



CaAIM Payment Reform CPT Codes for Fee For Service Providers

Quality Assurance Team (QA)

Alameda County Behavioral Health Services (ACBH)

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Topics

- What Is Changing
- Claims Payment
- New Utilization Table
- CPT Code Key Concepts:
 - Procedure Code Descriptions and Service Times
 - Direct Patient Care
 - Maximum Units Allowed
 - Dependent On Codes: Add On and Supplemental Codes
 - Lockouts and Modifiers
- Service Descriptions
- Clarification of Specific Services/Frequently Asked Questions
- New FFS Handbook
- Q&A

What is Changing

- Effective July 1, 2023, providers will need to use **CPT Codes** when billing Medi-Cal.
- ACBH is sunsetting its existing billing system, InSyst, and claims processing system, eCura, and replacing it with **SmartCare**.
- Currently SmartCare Go-Live Date for FFS Providers is TBD; Communication will be forthcoming.

Claims Payment

- Due to delays in transitioning to the new SmartCare billing system, ACBH is experiencing challenges processing the contract amendments to align with the new CPT codes mandated by California Advancing and Innovating Medi-Cal (CalAIM) and processing the July 2023 claims.
- ACBH recognizes the hardship of payment delays and sincerely apologizes for the impact on our providers.
- ACBH is currently processing the FY 2023-24 contract amendments. If you have not received your amendment for signature by September 6, 2023, please contact your ACBH Contract Manager.
- Please review these contract amendments closely, as they contain your new rates.

Claims Payment (Continued)

- After you sign the contract, please submit the July claims using the new rates and procedure codes.
- If you have already submitted your July claims using the old rates and procedure codes, you must submit a new, updated claim. These claims will be prioritized and expedited according to the original submission date.
- The goal of ACBH is to process payments as efficiently as possible and within 45 days of the receipt of invoice, e.g., by September 15, 2023, for July services submitted by August 1, 2023. After this transition period, ACBH anticipates invoice processing time to return to the previous expedited schedule.

Requirements for Submitting New Claims

- When submitting new claims for dates of service on or after 7/1/23, providers will need to submit the following documents along with their claim:
- MH Registration Form - This form only needs to be included with the first claim for a client and when client information changes. If you have already submitted your July and August claims, you do not need to resubmit. For all claims from September onwards, ACBH will return claims that are not accompanied by this Client Registration Data form, with a 30-day resubmission deadline.
- MHS Update Discharge Out-Patient - For Annual Data and outpatient discharge.
- The forms can be found on the SmartCare Page of the ACBH Provider's website

<p>Alameda County Behavioral Health</p> <p>MENTAL HEALTH SERVICES CLIENT REGISTRATION DATA FORM Confidential Patient Information See Welfare & Institutions Code: 5328</p>	<p>Open: <input type="checkbox"/> Update: <input type="checkbox"/></p> <p>Data Entry Initials: _____</p> <p>SmartCare Client ID Number: _____</p> <p>Program: _____</p> <p>Client Last Name: _____</p> <p>Client First Name: _____</p> <p>Client Middle Initial: _____</p>
<p>Please Print Legibly</p> <p>Highlighted fields with asterisks are required.</p>	
<p>Client Search: Go to the Client Search in SmartCare and either select <Client Search> or start typing the client's name. Go to the search icon and search for registration form, select the Mental Health Services Registration (Client) form.</p>	
<p>Program: *Primary Program Name: _____ *Program Status: <input type="checkbox"/> Enrolled <input type="checkbox"/> Requested <input type="checkbox"/> Discharged *Assigned Staff: _____ (Staff Client is Assigned To) Requested Date: ___/___/___ (Date Services are Requested) *Enrolled Date: ___/___/___ (Date Client is Enrolled) Comment: _____</p>	
<p>Episode: <u>Case Information:</u> Initial Referral/Screening Date: ___/___/___ (Date Of Screening) *Registration Date: ___/___/___ (Date Registered) Information: Information Needed. Registration Comment: _____ (Registration Comments) County Of Submission: _____ (County Entering Data)</p>	
<p><u>CSI Episode Information:</u> *Transaction Type: <input type="checkbox"/> Assessment <input type="checkbox"/> Admission <input type="checkbox"/> Admission/Discharge If completing Outpatient enrollment, the CSI Episode Information Transaction Type fields is <u>not required</u>.</p>	
<p><u>Inpatient Enrollment:</u> If completing Inpatient enrollment, the CSI Episode Information Transaction Type field is <u>required</u>.</p>	



Utilization Table Changes

Utilization Table and CPT Code Reference Guide

- ACBH has updated the two-page [Utilization Table](#) to include the changes to the CPT codes.
- Please use this as a guide for your claims.



MHP FFS General Utilization Table for Individual and Organizational Providers August 21, 2023

Core Services	Billing Code and Time Associated	Add On Codes and Other Information	Monthly Minimum Sessions Based on Practice Guidelines <small>(Not used for claims processing purposes.)</small>	Monthly Session Maximum¹
Individual Therapy**	90832- 30 min 90834- 45 min 90837*- 60 min	G2212 add on code for 15 min can be used for additional time for 90837 only. See below for example.	2	10 sessions
Case Management/Brokerage	T1017- 15 min	This CPT code allows for services beyond 15 minutes and no add on codes are needed. See below for example ² .	1	As clinically appropriate with no maximum limit per month
Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons ^{3**} (Formerly known as Collateral)	90887- 15 min	ACBH QA is in process of clarifying use of this code with DHCS. Information will be shared with Providers once received from DHCS.	1-4 if client has significant support person/people involved in their treatment	12 sessions
Family Psychotherapy with Patient Present**	90847*- 50 min	G2212 add on code for 15 min can be used for additional time. See below for example.	2 if clinically appropriate	8 sessions
Psychological Testing Evaluation	96130- 31-60min	This CPT code is used for the 1 st hour of psych testing. Use 96131 for each additional hour	n/a	22

¹ The type of service, time billed, and the frequency of service delivery must be justified by the clinical documentation of the client’s mental health needs in their Assessment and Problem List. The Assessment and Problem List must be updated as the client progresses through treatment to justify the ongoing delivery of mental health services. If a client is need of additional services over the amount listed on in the maximum column, the Provider can call Utilization Management at 510-567-8141 to request additional services.

² Example for use of T1017: If you have a 60 minute case management/brokerage session, you can bill one T1017 code for 60 minutes.

³ Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons (formerly known as collateral) cannot be claimed as a “stand alone” service. A provider must claim a “stand alone” service and then can also bill a collateral service on the same day. All other services listed on the Utilization Table are “stand alone” services. Please note that for care coordination, referral and follow up on referral activities, Case Management/Brokerage is the appropriate code to use.

MHP FFS General Utilization Table for Individual and Organizational Providers August 21, 2023

Psychotherapy for Crisis ⁴ (Formerly known as Crisis Intervention)	90839- 30-74 min	Please review footnote #4 below. Can bill this code up to 74 minutes per client per day. No maximum limit on the number of sessions a per client per month. Consult with ACBH ACCESS for clients with recurring or severe crises who may need a higher level of care. 1-800-491-9099.	As needed	As clinically appropriate with no maximum limit per month
OP Psychiatric Diagnostic Eval (Formerly known as Assessment)	90791*- 15 min	G2212 add on code for 15 min can be used for additional time. See below for example.	Initial month and annually: 2 All other months: as needed	6 sessions
Group Therapy ^{5**}	90853- 15 min	G2212 add on code for 15 min can be used for additional time. See below for example.	2 if clinically appropriate	8 sessions

*G2212 is an add on code to extend the time. See examples for specific codes below:

- If you have a 90 minute Individual Therapy session, you can bill 60 minutes using 90837 code and 30 minutes using G2212 code.
- If you have a 90 minute Family Therapy session, you can bill 50 minutes using 90847 code and 40 minutes using G2212 code.
- If you have a 2 hour OP Psychiatric Diagnostic Eval session you can bill 15 minutes using 90791 code and 105 minutes using G2212 code.

** If your agency utilizes student trainees please put STDNT followed by the code.

Link to [Specialty Mental Health Services Medi-Cal Billing Manual](#)

⁴ To bill Psychotherapy for Crisis, the presenting mental health problem must typically be life threatening or complex and require immediate attention to a client in high distress. This is an emergency response service enabling the beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate mental health crisis within a community or clinical treatment setting.

⁵ If you have not delivered group Therapy before and plan to do so, please contact ACBH QA office at QATA@acgov.org prior to delivering this service. Documentation and claiming for Group Therapy is significantly more complex than it is for other codes. ACBH will conduct training on the delivering, documenting, and coding for Group Therapy soon.



CPT Code Basics:

Procedure Code Descriptions and Service Times

Procedure Code Description with Set Times

- Some codes have set times associated with the service.
- In these situations, **the services can be claimed once they reach the midpoint** of the time associated with code.
- The Time Associated with Code column on the crosswalk shows the range of time that can be claimed using the code.
- For example, *T1017 Targeted Case Management* has a 15-minute time associated with the code. The service cannot be claimed unless it lasts at least 8 minutes, which is the midpoint of 15 minutes.
- The midpoint doesn't apply to codes with time ranges, only to those with set times.
- For codes that do not have a specific time associated with the service, DHCS has assigned a **15-minute** limit.

InSyst Procedure Code	InSyst Proc Description	SmartCare Procedure Code	SmartCare Procedure Code Description	Add on Code (X)	Standard Billing CPT or HCPC Code	Time associated with Code (Mins)	Maximum Units that Can be Billed
571	Brokerage Services	T1017 Targeted Case/Mgmt, per 15 min.	Targeted Case Management, Each 15 Minutes		T1017	8-15	96
580	CASE MGMT/BROKERAGE MEDICAL SV	T1017 Targeted Case/Mgmt (Medical Svc.), per 15 min.	Targeted Case Management, Each 15 Minutes Assists a beneficiary to access needed medical services. Service activities may include, but are not limited to: Communication, Coordination, Referral, Monitoring service		T1017	8-15	96

Procedure Code Description with Set Times (Continued)

- In some cases, there are multiple codes for the same service but each have a different time range associated with the code.
- *SmartCare Procedure Code* and *SmartCare Procedure Code Description* on the crosswalk will show the time associated with code.
- *Time Associated with Code* on the crosswalk shows the range of time that can be claimed using the code.
- For example, *90832 Psychotherapy 30 minutes w/Patient* should be used when a service lasts from 16-37 minutes.

- *90834 Psychotherapy 45 minutes w/Patient* should be used when a service lasts from 38-52 minutes.

- *90837 Psychotherapy 60 Minutes w/Patient* should be used when a service lasts over 53 minutes.

InSyst Procedure Code	InSyst Proc Description	SmartCare Procedure Code	SmartCare Procedure Code Description	Add on Code (X)	Standard Billing CPT or HCPC Code	Time associated with Code (Mins)	Maximum Units that Can be Billed
441	90832 Psychotherapy 30 min	90832 Psychotherapy, 30 Min. w/Patient	Psychotherapy, 30 Minutes with Patient		90832	16-37	1
465	90833 +PsyThpy with E/M 30min	90833 Psychotherapy w/E/M, 30 Min. w/Patient	Psychotherapy, 30 Minutes with Patient when Performed with an Evaluation and Management Service		90833	16-37	1
442	90834 Psychotherapy 45 min	90834 Psychotherapy, 45 Min. w/Patient	Psychotherapy, 45 Minutes with Patient		90834	38-52	1
467	90836 + PsyThpy with E/M 45min	90836 Psychotherapy w/E/M, 45 Min. w/Patient	Psychotherapy, 45 Minutes with Patient when Performed with an Evaluation and Management Service		90836	38-52	1
443	90837 Psychotherapy 60 min	90837 Psychotherapy, 60 Min. w/Patient	Psychotherapy, 60 Minutes with Patient		90837	53 >	1

Direct Patient Care

- Only the time it takes to provide direct services associated with a code can be claimed to the State.
- Direct Patient Care means time spent with:
 - The patient for the purpose of providing healthcare
 - The consultant/members of the beneficiary's care team (may include family)
- **Direct Patient Care does not include** travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.



**Maximum Units Allowed
Dependent On Codes:
Add On Codes
Supplemental Codes**

Maximum Units Allowed per Day

- Outpatient codes have a maximum number of units that can be billed per day.
- For example, only one unit, or one 15-minute *90791 Psychiatric Diagnostic Evaluation service* can be billed per day.
- Maximum Units are per beneficiary, per service line.
- For example, if provider A bills for one unit of 90791, provider B can also bill for one unit of the same service on the same day.
- Add-On codes can be used to extend the time associated with a service.

Code Type	Service	Code	Maximum Units that Can be Billed
Assessment Codes	Psychiatric Diagnostic Evaluation, 15 Minutes	90791	1
Assessment Codes	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	1

Combined Aggregate Limits

- There are some SMHS services that are limited to a specific amount of time in a **24- hour** period, according to California Code of Regulations. These include the following:
 - Medication Support Services are limited to 4 hours (9 CCR 1840.372)
 - Crisis Intervention Services are limited to 8 hours (9 CCR 1840.366)
 - Crisis Stabilization Services are limited to 20 hours (9 CCR 1840.368)
- These are known as Combined Aggregate Limits.
- The Combined Aggregate is equal to the sum of time associated with all approved services in DHCS claim history provided to the same beneficiary, on the same day.
- **Note:** Please see the DHCS SMHS Billing manual for the table list of all the procedure codes and the time associated with each procedure code that SD/MC will use to calculate the combined aggregate.

Dependent On Codes

- Dependent On Codes can only be used in conjunction with another procedure code.
- These codes cannot be billed unless the provider first bills for the primary procedure to the same beneficiary, on the same date.
- There are two types of Dependent On Codes:
 - **Add on Codes:** Add time to a primary procedure
 - **Supplemental Codes:** Modify a procedure

Maximum Units and Defined Add On Codes

- When *Maximum Units that Can be Billed* for a service are limited, and the service has a short time frame associated with it, the service may need to be claimed with two procedure codes: the **Primary code** and an **Add On code, to extend the time associated with the service.**
- Add On codes cannot be billed unless the provider first bills for the primary procedure to the same beneficiary, on the same date.
- Some services have their own Add-on codes.
- For example, if more than an hour of psych testing is provided, code *96130 Psych Testing Eval, First Hour* can be used along with the Add on Code of *96131 Psych Testing Eval, Ea Add'l Hour*.

SmartCare Procedure Code	SmartCare Procedure Code Description	Add on Code (X)	Standard Billing CPT or HCPC Code	Time associated with Code (Mins)	Maximum Units that Can be Billed
96130 Psych Testing Eval., First Hour	Psychological Testing Evaluation, First Hour		96130	31-60	1
96131 Psych Testing Eval., Ea. Add'l Hour	Psychological Testing Evaluation, Each Additional Hour	X	96131	31-60	22

Maximum Units and G2212

- For services that do not have established Add On Codes, **G2212** can be used as the Add On Code.
- This code has a **15-minute** limit and can be claimed once it's midpoint of **8 minutes** is reached.
- For example, 90791 *Psychiatric Diagnostic Eval* has a 15-minute time associated with code, and only one unit of this code can be claimed each day.
- Since 90791 doesn't have its own Add On Code, G2212 would be used along with 90791 if the service lasts more than 15 minutes.
- In this example, once the evaluation lasts 23 minutes or longer (15 minutes for the 90791 plus 8 minutes as midpoint of G2212), G2212 can be used to claim for the additional time.

InSyst Proc Description	SmartCare Procedure Code	SmartCare Procedure Code Description	Add on Code (X)	Standard Billing CPT or HCPC Code	Time associated with Code (Mins)	Maximum Units that Can be Billed
90791 Psychiatric Diag Eval	90791 Psychiatric Diag Evaluation, 15 min.	Psychiatric Diagnostic Evaluation, 15 Minutes		90791	8-15	1
90792 Psy Diag Eval w- medical	90792 Psy Diag Eval w- medical, 15 min.	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes		90792	8-15	1



Lockouts and Modifiers

Lockouts

- Some codes cannot be billed together, and others can only be billed together in special circumstances.
- Sometimes lockouts can be overridden with a modifier.
- Lockouts that can be overridden are indicated with either one or two asterisks in the lockout column of the Crosswalks.
- Lockout over-riding modifiers only apply to CPT codes, not HCPCS codes.
- SmartCare does not add lockout modifiers but will prompt users to add them when necessary.

Service	Code	SD/MC Allowable Disciplines	Lockout Codes	Modifiers
Psychiatric Diagnostic Evaluation, 15 Minutes	90791	MD/DO, PA, PhD/PsyD (Licensed or Waivered), SW (Licensed, Registered or	90792	59, 93, 95, GC, HK, HL, HV, HW, XE, XP, XU
			90832-90834	
			90836-90838	
			90839-90840*	
Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	MD/DO, PA, NP or CNS (Certified)	90791	59, 93, 95, GC, HK, HL, HV, HW, XE, XP, XU
			90832-90834	
			90836-90838	
			90839-90840*	

- In this example, CPT code 90791 cannot be claimed with 90792 and there are no modifiers that can be used to create an exception, since there is no asterisk on 90792 in the Lockout column.
- CPT code 90791 also cannot be claimed with CPT code 90839 and 90840, however, since there is an asterisk on these codes, an appropriate modifier can be used to override this Lockout.

Modifiers

- Modifiers provide a way to indicate that a service or procedure performed was **altered** by some specific circumstance **but not changed in its definition or code**.
- Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service.
- SmartCare is being programmed to apply most modifiers automatically or to prompt the user to apply the appropriate modifier.
- Information will be communicated to providers about this SmartCare functionality, once it becomes available.

Examples:

Modifier	Definition	When to Use
HQ	Group Setting	Use this modifier to indicate that a therapy service was provided in a group setting.
HL	Intern	Use this modifier when the service was performed by a registered, pre-licensed MH professional working in a clinical setting under supervision.



Service Descriptions

INDIVIDUAL THERAPY

Therapy means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective.

Service	Code	Disciplines
Psychotherapy, 30 minutes	90832	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS
Psychotherapy, 45 minutes	90834	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS
Psychotherapy, 60 minutes	90837	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS

ASSESSMENT

Assessment means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination, analysis of the beneficiary’s clinical history, analysis of relevant biopsychosocial and cultural issues and history, diagnosis and the use of testing procedures.

Service	Code	Disciplines	Notes
Psychiatric Diagnostic Evaluation, 15 minutes	90791	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS	Used to document assessments (initial, re-assessments) completed by non-physician licensed, license-eligible/ waived staff

CRISIS INTERVENTION

The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting.

Service	Code	Disciplines	Notes
Psychotherapy for Crisis, First 30-74 Minutes	90839	MD/DO, PhD/PsyD, LCSW, MFT, LPCC, PA, NP or CNS	The individual must be present for all or part of the service. Urgent assessment and exploration of an individual in crisis. Includes mental status exam as well as a disposition and treatment includes therapy, mobilization of resources and implementation of interventions to address the crisis.

CASE MANAGEMENT

Targeted Case Management (TCM) is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services. The service activities may include but are not limited to: communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient's progress; placement services and plan management.

Service	Code	Disciplines	Notes
Targeted Case Management, Each 15 Minutes	T1017	All disciplines	Targeted Case Management is also utilized to document Intensive Care Coordination (ICC) Services. The modifier "HK" will be utilized along with the TCM code to indicate that an ICC service was provided (remember that modifiers are generally managed by EHR setups).

FAMILY THERAPY/GROUP THERAPY CODES

Therapy may be delivered to a beneficiary or group of beneficiaries and may include family therapy directed at improving the beneficiary’s functioning and at which the beneficiary is present.

Service	Code	Disciplines	Notes
Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS	Code for “typical” family therapy services.
Group Psychotherapy (Other than that of a multiple-family group), 15 minutes	90853	MD/DO, PA, PhD/PsyD, LCSW, MFT, LPCC, NP or CNS	Code for “typical” general group therapy that includes multiple beneficiaries.

COLLATERAL SERVICES

- Collateral services can STILL BE BILLED under Payment Reform.
- There is simply no longer a distinct service code called “Collateral”.
- Collateral can be a component of many types of services including, but not limited to: Assessment, Rehabilitation, Plan Development, Peer Support Services, Targeted Case Management, TFC and Crisis Intervention.



Clarification of Specific Service Codes and Frequently Asked Questions

How do we claim for group services?

- Group services can be claimed using specific CPT Codes and if needed, can be extended using G2212 plus the HQ Modifier.
- Claims should be submitted separately for each beneficiary receiving group therapy as follows:
 - Enter total face-to-face time on each beneficiary claim.
 - Enter total travel time for the service on one of the client service records OR divide evenly between each participant in the group.
 - Enter individual documentation time for each client separately on each participant’s service.

Service	Code	Discipline
Group Psychotherapy	90853	PhD/PsyD, LCSW, LMFT (Licensed or Waivered)

What CPT codes can be used to connect clients to services?

- The Reference Guides provided can be sorted by Service Category.
- Search for “Referral Codes” for SMHS, or “Care Coordination Codes” for DMC-ODS, to find appropriate Brokerage/Case Management services.
- Targeted Case Management is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services.

Service	Code	Discipline
Targeted Case Management	T107	LP, PA, Pharma, Psy, LCSW, MFT, RN, NP, LPCC, AOD

What code can be used for Collateral session?

- Although there is no longer a distinct code for Collateral Services, providers can still bill for these services.
- Collateral services can be a component of many types of services, including but not limited to, Assessment, Rehabilitation, Plan Development, Peer Support, Targeted Case Management, Crisis, or Therapeutic Foster Care.
- Providers should select the service code that most closely fits the service provided and make clear in a Progress Note that the service was provided to a collateral contact.
- Some procedure code descriptions clearly describe the service as occurring with the client present. Those procedure codes should not be selected for collateral sessions.

Collateral Services- Continued

- CPT code 90887 "Interpretation or Explanation of Results of psychiatric of other medical procedures to family or other responsible persons" is identified as a possible collateral code on the Procedure Code Table.
- However, 90887 is a supplemental code, so it can only be used along with another code. It is also linked to specific Dependent On codes and is only 15 minutes.
- Since 90832 (psychotherapy with patient for 30 minutes) is one of the Dependent On codes for 90887, here is how it can be used: If you have a 30 minute therapy session with the client and then meet with the family alone to go over your assessment of the client's needs for 15 minutes, you would bill for 30 minutes using 90832 and add the supplemental code of 90887 for 15 minutes of time spent with the family.

InSyst Procedure Code	InSyst Proc Description	SmartCare Procedure Code	SmartCare Procedure Code Description	Lockout Codes/Rules
310	COLLATERAL - CAREGIVER	90887 Interpret or Explain Results of Psych/Other Med. Proc. to <u>Caregiver</u> , 15 Min.	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90791 90792 90839-90840
614	COLLATERAL HEALTHCARE PROVIDER	90887 Interpret or Explain Results of Psych/Other Med. Proc. to <u>Healthcare Prov.</u> , 15 Min.	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90791 90792 90839-90840



MHP FFS Handbook

New MHP FFS Handbook

- The new [FFS Provider Handbook](#) has been published on the MHP FFS Page on the Provider's Website.
- It includes a lot of helpful information including the new process to connect a client to Mental Health Services without a referral from ACCESS.
- Please review it carefully. Feel free to reach out if you have any questions.



Questions and Answers

- Respond to questions from current training
- Review questions from previous training
- Follow up questions sent to QATA@acgov.org

thank you.

For questions about the presentation, contact
QATA@acgov.org.



SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS