**Important Change to Mental Health Co-Therapist Group Process**

**Effective April 1, 2019**

What has changed and why?

Because of a new requirement under the Federal Final Rule for Managed Care, the State has changed the way mental health groups must be recorded and billed. This new requirement is described in DHCS Information Notice 18-002, Co-Practitioner Claim Submission Requirements. In short, we are required to supply the National Provider Identifier (NPI) for each therapist who is billing for a service. We will use the word “therapist” in this situation to refer to anyone who is eligible to bill Medi-Cal for Specialty Mental Health Services under the Mental Health Plan. Therefore, these rules apply to all staff, including those who are not licensed, registered, or waivered staff, such as Mental Health Specialists and licensed clinicians.

What does this mean for BHS?

In order to accommodate this new requirement for both County and Contract therapists, when a mental health group is facilitated by more than one therapist, each must document and record his/her own service separately via paper Encounter Document or an electronic progress note to enable us to send the NPI for each service.

As of April 1st, what is the new process?

Each therapist that facilitates a mental health group must document his/her own service separately. When documenting the service, the system will still ask how many therapists facilitated the group – continue to post that accurately (i.e.., continue to put the total number of therapists who facilitated the group).

Should a billable or a non-billable service be recorded?

This depends upon: 1) the client’s primary health plan, and 2) in the case of Medicare or Medicare Certified Medicare Advantage Plan (CMAP) it also depends upon the licensure of the therapists. Whether or not to record a billable service is reflected in the following guide.

**Guide for determining whether a Billable or**

**Non-billable service code should be recorded for a**

**Mental Health Group service conducted by more than 1 therapist**

Process effective April 1, 2019

First, determine the client’s **primary [first] health plan**. For County staff it is viewable on the banner bar of PowerChart; for Contract staff it can be found either in your company’s electronic health record or on the Blue Sheet in the paper chart. Use the guide below to determine what type of service to record, once the primary health plan is ascertained:

1. Medi-Cal Short Doyle or Self Pay: Primary Therapist Co-Therapist(s) Billable Svc Billable Svc
2. Medicare, or a Health Plan with the word “CMAP” in it. This requires the therapists to also consider whether they are eligible to bill Medicare, which is referred to as an eligible Provider Transaction Access Number (PTAN) provider. An eligible PTAN Provider is a therapist who is a LCSW, NP, PhD, DO or MD.

If none, or only one of the therapists

is an eligible ‘PTAN’ provider: Primary Therapist Co-Therapist(s)

 Billable Svc Billable Svc

If more than one therapist

is an eligible ‘PTAN’ provider: Primary PTAN Therapist Co-Therapist(s)

 Billable Svc Non-Billable Svc

1. All other Health Plans: Primary Therapist Co-therapist(s)

 Billable Svc Non-Billable Svc

Please note: continue reflecting both the number of clients and the number of clinicians when posting services.

We hope this explains how to document and bill for group services under the new requirements and thank you for your assistance in meeting them. If you have any questions or concerns about the information in this document, please contact BHS IRIS Liaison Help Line at (714) 347-0388.