

Substance Use: If "yes" is checked, an ICD-10 code must be provided.

NETWORK PROVIDER INTAKE FORM – Specialty Mental Health

The Network Provider Intake Form documents "medical and service necessity" and requests authorization for outpatient mental health services. The two components to the form are:

- Part A – Clinical Assessment
- Part B – Partnership Plan for Wellness

Medi-Cal requires the Intake Form be completed, signed, and dated **within 60 days** of the **first date of service**. The first date of service is the "Admission" date. The "Admission" date must match the date entered on the Network Provider Beneficiary Registration and Admission Form.

The first session with a beneficiary or the parent of a minor beneficiary must be face-to-face in order to start billing for services. If the case is closed within 60 days of the first date of service, it is not necessary to submit the Intake Form. In this scenario, submit only the "Registration and Admission" form and the "Network Provider Discharge" form. If you have billed for writing up part or all of the Intake document, print it out and file it in your chart to substantiate any time claimed.

PART A – CLINICAL ASSESSMENT

The Clinical Assessment sets the framework for establishing medical and service necessity. The assessment must document the presence of an "Included" primary diagnosis and at least one functional impairment to receive authorization for ongoing services. The assessment process begins with the first face-to-face visit and continues only as long as it is necessary to continue gathering assessment information.

Additional Guidance:

- **Mandatory Progress note(s) justifying billing for completing intake is/are dated:** Provide date(s) of progress notes that document the time billed for writing the clinical documentation portion of the Intake.
- **Beneficiary Guide and Provider List:** These must be offered to the beneficiary at the first session. It is not required that they be accepted.

Intake Form: PART A – (CONT'D)

- **Special Considerations:** provide details on any cultural diversity, physical and linguistic considerations and how they will be incorporated into treatment.

- **Admission Date:**
  Date of the first office face-to-face session. The admission date is a critical date. It can affect authorizations. No services can be entered into the mental health records system prior to the admission date. The date entered on this form must match the date that was entered on the "Registration and Admission" form.

- **Diagnosis:**

  - **DSM-5 Code**: All diagnoses must be made using the DSM-5 and must be on the included diagnosis list. The diagnosis must be consistent with the presenting problems, history, mental status examination, and/or other clinical data.

  - **DSM-5 Name**: The full diagnosis narrative must be written out with no abbreviations.

  - **ICD-10 Code**: The ICD-10 code that corresponds to the DSM-5 code that has been indicated, using the CCMHP-issued crosswalk.

"By history", "Rule Out" and "Provisional" diagnoses are not included diagnoses and as such they do not meet medical necessity criteria. However, a beneficiary may have a "by history", "rule out", or "provisional" diagnosis if there is also at least one included diagnosis.

NOTE: <u>THERE CAN ONLY BE ONE PRIMARY DIAGNOSIS.</u>

- **Substance Use Issue:** Check Yes or No. If "Yes" is checked, a DSM-5 code, and ICD-10 code must be provided. <u>Substance use disorders can never be the primary focus of treatment.</u>

NOTE: A BENEFICIARY MAY HAVE A SUBSTANCE USE ISSUE WITHOUT HAVING A SUBSTANCE RELATED DIAGNOSIS, BUT IF YOU HAVE ENTERED A SUBSTANCE USE DIAGNOSIS, YOU MUST CHECK "YES" IN THE SUBSTANCE USE ISSUE FIELD.

Intake Form: PART A – (CONT'D)

- **Current Presenting Problem:** What is the primary reason for referral? **Include signs and symptoms that support DSM-5 diagnosis, and how beneficiary's daily functioning is impaired.** Provider must document symptoms and functional impairments that meet the criteria for the above DSM-5 included diagnosis.

- **Safety Risk:** Situations that present a risk to the beneficiary and/or others, including past or current trauma. Check as currently appropriate. <u>**Provide additional detail for items checked in "Safety Risk" or "Report Filed" sections.**</u>

  NOTE: If either "Danger to Self" or "Danger to Others" is checked, there must be a corresponding treatment goal and/or strategy on the Partnership Plan to address this risk.

- **Mental Health History:** Summarize relevant data regarding beneficiary's history of mental illness or substance use, and major traumatic events/losses. Include diagnoses, suicide attempts, violence, hospitalization(s). Include previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response. If possible, include information from other sources of clinical data, such as previous mental health records and relevant psychological testing or consultation reports.

- **Relevant Family/Psychosocial History Including Mental Illness, Substance Use, Abuse/Neglect and/or Suicide:** Summarize relevant data regarding current information and family history of mental illness or substance use and major traumatic events/losses. Document history of physical, sexual, and/or emotional abuse. Include diagnoses, suicide attempts/unexplained death(s), include any education/school history.

- **This Section for Youth Only:** Complete this section for all beneficiaries under the age of 18.

- **Complete Developmental History:** Document developmental history of youth including prenatal and perinatal events. May include:

Intake Form: PART A – (CONT'D)

While pregnant did mother have any injuries, illnesses, physical traumas or use alcohol or drugs? Were there any complications at time of birth? Did the child experience any traumas during first 5 years? Did the child have any sleep, eating, or social problems in the first 5 years? Were there environmental stressors? Include Developmental Milestones as early, on time, or delayed.

- **Medical History:** Relevant physical health conditions reported by the beneficiary or a significant support person. List primary care provider, date of last physical exam, and last dental exam. Include history of surgeries or significant medical conditions. If the beneficiary does not have a primary care provider, clinician can refer beneficiary to Contra Costa Health Services Clinic at 1-800-495-8885 or a Private PCP. Indicate height and weight. List allergies or check "No Known Allergies" if applicable. If possible, include other medical information from medical records or relevant consultation reports.

- **Psychiatric Medication History:** Include relevant responses, adverse reactions, side effects and compliance.

- **Current Psychiatric & Non-Psychiatric Prescription and O.T.C. Medications:** List name of all medications including prescribed, over the counter, herbal, and homeopathic. Document dosage/frequency, who prescribed medication, date prescribed, and last dose. Check if the beneficiary is compliant with medication(s).

- **Functional Impairments:** Complete all sections. Check "none" as applicable. Must have at least ONE to meet service necessity.
  For impairments marked "severe," provide description in "comments section."

- **Targeted Symptoms:** Check all appropriate. Symptoms indicated should support the criteria for beneficiary's primary diagnosis.
  For impairments marked "Severe," provide description in comments section.

- **Impairment Criteria:** Must check **at least one** as appropriate. Checking box D in this section indicates the provider has determined

that the beneficiary does not meet medical and/or service necessity and services will not be authorized.

- **Intervention Criteria:** Must check at least A, B, and/or C. **Must also check box D in order for service to be authorized.**

PART B- PARTNERSHIP PLAN FOR WELLNESS

The Partnership Plan should be a realistic and understandable tool that the beneficiary and the clinician can utilize together to guide the journey of recovery. To be meaningful and effective, beneficiaries are encouraged and assisted in identifying their own life goals. Plans must be individualized, strengths-based, and address cultural and linguistic needs.

Each beneficiary will have a Partnership Plan for Wellness outlining Mental Health Services. The Plan must be developed during the 60-day period starting from the admission date, with input from the beneficiary. The Plan is effective for a maximum of 12 months and must be rewritten annually.

A beneficiary plan is effective once it has been signed (and co-signed, if required) and dated by the Network Provider. (MHP Contract; Cal. Code Regs., tit. 9. § 1810.440 (c)(1)).

The Partnership Plan should be considered a working document. Revisions or additional goals should be updated whenever there are significant changes to beneficiary's clinical presentation or relevant life circumstances.

There is no specific language in regulation or in the MHP contract defining a "significant change" in a beneficiary's condition. Examples may include a beneficiary who has never been suicidal makes a suicide attempt; or, a beneficiary who regularly participates in beneficiary plan services suddenly stops coming to appointments. Major life events that might lead to a change in the beneficiary's condition include, but are not limited to: job loss, birth of a child, death of a family member or significant other, change in relationship status (such as divorce), change in residence/living situation.

INSTRUCTIONS FOR COMPLETING THE PARTNERSHIP PLAN FOR WELLNESS

- **Beneficiary/Family Strengths:** Document the beneficiary's/family's strengths in achieving beneficiary plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

- **Life Goals:** The Goal identifies what the beneficiary and family hope to achieve or work toward. Use the person's own words if possible. May include the person's hopes and dreams, as appropriate.

- **Treatment Goals:** The provider helps the beneficiary identify areas in which he/she/they desire improvements in functioning. ***Goals must be specific, observable, or quantifiable (with timeframes) that link to the beneficiary's diagnosis, with the goal of decreasing their impairments or symptoms.***

- **Consider adding a plan for discharge.** How will you and the beneficiary know that therapy is no longer needed?

Example: Beneficiary will identify triggers in order to increase control over impulses as evidenced by a decrease of angry outbursts from 4x/week to 1x/week.

- **Requested Treatment Plan Duration**: Indicate a requested duration of 1-12 months. Do not leave blank. The Care Management Unit will make an authorization determination based on the symptoms and functional impairments as documented. **There must be at least one goal** with a timeframe that covers the full authorization period.

- **Strategies to Achieve Goals:** In this section, specify what the beneficiary/family/provider are to do to support beneficiary progress on treatment goals. The proposed frequency for delivery of an intervention/strategy must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4 x's monthly).

Intake Form: Part B – (CONT'D)

Example: Provider will support beneficiary to express unresolved grief to reduce symptoms of depression in weekly individual sessions for the next 12 months.

If applicable, document request for authorization to use **interpreter services (90837 code) in this section**. Please indicate whether interpreter services are necessary for individual and/or family therapy.

TBS Referral Made: If you have made the referral to TBS services, complete this section with the date you made the referral.

- **Modality & Frequency:** Select only modalities that will be provided **by you**, the provider completing the form. Choose one or more:

  Individual Therapy — Group Therapy
  Family Therapy — Medication Management
  Collateral — Therapy with Meds

  Check the appropriate frequency for both the first 6 months and subsequent 6 months, if applicable

- **Parties Involved:** Check as appropriate. If checking other, please explain.

- **For Prescribers Only:**
  Check to confirm current medication consents are on file.
  If beneficiary is a Contra Costa County Foster Child or Juvenile Dependent, check to confirm that the JV-223 form is on file.

- **Beneficiary Signature/Date:** Beneficiaries must sign and date the Plan to show participation and agreement. Beneficiaries 12 years and older may sign their own plans. **If the child is under 12 years of age the child's parent/guardian/other responsible adult must also sign the plan.**

- **If the child is a dependent of the Juvenile Court (ages 0-11), one of the following must be checked:**
  CFS worker signed above as legal guardian OR CFS Social Worker verbally agreed to Partnership Plan. Indicate the date that the social worker agreed to the plan and confirm that provider faxed the plan to Social Worker for signature and return.

Intake Form: Part B – (CONT'D)

- **Unable to obtain signature prior to submission**: If unable to obtain beneficiary's signature, the clinician must document the reason in a progress note. **Enter the date of this progress note in the space provided**. Attempts to obtain the signature must be documented in every progress note until the signature is obtained.

- **Page 5 -** Utilize this page when additional space is needed to provide the information requested in previous sections of the form. Please reference the applicable section from the intake form. If this page is not needed, type "This page intentionally left blank" and file the printed page in your chart with the rest of the intake document.

NETWORK PROVIDER ANNUAL UPDATE FORM
SPECIALTY MENTAL HEALTH

The Network Provider Annual Update Form documents continued "medical and service necessity" and requests continuing authorization for outpatient mental health services. The beneficiary's current presentation and treatment plan should be reviewed and updated based on the provider's progress notes and discussion with the beneficiary. Avoid copying information directly from a previous assessment and Partnership Plan. Document beneficiary progress or provide the 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 and daily functioning.

Beneficiary plans expire on the date that the CMU authorization expires. Annual updates should be completed and signed within the 30 days prior to the expiration of the previous authorization. Services between the expiration of the previous authorization, and the provider's signature date on the updated treatment plan, will not be covered. **See CMU web page for additional information regarding documentation due dates.**

Please refer to the instructions for completing the "Network Provider Intake Form" to complete each section, except for the following:

Page 2

- **Psychiatric Admissions in Last Year**: Check "Yes" or "No" as appropriate and indicate how many in the last year, if any.
- **Receiving Other Outpatient Mental Health Services**: Check "Yes" or "No" as appropriate and describe if necessary.
- **For Youth Only/Lives With:** Check the appropriate box (Family of Origin, Independent, Relative Caregiver, Foster Family, Other). Complete this section for all beneficiaries younger than 18.
- **Current Medical Conditions**: Indicate any updates since last assessment or indicate "No Change."

NETWORK PROVIDER PRIOR AUTHORIZATION FORM
Mild/Moderate MENTAL HEALTH SERVICES

The Prior Authorization form is submitted after the initial 8 sessions and every 8 sessions thereafter with the client.

Important areas to remember:

- **“Date additional units will be needed” – enter the date you would like the next authorization to begin. If this is blank, it will be returned with a request to identify the date.**

- **Justification - *Include Level of Impairment* (May be submitted as an attachment)**
  - **Information should be directly linked to the diagnosis.**
  - **Include symptoms and how symptoms are impacting the client’s daily functioning.**

- **Justification – Measurable goal(s) (May be submitted as an attachment)**
  - **Identify what will be addressed during treatment and the measurement of when goal will be achieved.**

NETWORK PROVIDER CHANGE OF TREATMENT AUTHORIZATION REQUEST-OUTPATIENT SERVICES SPECIALTY MENTAL HEALTH SERVICES

Prior to completing and submitting this form, contact CMU for consultation regarding your request. Contact CMU in advance of the date you believe the change is required. Do not submit this form unless directed to do so.

Requests for additional treatments are reviewed in the context of the following factors:

- Severity of diagnosis, symptoms, and functional impairments
- Safety risk, recent hospitalizations or incarcerations for violence.
- Recent traumas or life stressors
- Other resources/services available to the beneficiary

- **In the first box**, please specify the details of the change you are requesting. For instance, are you requesting additional sessions, ongoing weekly sessions, or an additional modality? For what length of time are you requesting the change? Do **not** provide the clinical justification for your request here.

- **Date that change is requested to start:** This should be the **future** date at which you are requesting the change to take effect.

- **Current Primary DSM-5 Included Diagnosis:** If this diagnosis does not match the diagnosis that was indicated on your intake or most recent annual, there should be a progress note in the beneficiary chart documenting that the beneficiary currently meets criteria for the diagnosis indicated. **DSM-5 Name:** Must write out the full diagnosis narrative, no abbreviations. **ICD-10 Code:** Enter the code that matches the DSM-5 code and diagnosis narrative indicated.

- **In the next box**, provide the ***clinical*** justification for your request. Read the prompts on the form ***in detail*** in order to understand the information that is necessary for you to provide.

- **Optional:** Complete the following section if the beneficiary has experienced a significant life change that has prompted the change request, and that requires an update to the beneficiary's Partnership Plan for Wellness. Updated goals and strategies may be entered in this section if needed.

NETWORK PROVIDER PROGRESS NOTE

The purpose of the Progress Note is to provide written documentation of services provided, and a narrative description of what was attempted or accomplished towards the goals, or what was necessary at the time of the visit. A Progress Note is required for each service contact. Time should reflect the true time spent on a given service. All Progress Notes should provide sufficient detail to support the chosen Procedure Code and reasonably justify the amount of time billed. Progress Notes must be legible.

CCMHP highly recommends that providers use CCMHP's progress note form. If providers do not use this form, the documentation must contain all of the elements in this form in order to meet documentation requirements.

INSTRUCTIONS FOR COMPLETING THE NETWORK PROVIDER PROGRESS NOTE FORM

Date of Session: The date the service was provided.

Duration (include start/end times): Time that provider spent providing the service. One unit of service includes time for documentation. Bill in quarter units as applicable.

LOCATION OF SERVICE: Identifies the location where the service was rendered. The choices are:

- **Office –** Services provided in the office where the mental health professional routinely provides services.
- **Phone –** Services provided by telephone contact with the beneficiary.
- **Home, School, or Other –** Specify location of service. Cannot bill for travel time.

Interpreter Services Provided: If an interpreter was utilized for the service, check Yes and write the name of the interpreter.

Service provided in another language by clinician: If service was provided in a language other than English, specify the language.

NETWORK PROVIDER PROGRESS NOTE (CONT'D)

Does beneficiary have restricted pregnancy-only Medi-Cal?
If "Yes," document in the description of the current situation either:

a) how the pregnancy affects the beneficiary's mental health issues OR

b) how the beneficiary's mental health issues affect the pregnancy

Individuals Present at Session/Relationship to Beneficiary: List the individuals present, and their relationship to the beneficiary.

CLINICAL DOCUMENTATION

Chart to: Goals/Strategies on Plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

Description of Current Situation: Document why this service was necessary. Chart as appropriate the reason for contact; Beneficiary's concern(s); status update since last contact; clinical behavioral acuity; current stressors; needs; progress/lack of progress toward specific goal (not a restatement of goal). Document observations of beneficiary's presentation at time of service, e.g. hygiene, speech, mood, etc. Is progress being made? Has there been a change in diagnosis? What are the remaining impairments?

Focus of Activity: What mental health intervention did you attempt? Use descriptive verbs. What was the beneficiary's response to the intervention? Did the beneficiary understand or accept the intervention, or appear resistant? Is there progress or lack of improvement? These are required elements in therapy notes. Include risk assessments if applicable.

The clinician's intervention should include an interactive verb. Examples can include:

Acknowledged	Analyzed	Articulated
Assisted	Assured	Clarified
Coached	Consulted	Demonstrated
Discussed	Educated	Empowered
Encouraged	Examined	Exhibited
Explained	Explored	Focused
Mirrored	Processed	Role Modeled

NETWORK PROVIDER PROGRESS NOTE (CONT'D)

Plan: The plan section outlines clinical decisions regarding the beneficiary, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Detail any referrals to community resources and other agencies when appropriate, and follow-up appointments if applicable. Document clinical thinking such as:

- Are new goals needed?
- Are treatment goals still appropriate, require revision?
- If lack of improvement, obtain a consultation to verify the diagnosis or consider change in treatment strategy.
- Consider treatment titration and plan for discharge.
- Explain the need for additional treatment due to continued medical necessity.

Clinician Name/Signature/License: Name of provider.

Date: The date the note was written.

Late Entry: Check if documentation of service does not occur on the day the service was provided.

NOTE: BENEFICIARY RECORDS ARE SUBJECT TO CCMHP REVIEW. MEDI-CAL TREATMENT RECORDS MUST BE MAINTAINED FOR TEN YEARS OR THE MINIMUM PERIOD REQUIRED BY APPLICABLE STATE AND FEDERAL LAW.

As of January 1, 2018, California Law states that Medi-Cal records must be maintained for a minimum of ten years. For minors, retain records for ten years, or seven years from the date the minor patient reaches eighteen years of age, whichever is longer.

(CA W&I Code 14100 – 14124.14, 42 CFR 438.3 (u))

This requirement is for Medi-Cal records only and is separate from laws and regulations pertaining to psychotherapy records for services not provided to Medi-Cal beneficiaries.

NETWORK PROVIDER DISCHARGE FORM

The Network Provider Discharge Form is the documentation source for the ultimate outcome of service provided to the beneficiary. The Discharge Form should be completed when a decision has been made to discontinue services or the beneficiary has dropped out. Until the Provider closes the case, they remain the "Provider of Record." Formally discharging a beneficiary may reduce the provider's exposure/risk in the case of a "sentinel" event.

In those cases when the beneficiary terminates in an unplanned manner, the Network Provider Discharge Form must be completed as soon as possible. Time spent completing the discharge form is not billable to Medi-Cal.

Discharge Date: This is the last date of service provided to the beneficiary, typically the last date of billable service.

Treatment Summary/Discharge Plan/Additional Info: Provide brief details regarding the beneficiary's treatment and explain why the beneficiary was discharged.

NOTICES OF ADVERSE BENEFIT DETERMINATION and NOTICES OF ACTION

The Contra Costa Mental Health Plan is required to issue notices to beneficiaries of their rights in situations where authorization for requested services is denied, delayed, or modified. CMU issues these notices directly to beneficiaries, with a copy to the Network Provider.

Notice of Action is the term used by the California Department of Health Care Services for these notices sent to beneficiaries of managed care plans. Notice of Adverse Benefit Determination is the name for notices sent to Medi-Cal beneficiaries covered by other plans.

NOTICES OF ADVERSE BENEFIT DETERMINATION AND NOTICES OF ACTION (CONT'D)

The Care Management Unit issues the following types of notices:

1. Denial of authorization

   These notices are typically issued by CMU when the Network Provider has made the determination that the beneficiary does not meet criteria for medical and/or service necessity. In this situation, notify CMU immediately and then send the Registration and Discharge forms as soon as possible. This notice will also be sent when an authorization decision cannot be made within 28 days from CMU receipt of the request.

2. Delay of authorization decision

   These notices must be sent by CMU when an authorization decision cannot be made within 14 calendar days of the receipt of the request by CMU. In situations where a decision cannot be made due to incomplete paperwork submitted by the provider, CMU will contact the Network Provider as soon as possible to request the correction. If the correction is not received by the 14-day mark, a Notice will be mailed to the beneficiary, with a copy to the Provider. If corrections are not received within 28 days from CMU date of receipt, a Denial notice will be sent as described above.

3. Modification of treatment request

   These notices are issued when CMU does not approve the treatment request as submitted by the provider. Please consult with CMU prior to submitting a request for treatment that is atypical or a request for a change to a previous authorization.

In many cases, the need for a Notice to be sent to a beneficiary can be avoided by either consulting with a clinician from the Care Management Unit or responding to requests for correction as soon as possible.

NOTE: If a denial is issued to a physician, that physician may contact the Care Management Unit for peer-to-peer consultation.

NETWORK PROVIDER
OUTPATIENT CLAIMS

The CCMHP Care Management Unit processes claims for authorized specialty mental health services provided to CCMHP Beneficiaries. Providers must submit claims within 60 calendar days after the date of service. There must be a corresponding progress note in the beneficiary's chart for each service claimed. No claims may be submitted if the beneficiary was never seen face-to-face, with the exception of an intake session with the parent(s) of a minor beneficiary.

Providers must use the CMS 1500 Claim Form when submitting services for payment. Claims can be mailed or submitted electronically 24/7 via Provider Portal or Availity.

On the CMS 1500 Form, "Signature on File" must be entered in Boxes 12 and 13. This certifies one of two things:

1. The Informed Consent Form that the provider has developed for their own private practice indicates that the beneficiary authorizes payment of medical benefits to the provider, and the beneficiary has signed this.

2. The provider has on file a blank claim form with the beneficiary's name and signature.

The date indicated in Box 12 is the date the beneficiary signed the informed consent document or the blank claim form that provider retains on file.

If not submitting claims via Provider Portal or Availity, original CMS 1500 Claim Forms must be mailed to:

Contra Costa Mental Health Plan
PO Box 5143
Forest, CA 92609

Claim receipt and payment status may be checked using Provider Portal.

DUPLICATE CLAIMS

The CCMHP claims adjudication process identifies two types of potential duplicate claims:

1. Two services billed on the same date, with different CPT codes

2. Two services billed on the same date, with the same CPT code

In order to avoid denials for duplicate services, providers must insert a duplicate override code (modifier) in the modifier box on the claim line for the second and subsequent services on the same date. Duplicate service override codes are:

59: Two Distinct Service Codes (e.g. 90834 & 90887)

Indicates services with different CPT codes were provided on the same day but are distinct services.

76: Two Identical Service Codes (e.g., 90887 & 90887)

Indicates a repeat procedure on the same day with the same code but are distinct services.

If modifier codes are not entered on a claim when there are two or more services on the same day, it may result in a denied claim.

Modifier 95 is also needed for any claims billed with Place of Service Type 02 (TeleHealth).

“Majesty”

By Stephen A. Boyd Jr.

Thank you for being a Network Provider with the Contra Costa Mental Health Plan. We appreciate your dedication to serving Contra Costa County beneficiaries.

We are here to provide help and support. Please contact us whenever we may be of assistance.

The Clinicians and Clerks of the Care Management Unit