CareSource™

FAQs

Coordination of Healthcare Exchange of Information

For DBHDD-Certified Behavioral Health Providers

What is the change?
CareSource will now reimburse Department of Behavioral Health and Disabilities (DBHDD) certified Behavioral health providers for appropriate coordination of care between behavioral health (BH) providers and the member's primary care provider (PCP) and/or specialist provider quarterly/four times per year.

Is this service reimbursable?
Yes, effective Jan. 1, 2020, DBHDD-certified BH providers may bill CPT code G9001 for the coordination of care of all CareSource Medicaid members. The provider group can bill this code once a quarter per member for a $25 reimbursement.

Is consent needed to coordinate care?
Yes, BH providers must receive written consent from the member or the member's parent/guardian to coordinate care. This process can be a part of the already established consent paperwork during intake to BH services.

What if the member does not give consent?
It is important to share the importance of coordination of care, but if a member chooses to refuse consent and the provider continues with treatment and without coordination of care taking place, the coordinated care code cannot be billed.

Is it a HIPAA violation to send this information to the PCP/specialist?
To ensure HIPAA compliance, BH providers must receive written consent from the member or the member's parent/guardian to coordinate care. This process can be a part of the already established consent paperwork during intake to BH services.

What if the member does not have a traditional PCP?
In an effort to ensure coordination of care, if a member does not have a PCP, this is an opportunity for BH providers to facilitate helping the member identify a PCP. During the assessment phase, if the member identifies having a specialist as his or her PCP, coordination of care is encouraged to be completed with the specialist. Our case managers are available to assist with this process if necessary.

How does the provider show proof of coordinated care to bill G9001?
Providers are requested to use the *Coordination of Healthcare Exchange of Information Form* that was released with the *Network Notification* Jan. 31 blast. This form is mandatory and required to be in each member's health record as an attestation of coordination of care when utilizing this benefit.

Who can fill out the coordinated care form?

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Any provider within the provider group can fill out the *Coordination of Healthcare Exchange of Information Form*. This person does not have to be clinical. As such, the G9001 code does not have a modifier when being billed.

How can the *Coordination of Healthcare Exchange of Information Form* be sent to the member's PCP/specialist?
The form can be faxed and/or mailed to the respective PCP and/or specialist. The medical chart needs to document the method that is used.

How often can I bill G9001?
The code can be billed for all CareSource Medicaid members once per quarter, per provider group (e.g., if multiple therapists within the same group practice are seeing a member, the group practice can only bill once a quarter for coordinated care for that member).