

Mental Health Claims Entry Quick Reference Guide

CenCal Health is committed to improve the health and wellbeing of our community. In an effort to focus more closely on whole person care, CenCal Health has elected to transition the Behavioral Health benefit inhouse effective January 1, 2022.

Claims should be submitted to CenCal Health via Electronic Submission (contact <u>edi@cencalhealth.org</u> for more details), Paper Claims to CenCal Health, PO BOX 948, Goleta, CA 93116-0948, or our Web Portal Restricted Site.

Web Portal Claims Entry Steps:

Begin by navigating to the CenCal Health provider portal by clicking on the the top of the CenCal Health's website <u>www.cencalhealth.org</u> .

icon located at

UserName	
Email	
Password	
LOG IN	
Reset/Create your password?	

After clicking on the Provider Portal you will need to enter your individual Username and Password. The username is your email and you can create your password by clicking on the "reset/create your password" function. If you forgot your password, click the 'Reset/Create your password?' function to reset your account.

The second is a vertical menu down the left hand side of your screen. This is labeled "Providers- Restricted" and specific to options that only contracted providers have the ability to perform.

Providers - Restricted	For the latest on COVID-19 relate	d claims questions, authorization changes, telemedicine codes and more: ps://www.cencalhealth.ore/providerservicesfag
> Home		
Authorization	Frontline Healthcare Heroes! CenCal He checklist of things you can	alth wants to help you welcome patients back to care. Click <u>here</u> to download a n do to continue caring for your patients during this unusual time.
Claims Entry	Me	di-Cal Rx: Medi-Cal Pharmacy Benefit
Downloads	Effective January 1, 2022, CenCal Health memb	ers will obtain their Medi-Cal pharmacy benefit through a new system. The Department of
Electronic Funds Transfer	vendor, Magellan Medicaid Administration. Maj which include claims management/adjudication	gellan will provide a comprehensive suite of administrative services as directed by DHCS, prior authorization, utilization management, and customer/support.
Eligibility	Rx is now responsible for administering the foll	owing when billed by a pharmacy on a pharmacy claim:
Pharmacy Medical Benefit	Covered Outpatient Drugs, including Physician-Administered Medical Supplies Enteral Nutritional Products	Drugs (PADs)
Procedure Pricer	Additional Information regarding Medi-Cal Rx c	an be found in the "Medi-Cal Rx News" tab below and directly from the DHCS Medi-Cal Rx
RBM Forms	For additional assistance, contact Medi-Cal You may also want to visit the <u>Medi-Cal Rx Com</u>	A: Customer Service at: (800) 977-2273 imunications page for any upcoming bulletins and news.
Reports	if you have changes to your Tax ID Number, DBA, or legal busin Department via fax at (805) 681-3019 or email providerservices	ess name, please submit a new W-9 to CenCal Health. Please submit this document to CenCal Health's Provider Services @cencalhealth.org.
SMART Programs	Data Forms Overview	This site requires latest Chrome, Firefox, Safari or IE11+. 🌀 🙆 🧭 🌔
Transaction Services	Security	
User Management	Cencal Health's Website employs Secure Socket Layer (SSL) technolo however, is only as strong as your organization's username and pas web site to perform their jobs. Protect sensitive patient information password can be changed. The Cencal Health webmaster can be co	ygy to ensure that all information transmitted between CenCal Health and your office is encrypted and secure. This security, sword, Within your organization, only share the account on a need-to-know basis with staff who must access the CenCal Health L bet the CenCal Health webmaster know whenever a privileged employee leaves your organization, so that the organization's insteade as webmaster@cencileabith.org.

Authorization, there are four (4) Authorization types that providers can submit online such as the Medical TAR (50-1), Request for Extension of Stay in Hospital (18-1), LTC Authorization Form (20-1), and the PCP Referral Authorization Form (RAF). The main home screen allows a provider to see a list of authorization types, a hyperlink to view a specific authorization, the status, Requesting Provider, and Servicing Provider.

Claims Entry, will take you to the Dashboard where you can enter or view submitted claims.

Downloads drops down to Explanation of Payment (EOP) which is a notice of payment to claim payments. When providers submit a claim, you will receive an EOP that explains the payment and any adjustment(s) made to a payment during the adjudication of claims.

Eligibility allows you to verify eligibility individually member eligibility with CenCal Health, or manage a Batch File so you can view a group of members eligibility status all in one report. It is important to check eligibility before providing a service at every visit

Pharmacy Medical Benefit provides details related to Physician Administered Drugs (PADs), and Medi-Cal Rx

Procedure Pricer is a great tool to review a rate per CPT code. This is not contract specific.

Reports are available for different provider types, but provides our Explain Code List which is a list of definitions for the claims explain codes for paid or denied claims submitted to CenCal Health.

User Management is a specific screen access permission that allows the portal administrator for your group create new username/passwords for staff, and manage their screen permission access as needed.

Claims Entry Module

Step 1 - To enter a new claim entry, or view a list of submitted claims, click on Claims Entry, Add/View Claims from the vertical menu. The Claims Module will appear. You may search for submitting claims using any field or any combination of fields within the 'Search Criteria' section.

Once you have entered your filtered search criteria, click on the **search** icon to start the search. Your results will populate to the lower grid.

Each column header in the GRID has the ability to sort and filter. By hovering your mouse over the column, 3 lines will appear that you may click on for further options. You may also click on the column title to alphabetize.

Each claim line within the "CCN" column of the Grid will have a paper clip icon indicating Attachments. By clicking on this icon, you will be taken to a screen that allows you to view existing attachments as well as adding additional attachments.

			CI	alms Module						
EW -			Search Cr							
	Billing Provider		CCN	Memberil	Member Firs	t Name	Member I	ast Name		
	Select Provider		•							
Date of Service			EOP Date	Patient#		Status		Result Size		
MM/DD/YYYY to	MM/DD/YYYY	MM/DD/YY	YY to MM/DD/YYYY			Select	-	Select -	Q	
		*;	fover over grid header labels to	o reveal additional sea	rch and sort fea	tures	N			
CCN	Billing NPI	Member ID	Member Name	Patient#	Total Billed	Total Paid	Status	DOS	EOP Date	
20211117029					\$239.00	\$0.00	Processing	11/15/2021	k	1
20211115024					\$355.98	\$150.75	Processing	11/13/2021		
20211116024					\$559.25	\$0.00	Processing	11/13/2021		
20211116024					\$236.76	\$0.00	Processing	11/13/2021		1
20211115024					\$331.80	\$238.98	Processing	11/13/2021		
					A107.10					

Step 2 - Click on the green "New" button at the top left and select CMS-1500 to submit a new Health Insurance Claim Form



Add/View Claims
Training Tutorials
mouse over the column

Claims Entry

Step 3 - **Member/Provider Information**, Enter the Member ID, the member's Firstname/Lastname or their Date of Birth (DOB). The gender will auto populate. The 'Relationship' category should always be indicated as 'Self' as the 'Child' option should only be used for newborn's using the mother's member ID# in the first 2 months of life. The MRN/Account No. is your internal patient identification if you have them specific to your practice (this is an optional field).

Health Insurance Claim Form - Professional														
Member / Patient Informa	Member / Patient Information													
Member No.*	Member Name*		DOB*	Gender			onship	MRN/Account No.						
				=	F	Self	~							
* Member ID and either DO	B or First/Last Name are required													
- Coverage Info (Mos	t Recent)													
Health Plan		Line Of Business	Effective Date		Term Date									
PCP Name		PCP NPI	PCP Phone		PCP Fax									

Once the member is successfully populated, you have the option to click on the 'Coverage Info' arrow to view the most recent eligibility information on file with CenCal Health, and determine who the member's assigned Primary Care Physician Group which includes their PCP NPI#, main phone line, and Fax# on file with CenCal Health.

Step 4 - **Provider/Billing Information**, the <u>Billing Provider NPI</u> will auto populate to the number that your login credentials are configured to your group organizational billing number.

Taxonomy - Used to define the category of service and ensure accurate classification of rates.

Referring Provider NPI - NPI is the provider that referred the patient to you and is usually the PCP. (this is not a required field)

<u>Service Facility NPI</u> - Is not applicable to Behavioral Health unless you provided services in a hospital or surgery center type of facility. In this case, please enter the Facility NPI#

Provider/Billing Information				
Billing Provider NPI*			Taxonomy	
		M		
Referring Provider NPI	Name	45	Service Facility NPI	Name

Step 5 - **Claim Information** is the body of your claim where you will need to enter the following:

<u>Claim Type</u>- Please use the drop down and click MH/BH

<u>Auth No</u>- please enter the RAFB authorization number here if you received a CenCal Health referral from the members assigned PCP.

<u>SOC</u>- enter the members Share of Cost (SOC) amount paid to you if applicable.

Chrg Amt- This field will auto populated once you enter your billing line item charges in Step 6

<u>Anesthesia Start/Stop time</u>- Leave blank as it is not applicable to your provider type

<u>Delay Reason</u>- You may select a delay reason from the drop down if more than 6 months has passed from the date of service and there is a possibility of a reduction in payment due to untimely filing.

<u>Patient No-</u> This is an optional field for you to enter an ID specific to this individual encounter.

<u>Reserved for Local Use- Remarks-</u> This field is for any additional information you feel is pertinent to the processing of this claim. Examples would include "corrected claim" or "mid-level NPI". If the claim is for a **"AMFT/ACSW/APCC/Psych Assistant**", you may enter their NPI here.

Claim Type"	Auth Nd	SOC	Chrg Amt	Anesthesia Start/Stop Tir	te Delay Reason	Patient No.	
мы/выт 🗸		00.0	0.00	1		~	
Reserved	For Local Use-Remarks						
Diagnosis Cod	es:*						
Diagnosis Cod A	es:" Q ^B	Q	с	Q 0	Q E	Q F	٩
Diagnosis Cod A	es:" Q B	٩	c	۵ ۵	Q E	م ۲	٩

<u>Diagnosis Codes</u>- can be manually entered or by clicking on the search icon. You may search by code or description. Please ensure that a description populates beneath each entry. This will confirm the diagnosis is valid and prevent any data entry errors. In the example below, a partial diagnosis has been entered and is therefore invalid.

Diagnosis Codes:*	
Α	Q
Invalid Code	

If you receive an "invalid code" error, you may then use the search tool to enter your diagnosis and be provided with additional options. After locating the correct diagnosis, click on Select.

Searc	h for a IC	CD Code	2
Enter:	F90	Search	
С	ode	Description	
0	F900	Attention-deficit hyperactivity disorder, predominantly inattentive type	
0	F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type	
\bigcirc	F902	Attention-deficit hyperactivity disorder, combined type	
0	F908	Attention-deficit hyperactivity disorder, other type	
0	F909	Attention-deficit hyperactivity disorder, unspecified type	
Page 1	1 of 1		
1			
			Select Cancel

Diagnosis Codes:*

Attention-deficit

combined type

hyperactivity disorder,

F902

Q

We can now see that the correct description is listed and the "Invalid Code" error has been removed.

Please note that the code provided here is a sample for this instruction guide, and may or may not apply to your claims.

Step 6 - Line Items have 2 rows each with a total of 6 line items available. You can click the items add 6 more line items for a total of 12 rows.

		POS Emg	Proc		2		4	Diag Ptr	Charge	Units	EPSDT	Auth No.	Rend NPI	Taxonomy
NDC/UPN	N Code	Quantity	UofM	Paid	Amount	Cap	Amount	Status	Reaso	n Codes				
T	to	×	Q	~	~	~	~		0.00		~			

Row 1. The first row is where you will enter the CPT code for the service you have performed. <u>Service From-Thru dates</u>- if your service occurred on 1 date, this would be the same date in both boxes. <u>POS-</u> place of service is an indicator for the location of the service. Please see attached list for reference. <u>EMG-</u> Select Y for Emergency and N for Non-Emergency.

<u>Proc</u>- Enter the procedure or CPT code corresponding to your service. Please see attached list for reference. <u>Modifiers</u>- Select up to 4 modifiers from the drop down options.

NOTE: Modifier "HO" indicates that the service was performed by an associate psychotherapist (AMFT, ACSW, APCC), Psych Assistant or an Assistant Behavioral Analyst under the supervision of a licensed/certified clinician. Modifier "HM" indicates that the service was performed by a behavioral technician. For BHT providers, please use HO modifiers for mid-level professional staff and HM for paraprofessionals. No modifier is required for provider level.

<u>Diag Ptr</u>- Enter the letter for each diagnosis field. These will need to be separated by a comma. <u>Charge</u> Enter your usual and customary billed amount for this service. This should not match your allowed amount exactly so that any change in rate can be accommodated.

Units- This is the quantity. BHT providers please bill in full units, partial units will not be accepted.

Fam Pln/EP SDT- Not Applicable to BH/MH.

<u>Auth No</u>. If you have a TAR for this CPT code enter in this field.

<u>Rend NPI-</u> Enter a rendering NPI here if different from the Group Organizational Billing NPI.

NOTE: However, if claim is for AMFT/ACSW/ APCC/ Psych Assistant, Assistant Behavioral Analyst, Behavioral Technician, Physician Assistant, or nurse who <u>is not board certified</u>, please enter the NPI of the fully licensed supervising clinician. If the supervising clinician's NPI is the same as the billing, leave the rendering field blank.

Taxonomy- Enter a Taxonomy here if different from the Billing Taxonomy.

Row 2. The second row is only used for medications being dispensed.

Important Notes

- If a claim is for AMFT/ACSW/ APCC/ Psych Assistant, Assistant Behavioral Analyst, Behavioral Technician, Physician Assistant, or nurse who **is not board certified**, please enter the NPI# of the fully licensed supervising clinician. If the supervising clinician's NPI is the same as the billing, leave the rendering field blank.
- Quantities always have to be billed in whole numbers, our system will deny claims with decimals in the quantity field. If the provider is seeing members for less than 1 hour, they would still have to bill quantity of 1, but can lower their billed charge to reflect the shorter time with the member. Or if billing for more than 1 hour, most codes allow for higher quantity to be billed per day but each "per day limit" is different, so they should verify those limits on the website. Any questions regarding the provider's contract should be directed to your provider service representative.

If this is a secondary claim, you may now enter Other Health Coverage at the line level. By clicking on the COB/OHC drop down arrow at the top of the Line Entry section. You may also add additional service lines

Line Items + Add C	ОВ/ОНС 🔽
--------------------	----------

By clicking on the COB/OHC drop

by clicking on the green +Add button. down option, a third row will be added to each line. See below:

Original line with Headers

							Modifie	Modifiers						Fam Pin				
#	Service	Date(s)*	POS*	Emg	Proc*				- 4	D	Diag Ptr*	Charge*	Units*	EPSDT	Auth No.	Rend NPI	Taxonomy	
	NDC/UPN	Code	Q	uantity	UofM	P	aidAmount	Ca	apAmou	nt	Status	Reas	on Codes					
1	te	0		~	٩	``	~	~	· •			0.00		~				
	~					-	0.00		0	0.00								

Third line added for OHC entry

#	Service	D	ate(s)*	POS"	Ema		Proc*			1	Mo 2	difie	rs 3	4		Diag Ptr*	Ch	narge*	Units*	Fam Pin EPSDT		Auth No.	Rend NPI	Taxonomy
	NDC/UPN	Γ	Code	<u> </u>	Quantity		Uof	м		Pa	idAmo	unt	Ca	pAm	ount	Status		Reaso	n Codes					
	EOB Date	OB Date Allowed Deductible		eductible		Coinsurance		e	Paid		Billed		Non-Cover	lon-Covered Adjusted		Denied								
1	t	to			~			Q		~	~	·	~		~			0.00		~				
Γ	~	·				T			~			0.00			0.00									
п	m/dd/yyyy	Ĺ	0	.00	0.0	0		0	.00			0.00			0.00	0	0.00		0.00	0	.00			

Step 7 – Submit your claim by clicking on the icon and the system will provide you with a green banner indicating that your 'Claim Created Successfully' or in red 'Claim not created Successfully with missing required fields'. You can then review your claims and see if you have any 'DN' denied status codes and the reason for the denied line item for corrections.

Your claim is now available on the dashboard grid. After the claim has been submitted, you can add attachments if necessary.

Once you have entered all of the claim lines, the 3 icons will be available at the top right after submission. You will also be able to view the current status of the claim at the line level.



The **green +** Add icon allows you to enter a new claim. The **orange paper clip** icon allows you to upload additional documentation to your claim. If you see errors on your claim after it has been submitted, the **blue Submit icon** will save any additional changes. After making changes and resubmitting, you will see a "Claim updated successfully" message in green at the top of the screen. The claim number will stay the same.

You may edit the claim up to the time that it appears on the EOP, and click the **blue Save icon**. If you need to make corrections to a claim that already appeared on an EOP, you may do so by submitting a new claim along with the required correction online.

When you are finished entering your claims, you may select the <u>Back to Claim List</u> option on the upper left side of the screen to return to the dashboard.

Once you submit your claim you will receive a **Claim Control Number (CCN)**. Every CCN is a unique identifier for each claim submitted to CenCal Health. The CCN consists of the date the claim is received (e.g. 20211026), the provider type (e.g. 02 is medical), the claim type (e.g. 88 is a Medi-Medi crossover claim), and a sequence number. For website submitted claims, the claim type is 09.

CCN										
Ø	2021111702916360									

An example of a CCN appears in this format:

Your claim is now available on the dashboard grid. After the claim has been submitted, you can add attachments if necessary.



Step 1: Click on the Red "Add" icon at the top right. You may choose
Initial or Additional attachment Category
Step 2: Click on "Choose File" to select a document from your
computer.

chments for Clain	n#: 202111120240	3261	Step 1
Category	Filename	Uploaded By	Upload Date
		Click "Choose File" and Select a file to	Attach to: 202111150241876
	Step 2	Upload File: Choose File No file chosen	Car
CenCalHEALTH®		File Types: .pdf .jpeg .jpg .txt	Max File Size: 4M

Step 3: After you select a file, click on "Upload Attachments"

Click "Choose File" and Select a file to	Attach to: 20211115024	18770.×		
Category: Initial O Additional				
Upload File:				
Choose File lorem_ipsum_test_1.pdf				
Step 3	UPLOAD ATTACHMENT	Cancel		
File Types: .pdf .jpeg .jpg .txt	Max File Size: 4ME			

Step 4: Your new attachment will now be visible on the list. It may take a Few moments to load if your attachment is large.

Place of Service/Modifiers/Procedure Code Tips:

Please note there are additional CPT/HCPCS codes that could be included, per your contract. These are the most common used for Behavioral Health/Mental Health claim types. Refer to the National Correct Coding Initiative (NCCI) edits or the California State Medi-Cal manual <u>www.medi-cal.ca.gov</u> for the full guidelines and restrictions.

Place of Service

11- Office 02- Telehealth

Modifiers

95-Telehealth

HO- Master's degree level, used to identify services performed by an AMFT/ACSW/ APCC/ Psych Assistant HM- Less than Bachelor's degree level

HN- DHCS has reassigned this modifier, and is no longer valid for behavioral health

HP- This is not on DHCS' list of approved modifiers, and will not be accepted.

Procedure Codes

90785-INTERACTIVE COMPLEXITY

90791- PSYCHIATRIC DIAGNOSTIC EVALUATION (PER SESSION)

90792- PSYCHIATRIC DIAGNOSTIC EVALUATION WITH MEDICAL SERVICES (PER SESSION)

90832- PSYCHOTHERAPY, 30 MINUTES WITH PATIENT

90833- PSYCHOTHERAPY, 30 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE

90834- PSYCHOTHERAPY, 45 MINUTES WITH PATIENT

90836- PSYCHOTHERAPY, 45 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE

90837- PSYCHOTHERAPY, 60 MINUTES WITH PATIENT

90838- PSYCHOTHERAPY, 60 MINUTES WITH PATIENT WHEN PERFORMED WITH AN EVALUATION AND MANAGEMENT SERVICE

90839- PSYCHOTHERAPY FOR CRISIS; FIRST 60 MINUTES

90840- PSYCHOTHERAPY FOR CRISIS; EACH ADDITIONAL 30 MINUTES

90846- FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT), 50 MINUTES

90847- FAMILY PSYCHOTHERAPY (CONJOINT PSYCHOTHERAPY) (WITH PATIENT PRESENT), 50 MINUTES

90849- MULTIPLE-FAMILY GROUP PSYCHOTHERAPY

90853- INDIVIDUAL MEDICAL PSYCHOTHERAPY BY A PHYSICIAN; 20-30 MINS

90880- HYPNOTHERAPY

90899- UNLISTED PSYCHIATRIC SERVICE OR PROCEDURE

96105- ASSESSMENT OF APHASIA W/INTERPRETATION AND REPORT, PER HOUR

96110- EVELOPMENTAL SCREENING (EG, DEVELOPMENTAL MILESTONE SURVEY, SPEECH AND LANGUAGE DELAY SCREEN), WITH SCORING AND DOCUMENTATION, PER STANDARDIZED INSTRUMENT

96112- DEVELOPMENTAL TEST ADMINISTRATION (INCLUDING ASSESSMENT OF FINE ANDOR GROSS MOTOR LANGUAGE COGNITIVE LEVEL SOCIAL MEMORY ANDOR EXECUTIVE FUNCTIONS BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS WHEN PERFORMED) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT FIRST HOUR

96113- DEVELOPMENTAL TEST ADMINISTRATION (INCLUDING ASSESSMENT OF FINE ANDOR GROSS MOTOR LANGUAGE COGNITIVE LEVEL SOCIAL MEMORY ANDOR EXECUTIVE FUNCTIONS BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS WHEN PERFORMED) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL WITH INTERPRETATION AND REPORT EACH ADDITIONAL HOUR

96116- NEUROBEHAVIORAL STATUS EXAM, PHYSICIAN FACE-TO-FACE TIME

96121- NEUROBEHAVIORAL STATUS EXAM (CLINICAL ASSESSMENT OF THINKING REASONING AND JUDGMENT [EG ACQUIRED KNOWLEDGE ATTENTION LANGUAGE MEMORY PLANNING AND PROBLEM SOLVING AND VISUAL SPATIAL ABILITIES]) BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

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

96131- 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

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 F

96133- 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

96137- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL TWO OR MORE TESTS ANY METHOD EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

96138- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN TWO OR MORE TESTS ANY METHOD FIRST 30 MINUTES

96139- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION AND SCORING BY TECHNICIAN TWO OR MORE TESTS ANY METHOD EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

96146- PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST ADMINISTRATION WITH SINGLE AUTOMATED STANDARDIZED INSTRUMENT VIA ELECTRONIC PLATFORM WITH AUTOMATED RESULT ONLY

99354- PROLONGED SERVICE(S) IN THE OUTPATIENT SETTING REQUIRING DIRECT PATIENT CONTACT BEYOND THE TIME OF THE USUAL SERVICE; FIRST HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR OUTPATIENT EVALUATION AND MANAGEMENT OR PSYCHOTHERAPY SERVICE, EXCEPT WITH OFFICE OR OTHER OUTPATIENT SERVICES (Can only be billed with 90847)

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

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