TERM Provider Claims Resources

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Claims Resources Table of Contents

Contents

Introduction	3
Frequently Asked Questions	4
CMS 1500 Form Completion Guidance	5-6
Navigating TERM Authorization Letters: Completing CMS 1500 Claims Form Introduction	7
Medi-Cal Funded Authorization Letter Sample and Key	8-9
CFWB Funded Authorization Letter Sample and Key	10-11
CFWB Funded GROUP Authorization Letter Sample and Key	12-13
Individual Therapy Introduction	14
Individual Therapy CMS 1500 Form Samples	15-16
Group Therapy Introduction	17
Group Therapy CMS 1500 Form Sample	18
Conjoint Therapy and Case Management Introduction	19
Conjoint Therapy and Case Management CMS 1500 Form Sample	20
Evaluation No-Show Consideration Fee Introduction	21
Evaluation No-Show Consideration Fee CMS 1500 Form Sample	22
Provider Authorization Letter to CPT Code Crosswalk	23-25

Dear TERM Provider,

Your time and expertise shared in the support of TERM-referred clients is immensely valuable within our community. You play an exceptionally important role in helping to reduce the risk of abuse and neglect in families involved with Child and Family Well-Being (CFWB).

The following resources were developed in partnership with Optum's Claims and Provider Services Departments with the intent to offer concrete support and guidance around submission of claims for services rendered to TERM clients. The resources are provided for informational and instructional purposes and do not constitute billing advice. It is our hope that these resources will assist with streamlining your claims submission practices and more efficiently utilize your time to meet the needs of your clients.

Please feel free to contact us at 877-824-8376 (Option 1) for any questions about TERM related processes. Please be in touch with Optum's Claims Department for any questions specific to reimbursement, denials, and claims processes more generally at 877-824-8376 (Option 2). We also welcome and appreciate you sharing any ideas you might have about how we can better serve you. Thank you for partnering with Optum TERM in serving the clients of the County of San Diego.

Respectfully,

Optum TERM Team

Common Billing Questions – FAQ for TERM providers

- What information should be entered for the Insured's ID in box 1a?
 - o For cases funded by CFWB, this information is the client's Case/State ID # listed on the referral form.
 - For cases funded by Medi-Cal, this information is the client's Medi-Cal policy # listed on the referral form.
- Can I sign a Claims form digitally or does it have to be done by hand?
 - Yes, a digital signature is acceptable.
- Is the client's signature required in box numbers 12 and 13?
 - No, the client is not required to sign these boxes. It is adequate to document 'SOF' or 'Signature
 on File' on these lines.
- How do I bill?
 - All claims, regardless of funding source, must be submitted 60 days from the date of service.
 A resubmission or corrected claim must be received within 60 days from the date of the denial EOB but no later than 4 months from the date of service.
 - Claims can be sent on the CMS1500 form to the following address: CFWB Claims, Attention to: Optum, P.O. Box 600340, San Diego, CA 92160-0340. Claims can also be faxed to 877-364-6945.
- Where do I get the required claims form?
 - The CMS1500 claims form can be purchased from retailers such as Amazon and Staples. These forms can also be requested from Optum's Provider Services Department at no cost by calling 1-877-824-8376, option 3.
- Can I submit claims electronically?
 - Contact Claims directly to discuss options for setting up electronic submission of claims. Please contact Claims at 1-877-824-8376, option 2.
- Why are my claims being denied?
 - For specific questions related to your claims submissions, please begin by referencing the Explanation of Benefits (EOB) for the specific denial explanation. If requiring further assistance, please contact Optum's Claim's Department by calling 1-877-824-8376, option 2.

Helpful Billing and Claims Tips – FAQ for TERM Providers

- Provide accurate data and complete all required fields on the claim.
- Be sure all billing staff are familiar with current billing and contract requirements.
- Familiarize all billing staff with the appropriate client information to document in the insured's ID in box 1a.
- Document 'Homeless' in box 5 of the CSM1500 form if a client is currently homeless.
- Remain aware of and utilize appropriate modifiers for services that require modifiers.
- Verify the effective dates for any authorization and remain aware of how many services are covered within the authorization period.
- For any requests to update any information related to authorized services, dates, and service frequency contact the assigned PSW to discuss the request.

How To Complete the CMS1500 Claim Form



Client Information

Box1: Select "Other"

Box 1a: State ID # (CWFB Funded) or Medi-Cal Policy # (Medi-Cal Funded)

Box 2-6: Client demographics to include Name, DOB, Address, and Gender

Box 12-13: Enter "Signature on File" or SOF

Provider/Line item details

Box 19: Indicate whether submission is an updated form with comment

"Corrected Claim" or whether the service is facilitated by an intern by entering the intern's full name, i.e., Daffy Duck, AMFT.

Box21: Diagnostic Codes according to DSM-V-TR. When CFWB funded, Z-codes are adequate. Medi-Cal funding requires that a Title 9 diagnosis be submitted for reimbursement.

Box 23: Enter the authorization number. When multiple authorizations exist, you may enter a range or list each one individually. The authorization number(s) can be found on the authorization letter sent to you by TERM.

Box 24a: Date(S) of Service. Each CMS-1500 form can reflect up to 6 Dates of Service. Line Item details/charges about services rendered by Provider.

Box 24b: Place of Service. Common approved Places of Service include: 02-Telehealth other than in Client's home, 10-Telehealth in Client's home, 11-Office.

Box 24d: Approved CPT Codes only. Include any approved, relevant modifiers. Common modifiers include: 93-Telephone, 95-Video and Telephone, and TU-Bilingual Rate Applies.

Box 24e: Corresponds to diagnosis in Box 21 A-L.

Box 24f: Charge(s) for the rendered service. Rates are pre-determined during the contracting phase.

Box 24g: Indicate the number of units billed. CPT Code T1017 (Case Management) is billed in units of 15mins. For example, a 30-minute T1017 service would reflect 2 units in box 24g.

24j: NPI

Box 25: Federal Tax ID Number/Social Security Number of "Pay To" Box 28: Total charge for all services (lines 24a., 1-6) rendered

Box 31: Provider signature and date. Electronic signatures are adequate.

Box32: Service facility location information. If services are rendered in Client's home, enter Client's home address.

Box 33: "Pay To" Provider's name, address, and telephone number. Enter Agency or Group

address if you are working under an Agency or Group (e.g., The San Diego Outpatient Group). Box^5

25 should correspond to provider or Agency/Group reflected here.

1500 Claim Type Image

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Navigating TERM Authorization Letters: Completing CMS 1500 Claims Form

The following are samples of TERM generated authorization letters that capture key areas used when completing the CMS 1500 Claim Form, as well as areas that orient the provider to understanding how treatment services are funded.

Each sample authorization letter is followed by a letter key that is intended to support the provider's navigation and understanding of the authorization letter.

The first authorization letter reflects a Medi-Cal funded authorization for Child Family Well-Being (CFWB) treatment services that will be rendered to a child. The second authorization letter reflects a CFWB funded authorization of services rendered to a child. Finally, the third authorization letter reflects a CFWB funded authorization of group services.

Treatment Authorization



Monday, October 7, 2024

Prov, Termy B 123 Healing Rd. San Diego, CA 92108

Phone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: Last, First © Client ID: 123456789 D Insured ID:77777777			
Authorization # 🗏	Date and Type of Service F	# of Units 6	Frequency 👭
001	10/21/2024-10/20/2025	1 Unit	1 Once a year
	A&E- Child J -A&E- Child Psych Assessment		
	and Med Eval		
Comment:	INDIVIDUAL THERAPY K		

Please bill with the applicable CPT code listed above and what is included in your fee schedule. Please ensure to bill with any applicable modifiers.

Should you have any questions, please contact us at (877) 824-8376 option 3, then option 4.

Disclaimer: Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Payment for services is subject to client's Medi-Cal eligibility. Authorization is neither a statement of benefit coverage nor a guarantee of payment. Incomplete submissions re not authorized and will not be reimbursed. If a client has other health coverage (OHC), you must bill OHC first. The 'Good Thru' date is the last day authorized. Please submit a request for additional days to Optum Public Sector.

All providers serving children and youth ages 0-21 are REQUIRED to complete Child and Adolescent Needs Assessment and Strengths (CANS) & Pediatric Symptom Checklist (PSC) outcome tools. Please submit completed tools to Optum Public Sector.

Incomplete submissions are not authorized and without authorization, services may not be reimbursed.

Fax to: (866) 220-4495 or

Mail to: Optum Utilization Management at PO Box 601370 San Diego, CA 92160-1370

Medi-Cal Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a Medi-Cal funded authorization.	Funding source will inform the ID number entered in box 1a.
8	Address reflects the provider/practice mailing address.	Use the mailing address when completing box 33 of the CMS-1500 form. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6.
D	In Medi-Cal funded cases, the Insured ID is the client's 9-digit Medi-Cal Policy ID.	Enter the client's 9-digit Medi-Cal Policy ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column reflects that <i>only</i> the Psych Assessment and Med Eval is authorized at the start of the authorization period in Medi-Cal funded cases.	CPT coded entered in box 24D.
6	Number of units authorized during the authorization period. Please request additional units by coordinating with UM. One unit of A&E Child Psych Assessment and Med Eval is authorized in the year.	Enter the number of units rendered for the corresponding CPT code in box 24G. Do not exceed the number of units authorized.
H	The number of units that can be billed during the period described. When additional units are needed (ex. Multiple individual sessions in one week) and clinically indicated, coordinate with UM and the assigned PSW.	Enter in box 24G.
0	Date range reflects the period in which the client is authorized to receive services. Medi-Cal funded therapy is initially authorized for a period of one year.	
J	Child designates that the service is authorized to a child. The modifier 'TJ' must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box 24D.
K	Comment describing the service modality that is authorized. When authorized to group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.



Monday, October 7, 2024

Prov, Termy B 123 Healing Rd. San Diego, CA 92108

Phone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: Last, First © Client ID: 123456789 D Insured ID:0T00				
Authorization # 🗏	Date and Type of Service F	# of Units 6	Frequency 📙	
001	10/21/2024-04/21/2025 A&E- Child J -A&E- Child Psych Assessment and Med Eval	1 Unit	1 Once a year	
002	10/21/2024-04/21/2025 CM-Child- CM- Child Team Conference	12 Units	1 Twice a month	
003	10/21/2024-04/21/2025 TCM- Child- TCM-Child Targeted Case Management	12 Units	1 Twice a month	
004	10/21/2024-04/21/2025 INDIV-Child – INDIV- Child Therapy	23 Units	1 Weekly	

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent.

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

- *All CFWB Initial Treatment Plans and Group Intake Assessments are due 14 days from the authorization start date.
- *All treatment plan updates are due every 12 weeks thereafter.
- *Discharge summaries should be submitted on completion or termination of services.
- *CFWB psychological evaluations are due 30 days from the authorization or receipt of background records from CFWB.

Fax to: (877) 624-8376

Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

CFWB Funded Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization.	Funding source will inform the ID number entered in box 1a.
8	Address reflects the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this individual's demographic information to complete boxes 2-6
D	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
E	Authorization number assigned to each CPT code/service.	Enter in box 23 of the CMS-1500 form. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column will reflect the services/CPT codes the client is authorized to receive. CFWB funded cases will be authorized to receive Psych Assessment and Med Eval, Team Conference, Targeted Case Management, and Therapy.	CPT code entered in box 24D.
G	Number of units authorized during the authorization period.	
H	The number of units that can be billed during the period described. When additional units are needed (ex. Multiple sessions during a one-week period) and clinically indicated, coordinate with the assigned PSW.	Enter in box 24G.
0	Date range reflects the period in which the client is authorized to receive services. CFWB funded therapy is initially authorized for a period of 6 months.	
J	Child designates that the service is authorized for a child. The modifier TJ must be entered for each CPT code authorized and being billed during a child's treatment. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box 24D.
K	Consider any applicable modifiers. When multiple modifiers apply, the language modifier must be primary (ex. TU, TJ, 95).	The modifier(s) is entered in box 24D.



Monday, October 7, 2024

THE BEST GROUP PRACTICE INC B

123 Healing Rd. San Diego, CA 92108 Phone: (XXX) XXX-XXXX Fax: (XXX) XXX-XXXX

We have authorized the following treatment services:

Client: Last, First © Client ID: 123456789				
Authorization # 🗏	Date and Type of Service F	# of Units 🜀	Frequency H	
001	10/21/2024-04/21/2025	1 Unit	1 Once a year	
	A&E- A&E Psych Assessment and Med Eval			
002	10/21/2024-04/21/2025	1 Unit	1 Once a year	
	DVIA- DV- Additional 30min for Intake/Assessment for DV			
003	10/21/2024-04/21/2025	12 Units	2 Monthly	
	CM-CM- Team Conference			
004	10/21/2024-04/21/2025	12 Units	2 Monthly	
	TCM- TCM- Targeted Case Management			
005	10/21/2024-04/21/2025	26 Units	1 Weekly	
	GROUP- GROUP- Group Therapy			
Client: Last, First	Client ID:1234567	789 Insured ID: 0	T000-0	
Authorization #	Date and Type of Service	# of Units	Frequency	
Comment:	AUTHORIZING PROVIDER: TERMY PROV DOME GROUP J	ESTIC VIOLENC	E VICTIM	
	GROUF U			

Please bill with the applicable CPT code listed above and that is included in your fee schedule. Please ensure to bill with any applicable modifiers: 93-Telephone, 95-Telehealth, TU-Bilingual rate applies, TJ-Child and/or Adolescent.

Should you have any questions, please contact us at (877) 824-8376.

Disclaimer: This authorization is being issued on behalf of Child and Family Well-Being. Funding for the Optum Public Sector Services is provided by the County of San Diego Health and Human Services Agency.

Fax to: (877) 624-8376

Mail to: Optum TERM at PO Box 601340 San Diego, CA 92160-1340

CFWB Funded GROUP Authorization Letter Key

	Description	CMS-1500 Application
A	Designates funding source: CFWB for CFWB funded services or CFWB MC for Medi-Cal funded CFWB cases. This example shows a CFWB funded authorization as all groups are CFWB funded.	Funding source will inform the ID number entered in box 1a.
8	Address reflect the provider/practice mailing address.	Use the mailing address when completing box 33. The mailing address may be different to the Service Facility Location address (box 32), which designates the physical location in which the service took place.
C	Name of the individual authorized to receive services.	Use this name to complete boxes 2-6.
D	In CFWB funded cases, the Insured ID is the client's State ID.	Enter the client's State ID in box 1a.
	Authorization number assigned to each CPT code/service.	Enter in box 23. Multiple authorization numbers can be entered in range (ex.0001-0004) or listed (ex. 0001, 0002, 0003, 0004) form.
F	This column will reflect the services/CPT code the client is authorized to receive and bill. CFWB funded group cases will be authorized to receive Psych Assessment and Med Eval, Intake/Assessment Additional 30 min, Team Conference, Targeted Case Management, and Group Therapy.	CPT code entered in box 24D.
G	Number of units authorized during the authorization period.	
H	The number of units that can be billed during the period described. When additional units are needed (ex. Intake/Assessment) and clinically indicated, coordinate with the assigned PSW.	Enter in box 24G.
0	Date range reflects the period in which the client is authorized to receive services. CFWB funded group therapy is initially authorized for a period of 6 months.	
J	Comment describing the authorized service. When authorized to group practice, this area will also reflect the provider who is authorized to render treatment.	Box 31 is signed by the treatment rendering provider designated in the comments section.

Sample CMS 1500 Claims Form

Individual Therapy

The following two pages include sample CMS 1500 Claims Forms to capture how a provider would submit claims for individual therapy services. In the first sample, the individual therapy was rendered to an adult while the second sample reflects individual therapy with a child. Both samples include submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
- 3) CPT Service Code 90837 for Individual Therapy lasting 60 minutes

Both samples also include use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the samples, Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The child sample includes the use of the 'TJ' Modifier code to denote that the service was rendered to a child. The required use of this Modifier is effective as of 9/1/2024. The 'TJ' Modifier is not required when billing CPT codes H0032 (CFWB Report), 99499 (No Shows- Psych Eval).

When multiple Modifiers are being documented by the provider, the language Modifier should be entered as the primary Modifier.

These samples further illustrate usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).

Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.



If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA T Medi-Cal Policy ID or CFWB State ID X (ID#) (Medicaid#) (ID#/DoD#) (Member ID# IENT'S NAME (Last Name, First Name, Middle Initia INSURED'S NAME (Last Name, First Name, Middle Init SEX Client Name 01 01 1993 4 1234 Disneyland Way Self X Spouse Child CA Wonderful World ZIP CODE TELEPHONE (Include Area Code ZIP CODE 54321 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial 10. IS PATIENT'S CONDITION RELATED TO ICY GROUP OR FECA N **IENT AND INSURED** a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) INSUE BIRTH YES ь. AUTO ACCIDENT? b. RESERVED FOR NUCC USE R CL YES c. OTHER ACCID d. INSURANCE PLAN NAME OR PROGRAM NAME I. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO If yes, complete items 9, 9a, and 9d READ BACK OF FORM BEFORE CO 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for & SIGNI to process this claim. I also request payment of government below. SIGNED Signature on File 12/15/2023 SIGNED Signature on File DD 8. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM , DD , YY 17. NAME OF REFERRING PR FROM Corrected Claim or Intern Name - Only Use When Applicable YES service line below (24E) ORIGINAL REF. NO F43.10 D. 1333325-326 or 1333325, 1452658 DATE(S) C SUPPLIER INFORMATION DIAGNOSIS RENDERING (Explain Unusual Circumst S CHARGES 12 15 23 12 15 23 10 250. 00 1 5279384 TU 95 90791 NPI 12 22 23 12 22 23 95 5279384 99366 75.00 1 NPI 5279384 12 23 23 12 23 23 10 90837 **TU 95** 150.00 1 NPI OB NPI 5 NPI NPI 26. PATIENT'S ACCOUNT NO 30. Rsvd for NUCC Use 88-888888 0 YES 475. 00 X 32. SERVICE FACILITY LOCATION INFORMATION 31. SIGNATURE OF PHYSICIAN OR SUPPLIER (XXX)XXX-XXXX INCLUDING DEGREES OR CREDENTIALS Termy Prov, LMFT Termy Prov, LMFT (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 123 Healing Rd. 123 Healing Rd. Sun Diego, CA 92108 Termy Prov LMFT Sun Diego, CA 92108

NUCC Instruction Manual available at: www.nucc.org

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service). Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while Client is in the community (02-Place of

Service). Line 3 CPT Code 90837 depicts an individual therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service). Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Code 90791. Up to six service dates can be captured per CMS 1500 Claims Form.

Services provided to a child must be accompanied by the 'TJ' modifier, as noted below in CPT Codes 90791, 90837. The 'TJ' modifier must follow the language modifier. Up to six service dates can be captured per CMS 1500 Claims Form.



HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12						
PICA MEDICARE MEDICAID TRICARE CHAMP\ (Medicare#) (Medicaid#) (ID#/DoD#) (Member	— HEALTH PLAN — BLK LUNG	OTHER X (ID#)	1a. INSURED'S I.D. NU) or ((For Program in Item 1) CFWB State ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client Name	3. PATIENT'S BIRTH DATE SE	X F	4. INSURED'S NAME (
5. PATIENT'S ADDRESS (No., Street) 1234 Disneyworld Avenue	6. PATIENT RELATIONSHIP TO INSUF	ED ther	7. INSURED'S ADDRE	SS (Nc., Stree	et)	
Wonderful World STATE	8. RESERVED FOR NUCC USE		CITY			
ZIP CODE TELEPHONE (Include Area Code) 54321 ()			ZIP CODE	TE	(code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATE			Y GROUP OR	FECA N	
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE	a. EMPLOYMENT? (Current or Previous YES NO		a, INSURI. Mi	F BIRTH YY		F
c. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES C. OTHER ACCIDENT?	(Sole	JANCE PLAN	ite.	OGRAM I	NARAL
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INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Termy	ACILITY LOCATION INFORMATION Prov, LMFT Paling Rd.		33. BILLING PROVIDE Termy Prov, 123 Healing	LMFT Rd.	# (X	XX ₎ XXXXXXX
	ego, CA 92108		Sun Diego,	CA 921	80	

NUCC Instruction Manual available at: www.nucc.org

Sample CMS 1500 Claims Form

Group Therapy

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for group therapy services. The sample includes submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 99366 for the provider's attendance at a CFT meeting
- 3) CPT Service Code 90853 for Group Therapy

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telehealth through use of the '95' Modifier code.

Line 2 CPT Code 99366 depicts attendance at a CFT meeting rendered via telehealth (modifier 95) while the Client is in the community (02-Place of Service).

Line 3 CPT Code 90853 depicts a group therapy service rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Services provided in languages other than English are captured with the 'TU' modifier, as noted below in CPT Codes 90791 and 90837. Up to six dates can be captured per CMS 1500 Claims Form.



If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.

HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) (TTT) PICA	02/12		PICA T
	LIEALTH DIAN DUZIUNG	ER 1a. INSURED'S I.D. NUMBER Medi Cal Policy ID or	(For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	mber ID#) (ID#) (ID#) (ID#) (ID#) (ID#) 3. PATIENT'S BIRTH DATE SEX	Medi-Cal Policy ID or 4. INSURED'S NAME (Last Name, First Name	
Client Name 5. PATIENT'S ADDRESS (No., Street)	05 01 1990 X F	7. INSURED'S ADDRESS (Nc., Street)	
1234 Disneyland Way	Self Spouse Child Other]	
	FATE 8. RESERVED FOR NUCC USE	CITY	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEA	code)
54321 () 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. IN DLICY GROUP OR FECAN	W.
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b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	ER CLAI Item	
c. RESERVED FOR NUCC USE	c. OTHER ACCIPANT?	JRANCE PLAN OGRAM	NAME
A INCURANCE DI ANAME OR RECORAMANA		A 10 THERE ANOTHER HEALTH RENEELT	ZI, ANIC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. C signated to	d. IS THERE ANOTHER HEALTH BENEFIT F	PLAN? lete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COM- 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	& SIGNII F rmation in	13. INSURED'S OR AUTHORIZED PERSON' payment of medical benefits to the unders	
to process this claim. I also request payment of governmental below.	self or ty ty assignma	services described below.	
SIGNED Signature on File 14. DATE OF CURRENT ILLNESS PREGNANCY (LM)	12/15/2023	SIGNED Signature on F	
14. DATE OF CURRENT ILLNESS. PREGNANCY (LMI MM DD YY C	DD YY	16. DATES PATIENT UNABLE TO WORK IN MM DD YY FROM T	0
17. NAME OF REFERRING PRO	170	18. HOSPITALIZATION DATES RELATED TO MM DD YY TROOK TO TO THE TOTAL TO THE TOTA	
19. ADDITIONAL CLAIM INFORMAL Signates	Only Line When Applicable		CHARGES
Corrected Claim or Intern Name -	o service line below (24E) ICD Ind.	22. RESUBMISSION CODE . ORIGINAL	
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F. J. I	G. L. H. L. I	1333325-326 or 13333	325, 1452658
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVI	CE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()	(XX)XXX-XXXX
	ny Prov, LMFT	Termy Prov, LMFT 123 Healing Rd.	
	Healing Rd. Diego, CA 92108	Sun Diego, CA 92108	
SIGNED DATE12/23/23 a.	NPT b.	a. P b.	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample CMS 1500 Claims Form

Conjoint Therapy and Case Management

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for conjoint therapy and case management services. The sample includes submission of claims for reimbursement of three separate services rendered to the client.

- 1) CPT Service Code 90791 for the Initial Intake Assessment
- 2) CPT Service Code 90847 for Conjoint Therapy
- 3) CPT Service Code T1017 for Case Management

Case Management services are billed in units of 15 minutes. For example, a 30-minute Case Management service should be documented with number 2 under column 24g on the CMS 1500 form.

The sample also includes use of the 'TU' Modifier code to capture services rendered in languages other than English. As shown in the sample, language Modifiers are to be documented immediately after the CPT Service Code on the CMS 1500 Form.

The sample further illustrates usage of Modifiers to capture services rendered via telephone through use of the '93' Modifier code and telehealth through use of the '95' Modifier code.



HEALTH INSURANCE CLAIM FORM

Line 1 CPT Code 90791 depicts an intake assessment rendered via telehealth (modifier 95) while the Client is at home (10-Place of Service).

Line 2 CPT 90847 depicts a conjoint service rendered via telehealth (modifier 95) while the Client is

at home (10- Place of Service).
Line 3 CPT T1017 depicts 1 unit of Case Management service rendered via telephone (modifier 93) while the Client is in the community (02- Place of Service).

Services rendered in languages other than English are captured with the 'TU' modifier, as noted below in Line 2 CPT Code 90847. Up to six services can be captured per CMS 1500 Claims Form.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12 PICA		PICA TITLE
1. MEDICARE MEDICAID TRICARE CHAMPV. (Medicare#) (Medicaid#) (ID#/DoD#) (Member IL	- HEALTH PLAN - BLK LUNG -	1a. INSURED'S I.D. NUMBER (For Program in Item 1) Medi-Cal Policy ID or CFWB State ID
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client Name	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 1234 Disneyland Way	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (Nc., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY
ZIP CODE TELEPHONE (Include Area Code)	_	ZIP CODE TELEP CODE)
54321 () 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INF OLICY GROUP OR FECA NU
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a INSUR. F BIRTH
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	FR CLA
c. RESERVED FOR NUCC USE	c. OTHER ACCIDINT?	JHANÇE PLAN JOGHAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. C Signated L	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of government	** SIGNI F ase of a val rmation it assignments	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
signed Signature on File	12/15/2023	_{SIGNED} Signature on File
14. DATE OF CURRENT ILLNESS. PREGNANCY (LM)	HER YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY
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		NPI
		NPI
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A 88-8888888	CCOUNT NO. 27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE 29. AMOUNT PAID 30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS Termy I	CILITY LOCATION INFORMATION Prov, LMFT	Termy Prov, LMFT (XXX)XXX-XXXX
apply to this bill and are made a part thereof.)	ealing Rd.	123 Healing Rd.
Termy Prov LMFT Sun Die	ego, CA 92108	Sun Diego, CA 92108
NUCC Instruction Manual available at: www.nucc.org	PLEASE PRINT OR TYPE	APPROVED 0MB-0938-T197 FORM 1500 (02-12)

Sample CMS 1500 Claims Form

Evaluation No-Show Consideration Fee

TERM evaluators accepting Child and Family Well-Being evaluation referrals (CFWB, formerly CWS) through Optum TERM will be pre-authorized for one unit CPT code 99499 (no-show) and sent to providers by Optum with the referral form and questions. Evaluators that did not receive this information with the aforementioned documents should follow up directly with TERM by contacting the TERM provider line: 877-824-8376 (Option 1).

There will be only one \$200 no-show fee reimbursed per client per evaluator. This no-show consideration fee only pertains to CFWB/Probation evaluation referrals at the time of this document's publishing.

The following page includes a sample CMS 1500 Claims Form to capture how a provider would submit claims for an evaluation no-show consideration fee (CPT Service Code 99499). This no-show consideration fee is reimbursed at a rate of \$200 considering the time blocked out for the missed evaluation and does not reimburse the provider at the same rate as a completed evaluation, attended by the client.

As displayed on the sample, Evaluators are to document the code '11' for the Place of Service and a diagnosis code of R69 when submitting for reimbursement of the evaluation no-show consideration fee.

Please Note: When granted, evaluation no-show consideration fees will be paid using CFWB funding. Therefore, a CFWB case number must be used when submitting for this fee. If evaluation services are financed by Medi-Cal, the 99499 must be reported on a different claims form than the evaluation services because it is paid for separately using CFWB funding.

Line 1 CPT Code 99499 depicts a claims submission for compensation related to a CFWB Evaluation that was not attended by the client. This reflects the Evaluator seeking reimbursement for the CFWB evaluation no-show consideration fee.

If the client's address is documented as 'Homeless' on the referral from, please document 'Homeless' in box 5 for the Patient's Address.



HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02.	/12				
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Client Name	3. PATIENT'S BIRTH DATE SI	X (10#)	4. INSURED'S NAME		Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) 1234 Disneyland Way	6. PATIENT RELATIONSHIP TO INSUR	RED Other	7. INSURED'S ADDRI	≘SS (N∈., Street)	
CITY	TE 8. RESERVED FOR NUCC USE	other	CITY		
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SIGNED Signature on File 4. DATE OF CURRENT ILLNESS PREGNANCY (LMN	12/15/2023			nature on	
14. DATE OF CURRENT ILLNESS PREGNANCY (LM) MM DD YY		Y	FROM		K IN CURRENT OCCUPATION MM DD YY TO D TO CURRENT SERVICES MM DD YY
9. ADDITIONAL CLAIM INFORM. Signates	17b		FROM DI	D YY	TO DD YY TO S CHARGES
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INCLUDING DEGREES OR CREDENTIALS	FACILITY LOCATION INFORMATION y Prov, PhD		33. BILLING PROVIDE Termy Prov	ER INFO & PH# , PhD	(XXX)XXX- XXXXX
apply to this bill and are made a part thereof.)	Healing Rd.		123 Healing San Diego,	Rd.	3
Termy Prov PhD San [Diego, CA 92108		a. NPI	b.	

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



TERM Provider Authorization Letter to CPT Code Crosswalk

Psychiatric Diagnostic Procedures (Intake Assessment)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eval	90791	Psychiatric diagnostic evaluation	50
A&E Psych Assessment and Med Eval	90791TU	Psychiatric diagnostic evaluation - Bilingual	50

Psychotherapy (Individual, Conjoint, and Family Therapy)

Provider Auth Letter Description	CPT Code	Description	Minutes
INDIV Therapy	90834	Psychotherapy, 45 minutes with patient	45
INDIV Therapy	90834TU	Psychotherapy, 45 minutes with patient - Bilingual	45
INDIV Therapy	90837	Psychotherapy, 60 minutes with patient	60
INDIV Therapy	90837TU	Psychotherapy, 60 minutes with patient - Bilingual	60
CONJ Conjoint Therapy	90846	Family psychotherapy (without the patient present), 50 minutes	50
CONJ Conjoint Therapy	90846TU	Family psychotherapy (without the patient present), 50 minutes - Bilingual	50
CONJ Conjoint Therapy	90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	50
CONJ Conjoint Therapy	90847TU	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes - Bilingual	50

Group Therapy (All TERM Group Therapy Services)

Provider Auth Letter Description	CPT Code	Description	Minutes
A&E Psych Assessment and Med Eva	90791	Intake/Assessment for Group	N/A
A&E Psych Assessment and Med Eva	90791TU	Intake/Assessment for Group - Bilingual	N/A
DVIA DV Intake Assessment	90785	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group	30
DVIA DV Intake Assessment	90785TU	Additional 30 min. for Intake/Assessment for Domestic Violence Offender and Victim Group - Bilingual	30
GROUP Group Therapy	90853	Group Therapy Session	N/A
GROUP Group Therapy	90853TU	Group Therapy Session - Bilingual	N/A

TERM Provider Authorization Letter to CPT Code Crosswalk

Quarterly Treatment Report

Provider Auth Letter Description	CPT Code	Description	Minutes
Report Preparation	90889	Quarterly Treatment Report – 4x per year	N/A
PLDV Plan Development	H0032	CFWB Report(s) – Initial Treatment Plan, Treatment Plan Update and Discharge Summary for TERM CWS Clients (per report)	N/A

Care Coordination (CFT Meeting Attendance and Case Management)

Provider Auth Letter Description	CPT Code	Description	Minutes
CM Team Conference	99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional. Includes Child, Family and Interdisciplinary Team (CFT) meetings for CWS clients. (1 unit per day maximum)	N/A
CM Team Conference	99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional/ (1 unit per day maximum)	N/A
TCM Targeted Case Management	T1017	Targeted case management, each 15 minutes	15

CANS

Provider Auth Letter Description	Billing/CP1 Code	Description
CANS Report Preparation	90889	Submission of an appropriate CANS Report (1 each/1 unit)

Psychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
Psych Test Eval 1 st Hr	96130	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1	60
Psych Test Eval 1 st Hr	96130TU	* Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour (Max 1 unit/1 hour) - Bilingual	60
Psych Test Eval Addtl 1 Hr	96131	Each additional 1 unit/1 hour (services as described in 96130)	60
Psych Test Eval Addtl 1 Hr	96131TU	Each additional 1 unit/1 hour (services as described in 96130) - Bilingual	60
Neuropsych Test Admin 1st 30 Minutes	96136	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1st 30 Minutes	96136TU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - Bilingual	30
Neuropsych Test Admin Addtl 30 Minutes	96137	Each additional 1 unit/30 minutes (services as described in 96136)	30

TERM Provider Authorization Letter to CPT Code Crosswalk

Neuropsych Test Admin Addtl 30 Minutes	96137TU	Each additional 1 unit/30 minutes (services as described in 96136) - Bilingual	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

Neuorpsychological Testing

Provider Auth Letter Description	CPT Code	Description	Minutes
NeuorpsyTesting Evaltion1stHr	96132	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	60
NeuorpsyTesting Evaltion1stHr	96132TU	* Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour - Bilingual	60
NeuropsyTestingEvalAdd1Hr	96133	Each additional 1 unit/1 hour (services as described in 96132)	60
NeuropsyTestingEvalAdd1Hr	96133TU	Each additional 1 unit/1 hour (services as described in 96132) - Bilingual	60
Neuropsych Test Admin 1st 30 Minutes	96136HU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit)	30
Neuropsych Test Admin 1st 30 Minutes	96136HU TU	Psychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes (Max 30 minutes/1 unit) - Bilingual	30
Neuropsych Test Admin Addtl 30 Minutes	96137HU	Each additional 1 unit/30 minutes (services as described in 96136)	30
Neuropsych Test Admin Addtl 30 Minutes	96137HU TU	Each additional 1 unit/30 minutes (services as described in 96136) - Bilingual	30
No Show- Psych Eval	99499	No Show Consideration Fee for Psychological Evaluations	N/A

Psychiatric Evaluations

Provider Auth Letter Description	CPT Code	Description	Minutes
Psychiatric Evaluation 1 Hour	90899	Psychiatric Evaluations	N/A
Psychiatric Evaluation 1 Hour	90899TU	Psychiatric Evaluations - Bilingual	N/A