Progress Notes

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CONFIDENTIALITY

HIPAA regulations mandate that all client information be treated confidentially.

Access to CCBH is based on your position and your job classification. You will have the access you need to complete your job duties. This can include access to clients in your Unit/SubUnit or may include full client look up. Remember – with more access comes greater responsibility regarding confidentiality!

You are not to share passwords with other staff. The Summary of Policy you signed before receiving your access to CCBH included your agreement to this directive. You are still responsible if someone with whom you have shared your password violates confidentiality!

The MIS unit investigates any suspicions regarding sharing of passwords. Consequences are up to, and may include termination.

Do not open any active client charts unless instructed to do so, or if it is required to complete your job duties. "Surfing" clients is a blatant breach of confidentiality.

Remember you are personally and legally responsible for maintaining confidentiality. Take it seriously.

Do not leave your computer unlocked with client data on the screen for others to access or view while you are away from your desk. Lock your CCBH session before leaving your computer.

When printing, make sure you are printing to a confidential printer, and pick up your paperwork quickly. Leaving printed Protected Health Information (PHI) out is also a confidentiality violation.

Play it safe – keep in mind how you would want your own PHI handled!

CLONED DOCUMENTATION

From the Compliance Bulletin # 30, October 17, 2011

"When documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation.

"Whether the cloned documentation is handwritten, the result of pre-printed template, or use of Electronic Health Records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

"It would not be expected that every patient had the same exact problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information for each unique patient.

"Documentation exactly the same from patient to patient is considered cloned and often occurs when services have a specific set of limited or select criteria. Cloned documentation lacks the patient specific information necessary to support services rendered to each individual patient."

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OVERVIEW OF CLIENT PLANS

There are different ways to hold progress notes in CCBH. You can think of them as "folders" in which to keep your progress notes:

These "folders" may or may not all be used by your program. Each is a "stand alone" folder and they are not sequential (that is to say, you do not need to move from one to the other in order of this listing). Each has a specific purpose, defined below:

The Limited Service Log is intended to be used for short term services by programs (i.e. ESU, walk-in clinic) where a Client Plan will never be completed. If your program does not provide these short term services, you probably won't use this "folder."

The Interim Folder: The standard for completing a Client Plan has not changed – you still have 30 days from the time a client comes to your program to complete a Client Plan. However, CCBH needs a place to "hold" your progress notes, and the Interim Folder performs that function. This is the "folder" where you will document all your services prior to opening the Client Plan. Can you leave this folder open indefinitely? No! The Interim folder needs to be closed:

1. If the client leaves the program without a Client Plan being started and you are the only provider;
2. If you are ready to begin the Client Plan.

The Interim Folder needs to be closed on a date prior to opening your Client Plan.

Day Treatment Med Folder: The Day Treatment Med Folder is only used for children's day treatment medical staff to store their progress notes. The folder will be opened upon the first date of service with the day treatment program and will only be closed once the client discharges. If the client receives day treatment services for more than 2 years, a new "folder" will need to be opened. Only day treatment medical staff notes should be stored in this folder.

The Client Plan holds all the progress notes written after opening the plan. You do not need to open an Interim Folder before opening a Client Plan if that is your workflow (for example, many programs complete the BHA and Client Plan at the initial appointment). In other words, the Client Plan can be opened immediately as you start seeing your client.

STRUCTURE OF A CLIENT PLAN IN CCBH

"Planning Tiers"

In CCBH speak, the elements below are identified as Planning Tiers. Think of them as levels or layers in the Client Plan.

Strengths

This is the client's general strength(s) and how the client might utilize this strength(s) to help them to help achieve their objective(s).

Area of Need

This is an area or areas for the client where a level of impairment has been identified.

Goal

This is the broad goal that the client wants to achieve in treatment. *No narration is required for this Planning Tier.*

Objective

These are the actions/activities/steps of the client or others to help reduce the impairment. *Objective(s) narration is observable & measurable.*

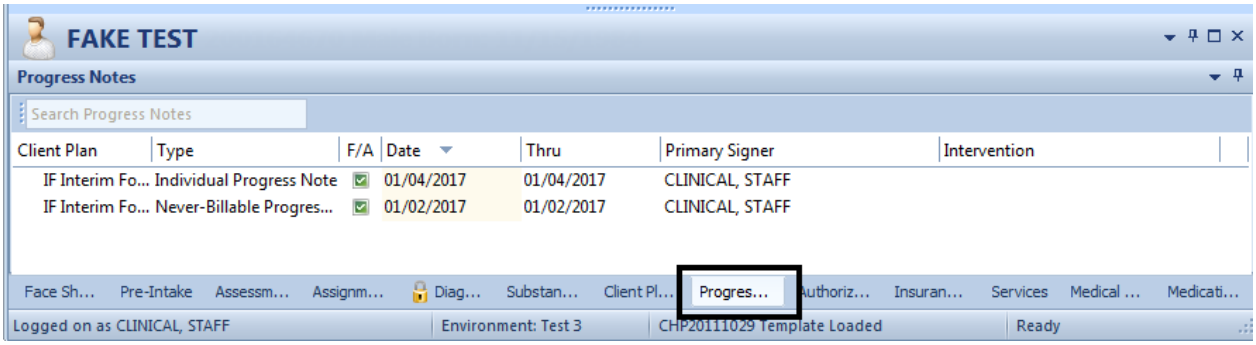
Intervention

Interventions are the service codes to be used to treat the client. *Frequency, duration will be specified and the individualized purpose for all service codes.*

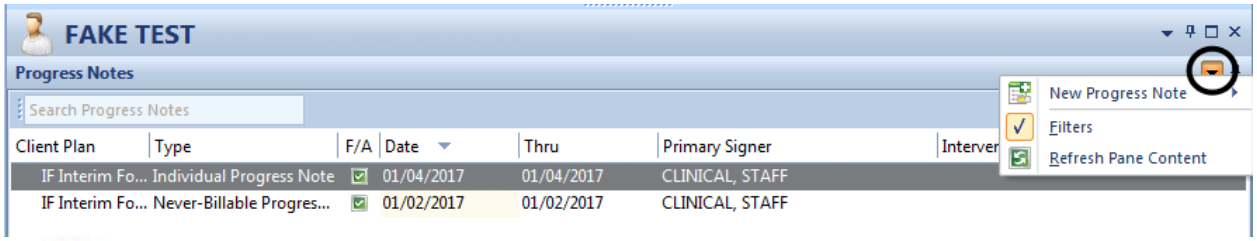
HOW PROGRESS NOTES DISPLAY IN THE CLIENT PANEL

To View Existing Progress Notes:

1. On the Client Panel, find the “Progress Notes” pane and single click on it.



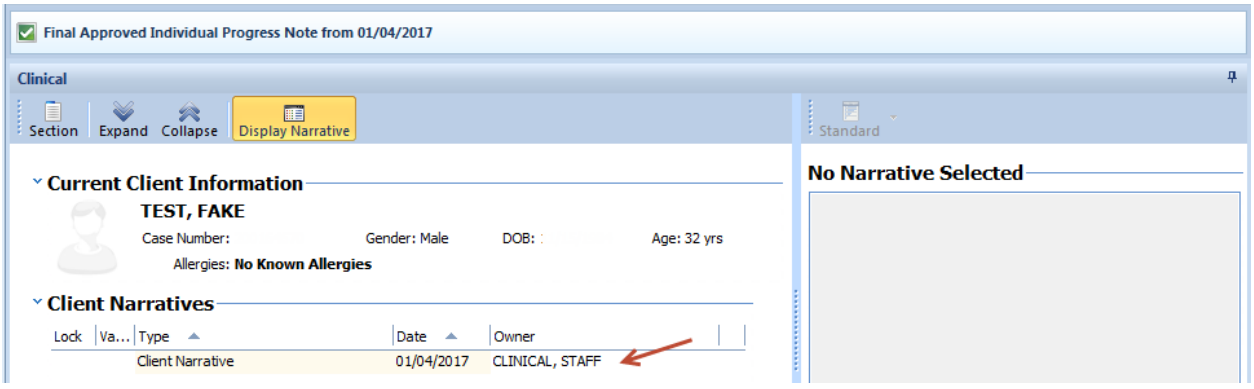
2. Click on the black drop down arrow to open display options.



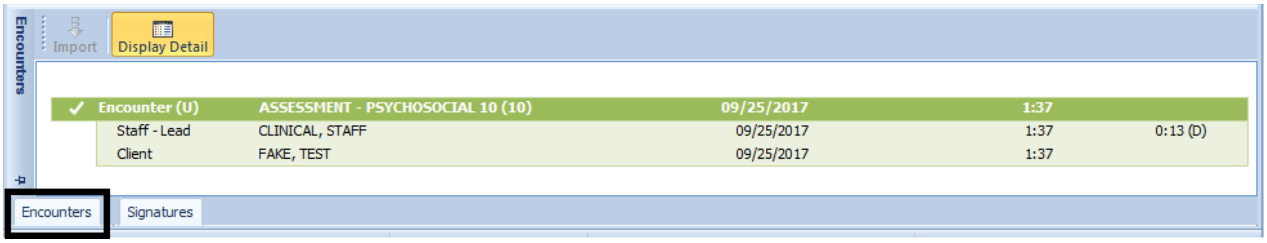
Note: “Filters” allows you to select how you want to view progress notes (in a particular date range, by Client Plan Type, by Progress Note Type, by a particular Intervention, Final Approved & Pending progress notes, and/or voided progress notes.)

3. Double click on any progress note you would like to see in its entirety.

4. Click on the “Client Narrative” line to read the narrative.



5. To view encounter information select the “Encounter” pane, and double click on the encounter to open details.

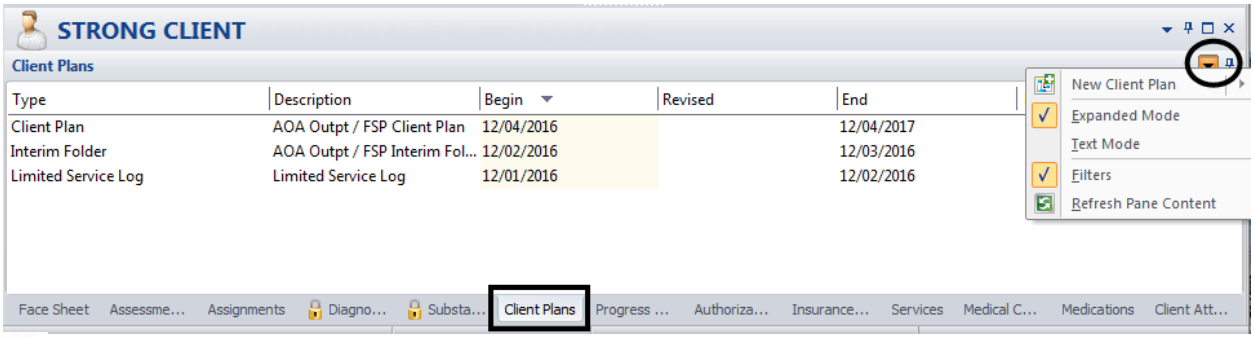


NOTES

HOW CLIENT PLANS DISPLAY IN THE CLIENT PANEL

To View Existing Client Plans:

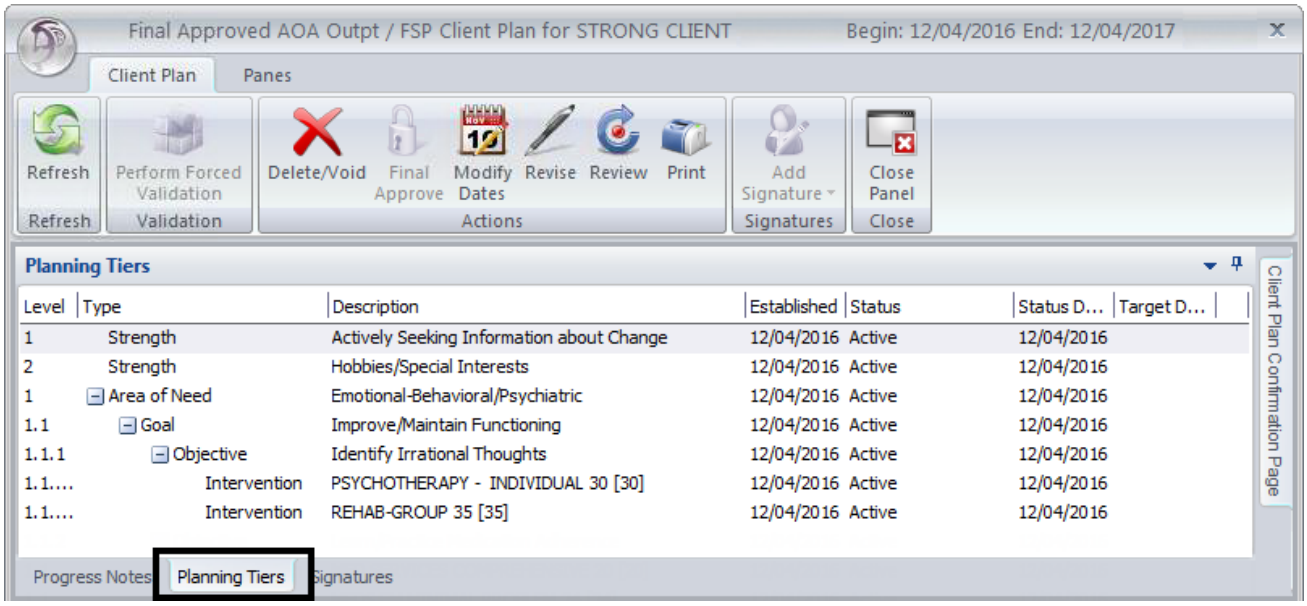
1. On the Client Panel, find the “Client Plans” pane and single click on it.



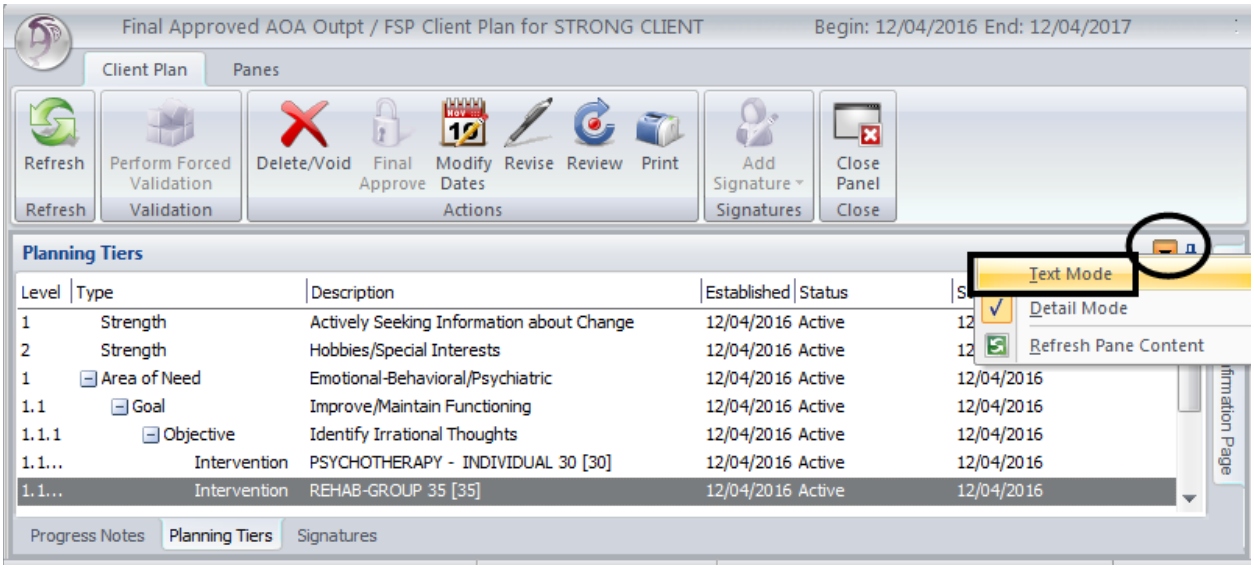
Note: “Expanded Mode”- displays all Client Plans, regardless of the plan type, or dates. “Text Mode” displays the text associated with the Plan. “Filters” will allow you to adjust the dates or types of plans that display.

2. Double click on the client plan you wish to view.

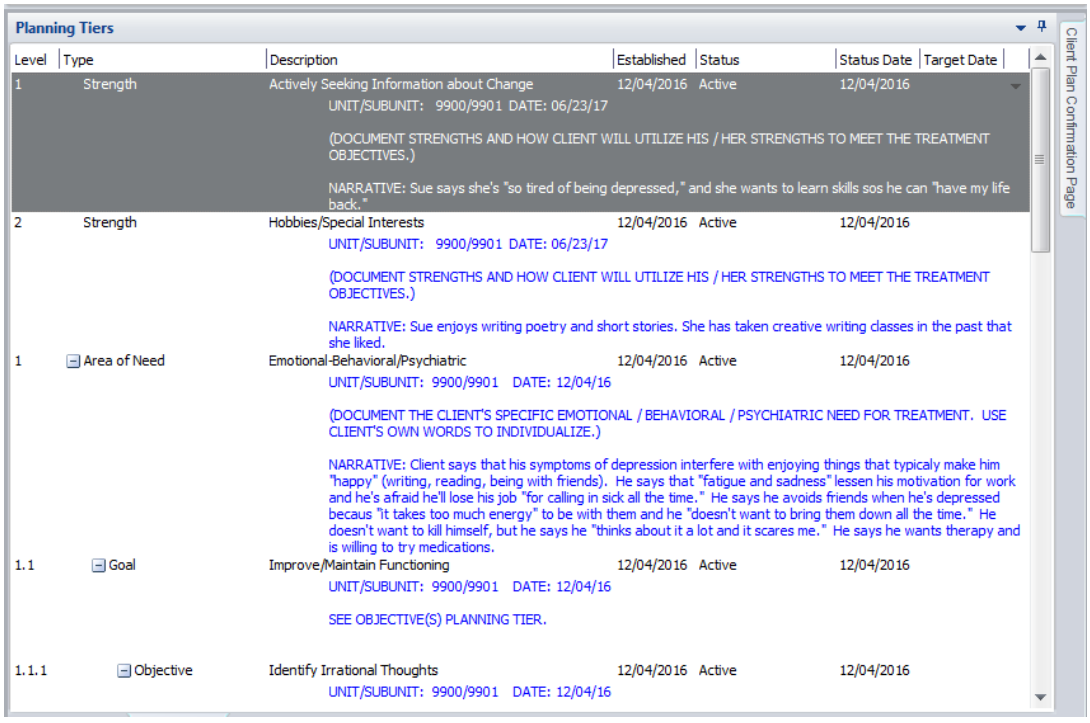
3. To view all the planning tiers, click on the “Planning Tiers” pane. The client plan will appear.



4. To view the narrative for the planning tiers, click on the black drop down arrow, and select “Text mode.”



5. Planning tiers will display with the narrative portion listed below it.



INFORMATIONAL NOTE

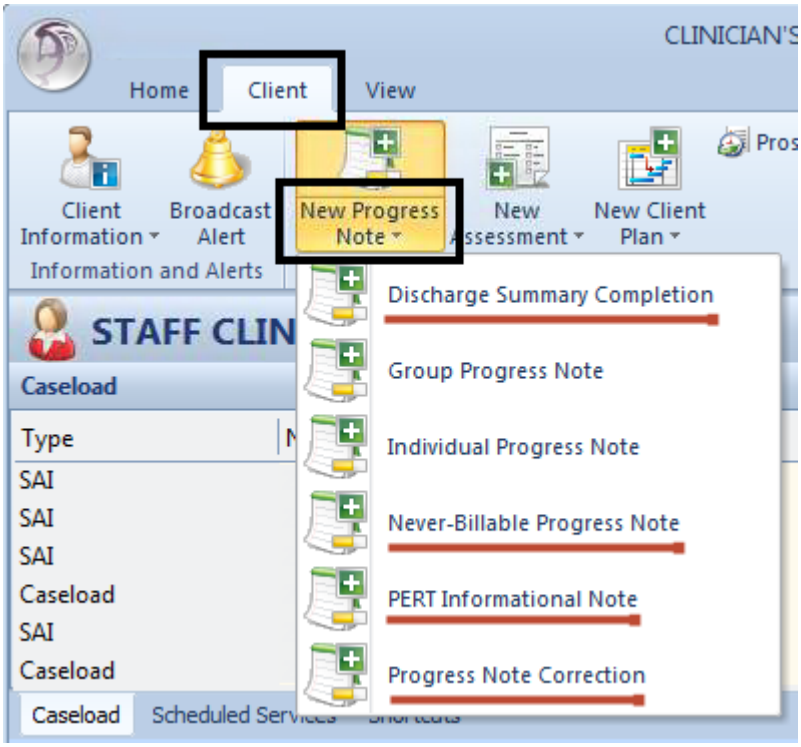
Informational notes are used when a not-billable activity is provided. The services documented in these notes are not connected to the client plan and no billing is generated. These notes are also used to record billing errors. You must select the type of informational note you wish to write.

- Discharge Summary Completion
- Never-Billable Progress Note
- PERT Informational Note
- Progress Note Correction

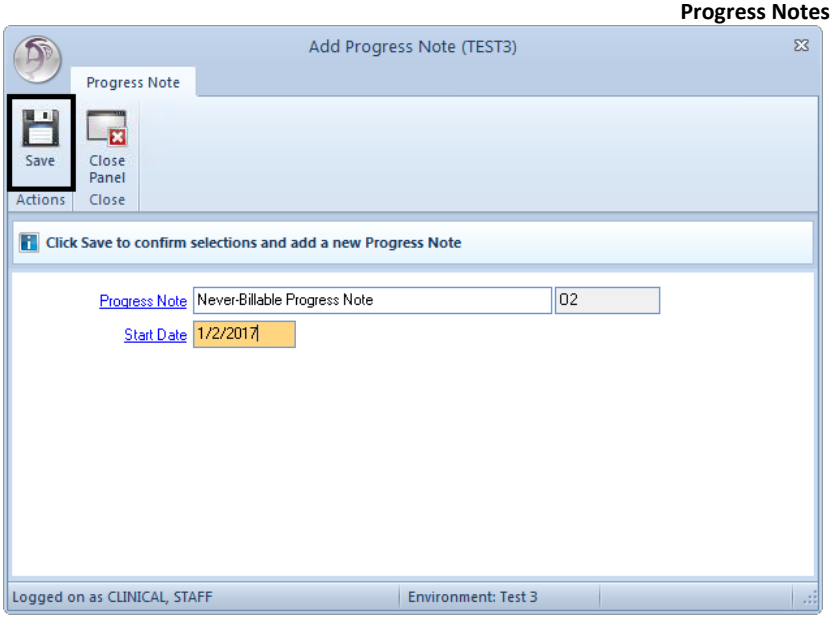
Note: A *folder* should be in place before you create an Informational Progress Note.

Accessing a New Informational Progress Note:

1. Click on the "Client" tab.
2. Click on the lower portion of "New Progress Note" button.
3. Select one of the Informational Notes noted below, (there are 4 types).



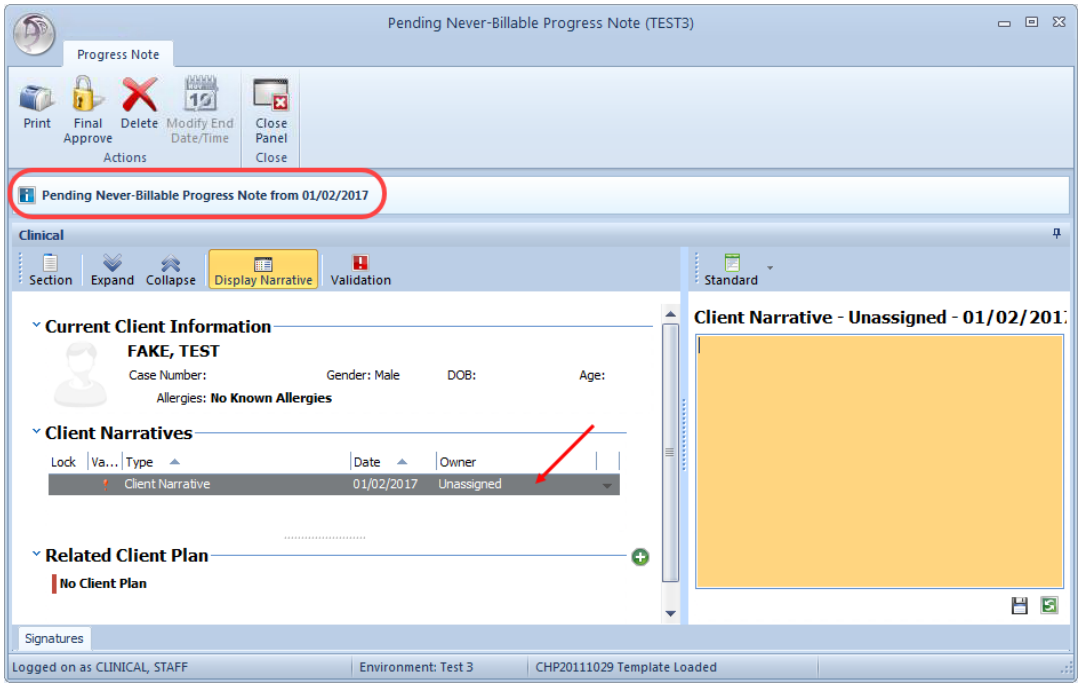
4. The begin date will automatically choose today's date. Be sure to change the date if the event took place on a different date. **Be mindful when entering this date, as it cannot be changed.** After selecting the appropriate date, click on the "Save" button.



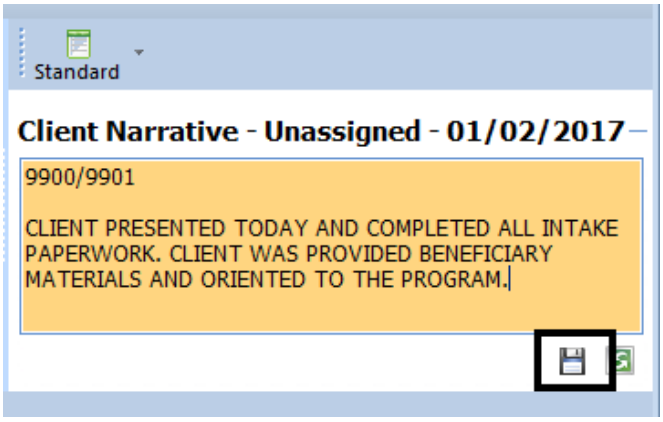
Enter a Narrative in a Progress Note:

5. The empty note window displays ready for data entry. In the "Pending *Never-Billable* Progress Note" window, verify the "Date" for the Progress Note. If the date is not correct, select "Delete" and start again.

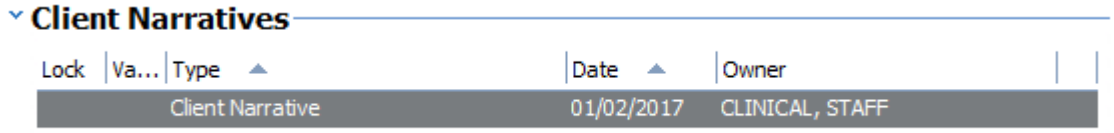
6. The yellow narrative section indicates you are ready to begin typing. If the section is not yellow, double click anywhere on the "Client Narrative" line to open the narrative for data entry.



7. Once you have completed the narrative entry select the save icon below the narrative.

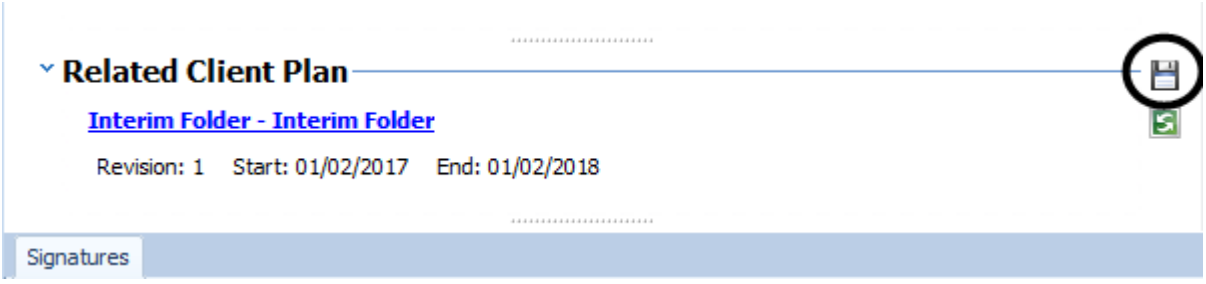


8. Your name will now show as Owner of that narrative.



9. Select the green plus symbol, under “Related Client Plan,” to indicate which *folder* you would like to store your note in. If there is only one option, it will auto select it for you.

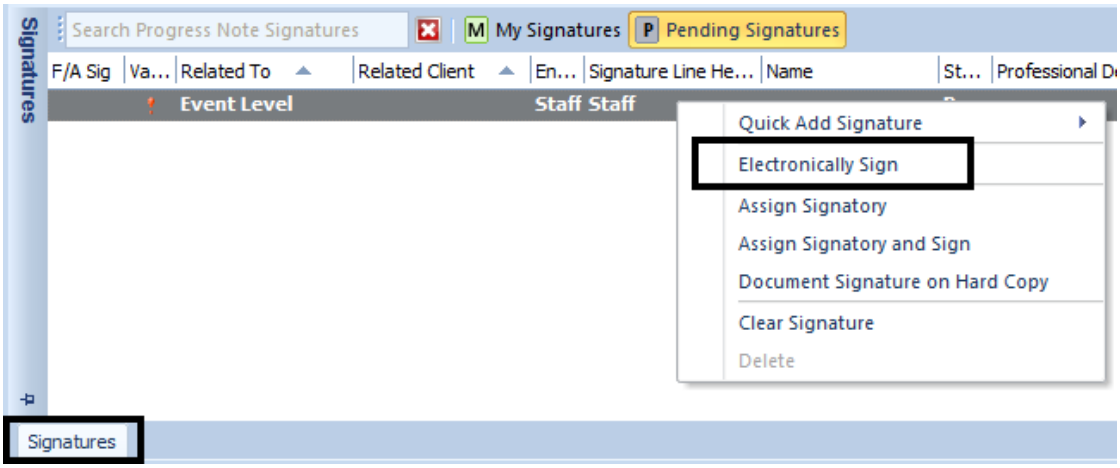
10. Once the correct client plan type is populated, click the save icon. (*It will change to a pen icon once it is successfully saved).*



Progress Notes Signatures:

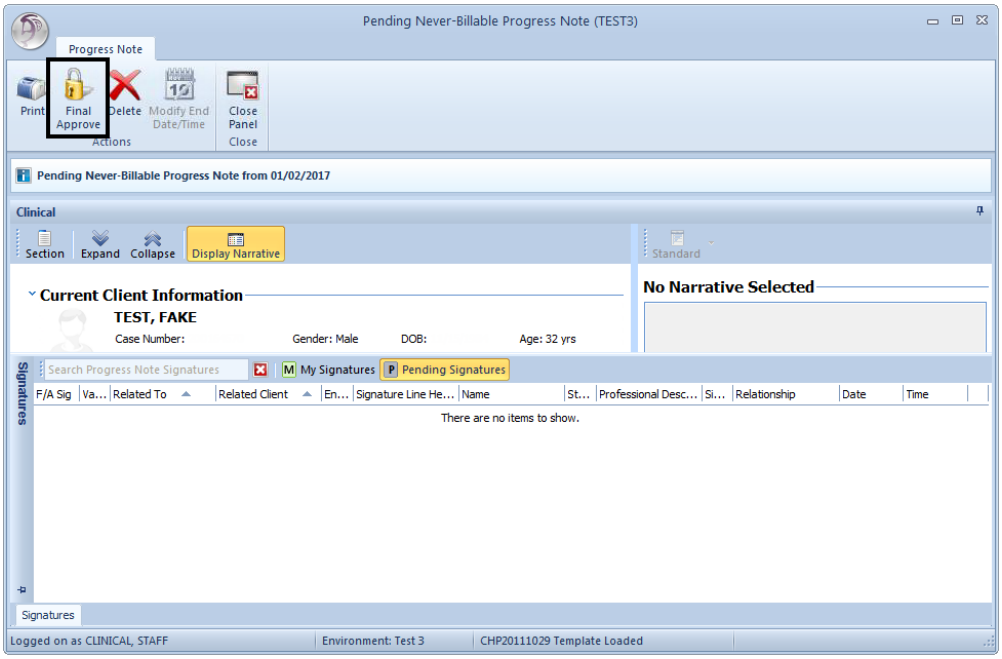
1. Select the “Signatures” pane by single clicking at the bottom. This will automatically show all pending signatures.

2. Right click on the “Staff Signature” line and choose “Electronically Sign”.



Note: If your program requires a co-signature on informational notes, right click → select “Quick Add Signature” → “Add Staff Signature,” select “Supervising/Co-Signer Staff,” and then assign the signature to your supervisor.

3. Select “Final Approve.”

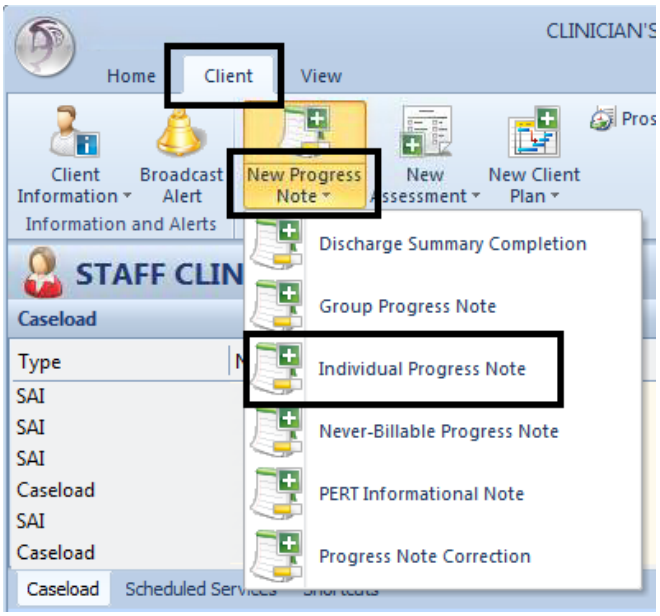


INDIVIDUAL PROGRESS NOTE

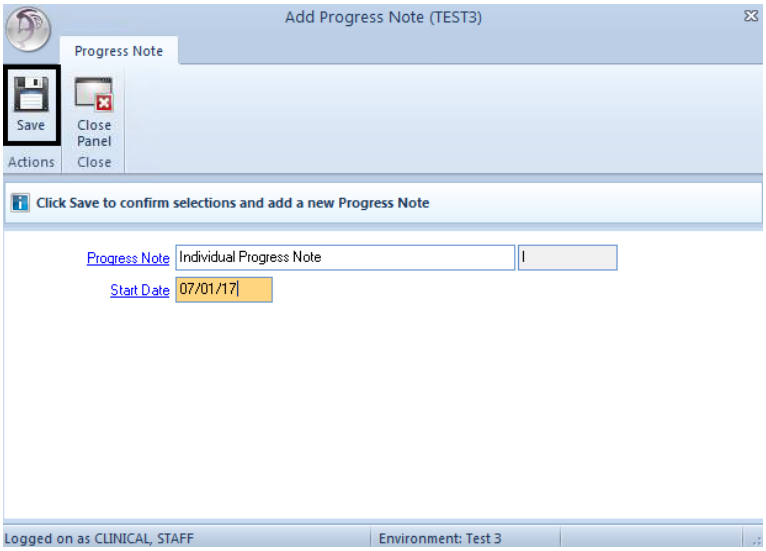
Each individual service provided to a client and/or their family must be documented using an individual progress note (one service, one note). Billing is generated from these types of notes.

To create An Individual Progress Note:

1. Click on the "Client" tab
2. Click on the lower portion of "New Progress Note" button.
3. Select "Individual Progress Note."



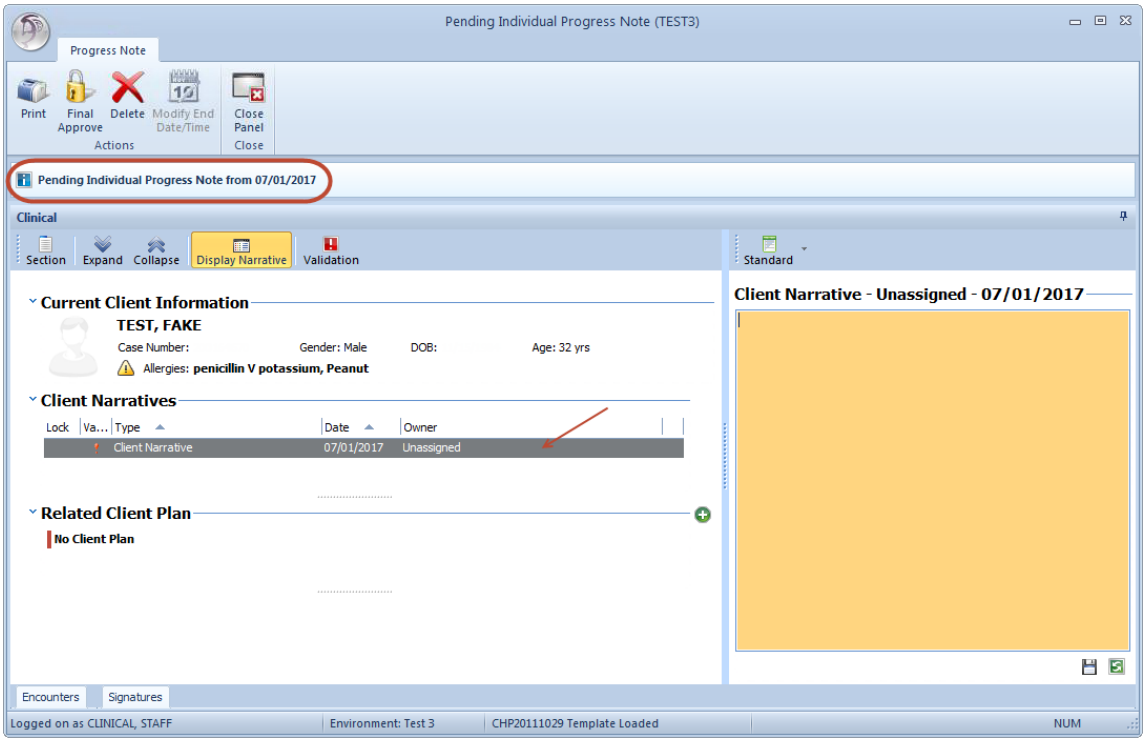
4. The begin date will automatically choose today's date. Be sure to change the date if the encounter took place on a different date. **Be mindful when entering this date, as it cannot be changed.** After selecting the appropriate date, click on the "Save" button.



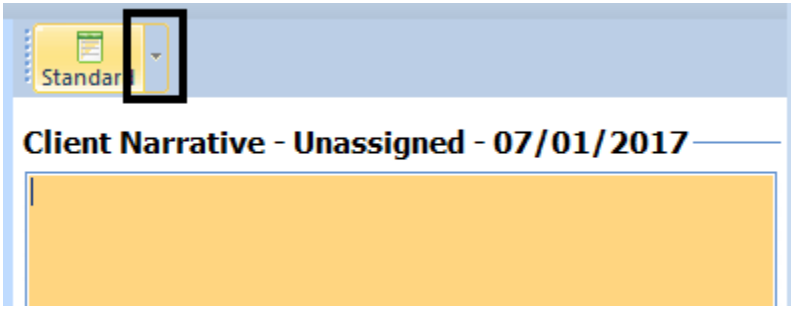
Enter a Narrative in a Progress Note:

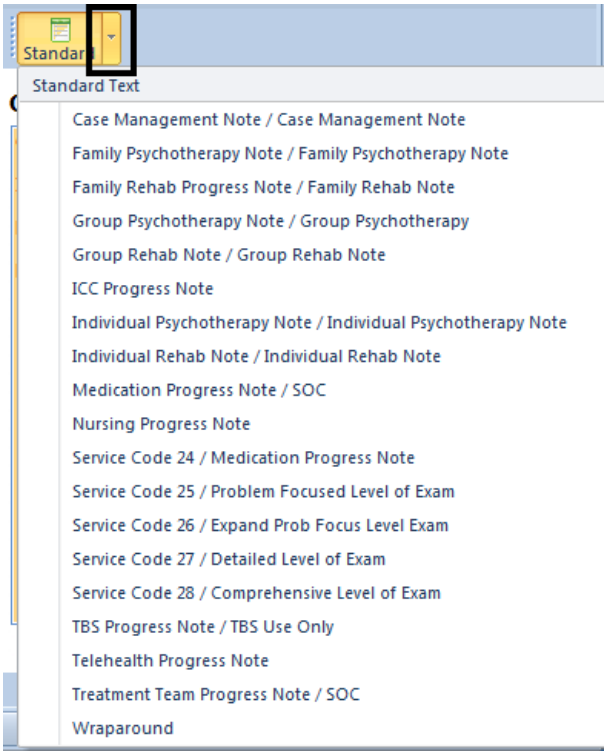
1. The empty note window displays ready for data entry. In the “Pending Individual Progress Note” window, verify the “Date” for the Individual Progress Note. If the date is not correct, select “Delete” and start again.

2. The yellow narrative section indicates you are ready to begin typing. If the section is not yellow, double click anywhere on the “Client Narrative” line to open the narrative for data entry.

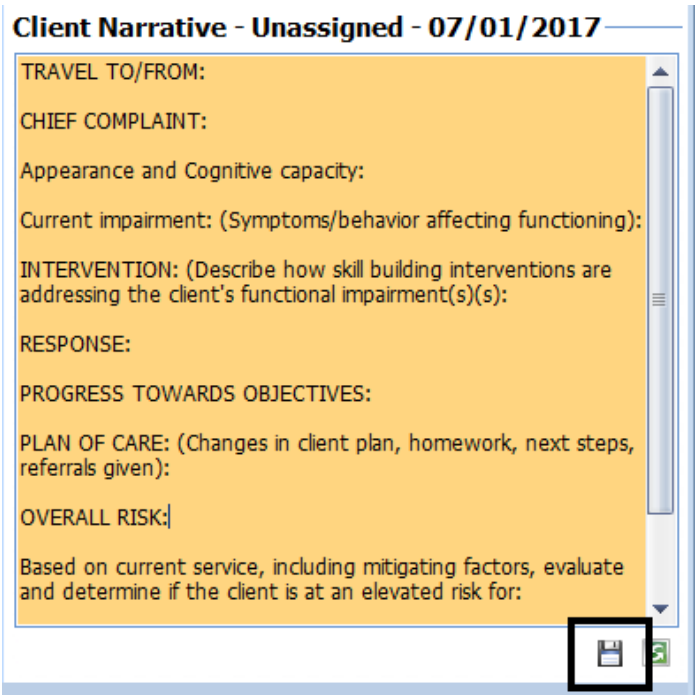


3. To import the standard text template client narrative, click on the down arrow next to the “Standard” button to launch the standard text menu.



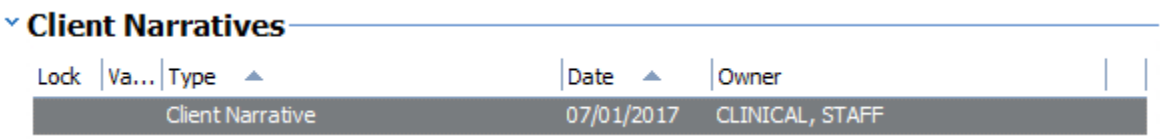


4. Select the appropriate standard text prompt that you wish to populate for the client's progress note.



5. Based on your clinical judgment, clarify and complete all the prompts that have been populated in the narrative section. Once you have completed the narrative entry, select the save icon below.

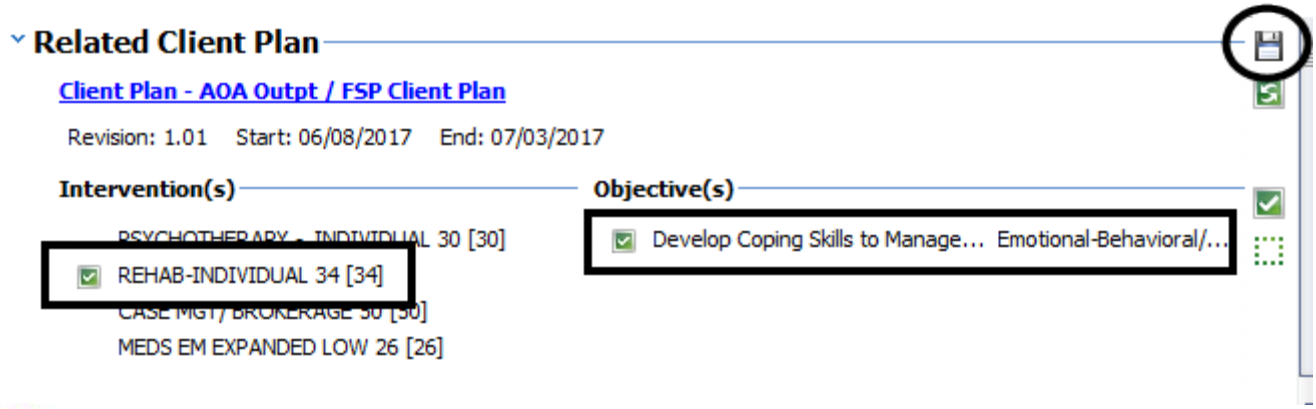
6. Your name will now show as Owner of that narrative.



7. Select the green plus symbol to select which *folder* you would like to store your note in. If there is only one option, it will be auto-selected it for you.

8. If this is a planned encounter, also select the Intervention and the linked Objective from the Client Plan. The green check box will indicate which are selected. Once the correct Client Plan type, Intervention, and Objective are populated, click the save icon. (*It will change to a pen icon once it is successfully saved).*

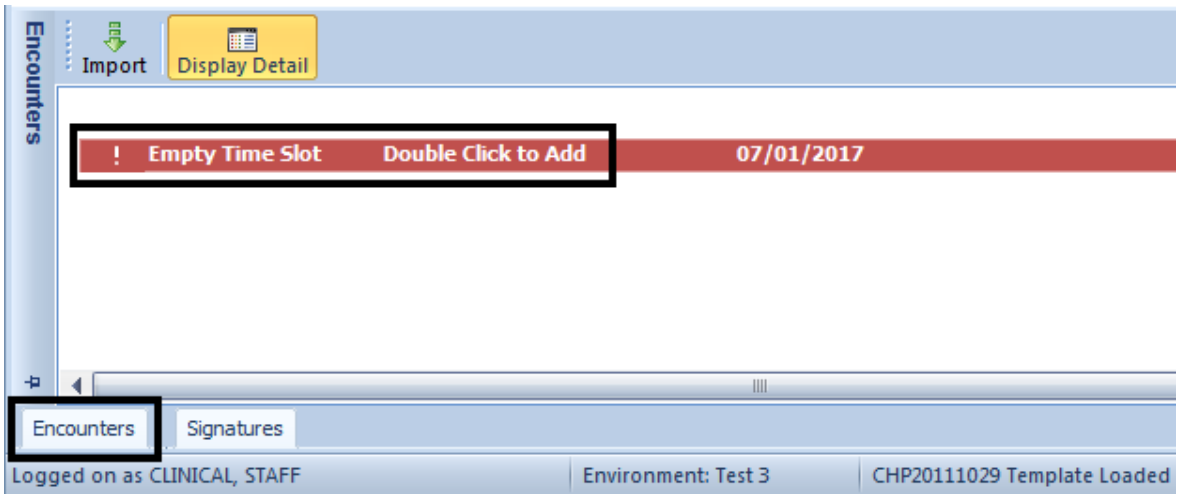
9. If this is an unplanned encounter, select the Client Plan and click the save icon. (*It will change to a pen icon once it is successfully saved).* The Interventions and Objectives shall be left blank.



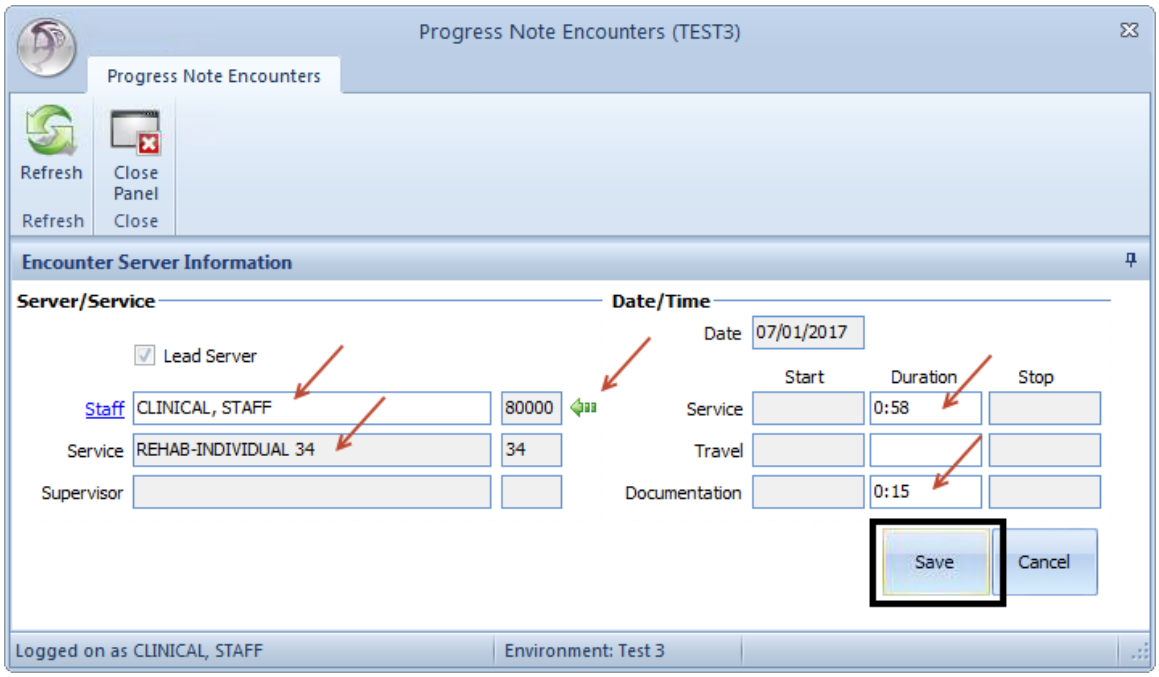
Note: If the intervention is on the Client Plan, but is not selected in the Progress Note, it will be considered ***Unplanned****.*

Enter/Edit a Client Encounter:

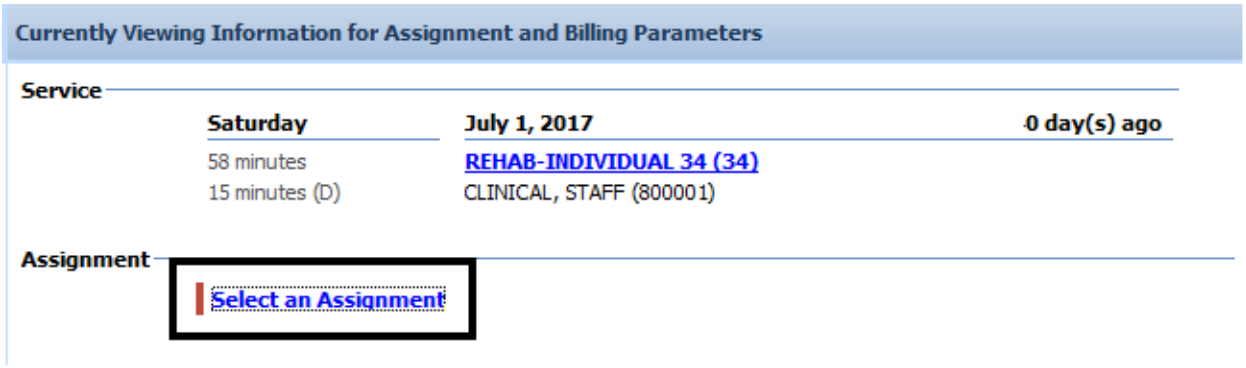
1. Select the “Encounter” pane at the bottom. Double click on the red line to add a client encounter.



2. Click on the green arrow to populate yourself as the server. If you selected an Intervention as a planned encounter in the client plan, it will also populate the service code. If it was an unplanned encounter, enter in the service code. Enter the Service time, Travel time, and Documentation time (as applicable). Then select “Save.”

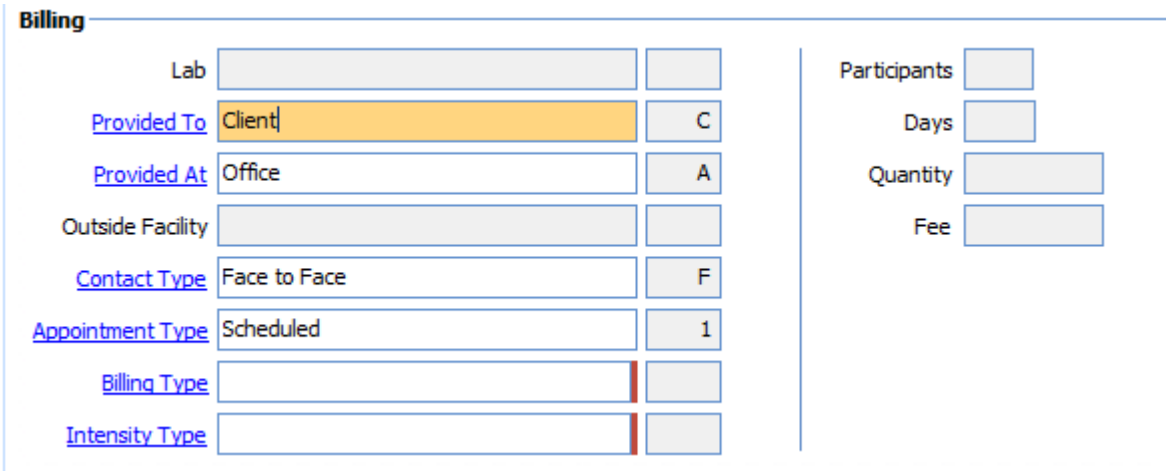


3. Select the blue hyperlink to select the client's assignment. This will link the encounter to your program's Unit and Sub-Unit.



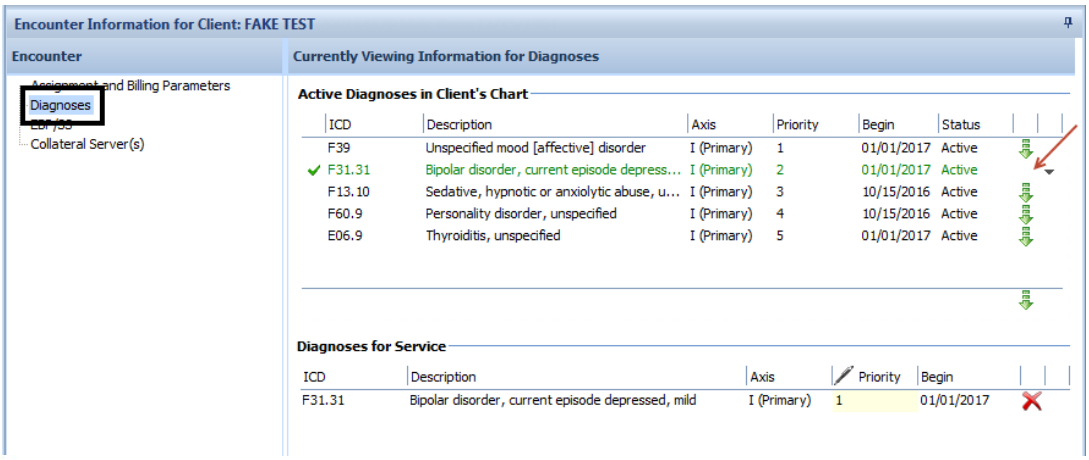
Note: Loaded Assignment for Unit/ Sub-Unit should appear; if not, check the client's assignment to ensure the client is open to your program during the date of service.

4. Check the service indicators to ensure proper documentation, and adjust service indicators accordingly.
    a. In "Billing Type," select the language utilized for the service delivery.
    b. In "Intensity Type," select the type of interpreter utilized for service delivery.



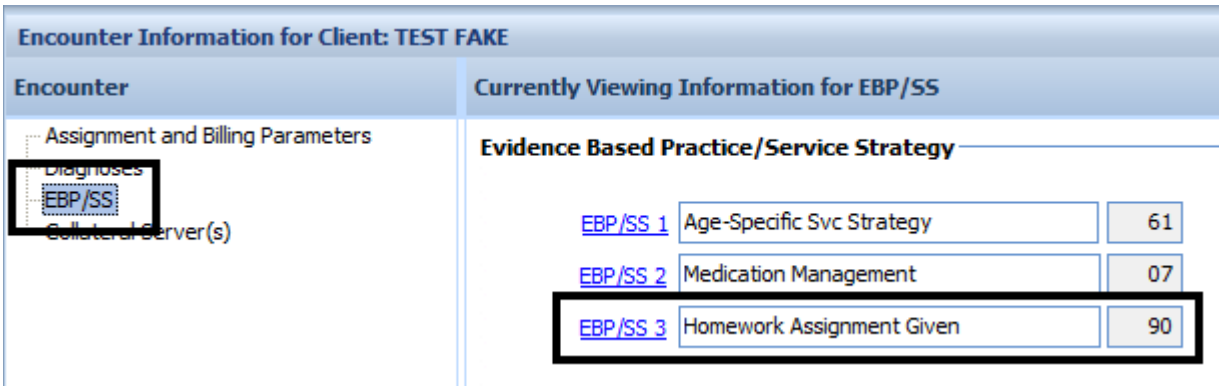
5. Click on “Diagnoses.” In the top portion, all of the client’s active diagnoses on that date of service will pull from the most recent final approved diagnosis assessment. Select the green arrow next to the diagnosis that was the focus of the treatment. The diagnosis will now display in bright green at the top and move to show in the lower portion of the screen. This indicates it is linked to the service.

Note: If a desired diagnosis is not on the list, a new Diagnosis Assessment must be entered. Only diagnoses that were active on the date of service will show.



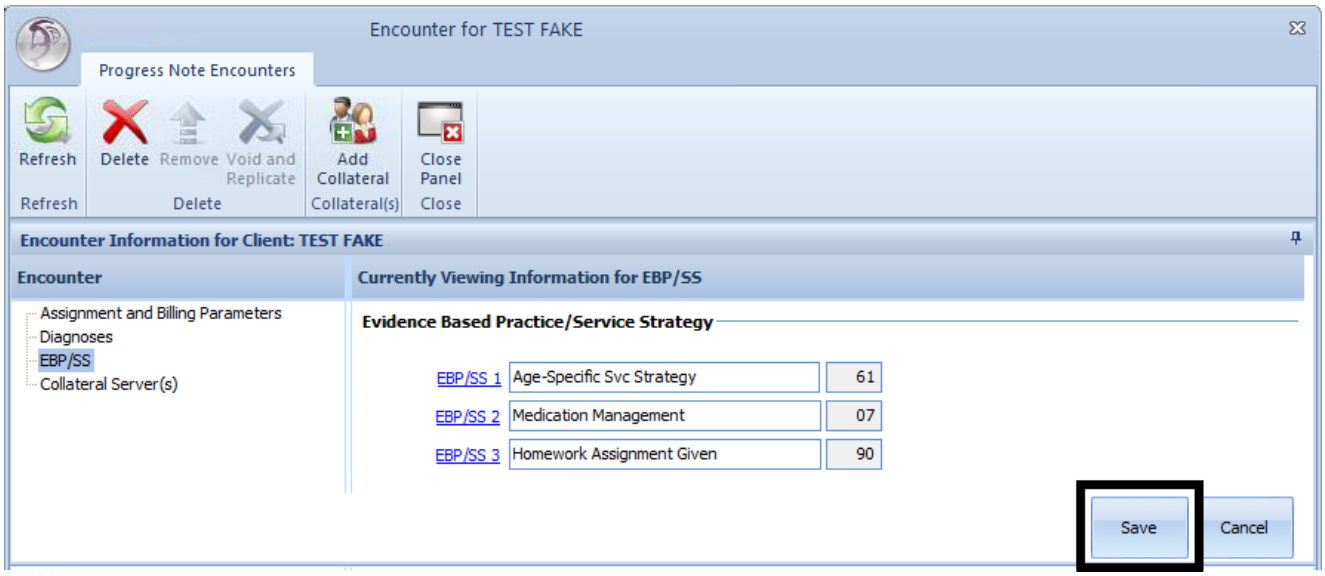
Note: To remove an attached diagnosis, click on the red “X” in the lower portion.

6. If homework was assigned or completed in the course of a mental health service, OR if a Child Family Team meeting was conducted for Pathways to Well Being clients, it must be indicated in the EBP (Evidence Based Practice). You may enter the selection on lines 2 or 3. If all 3 lines are already filled you may remove what populated on default in lines 2 or 3. Selection 1 should always remain what populated. If these 3 options do not apply, staff will skip this step.



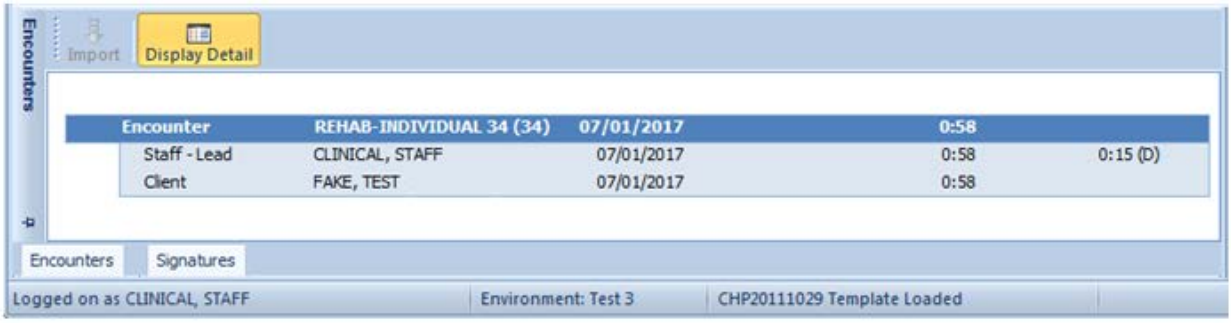
Note: If there was a collateral server- a separate service will be entered to bill for their unique contribution for the specialty mental health service. Do not input their service information in the individual progress note.

7. When all the encounter information is entered and correct, select “Save”.



Note: The “Cancel” button will eliminate all entry for re-entry.

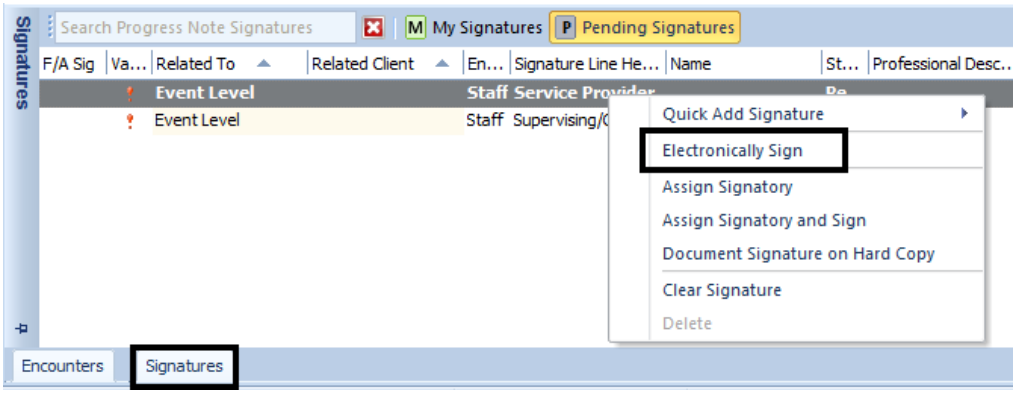
8. After you click on the “Save,” the window closes and the services are displayed on the Encounter pane of the “Individual Progress Note” window. Ensure they are correct as they **cannot be edited after the note is final approved**.



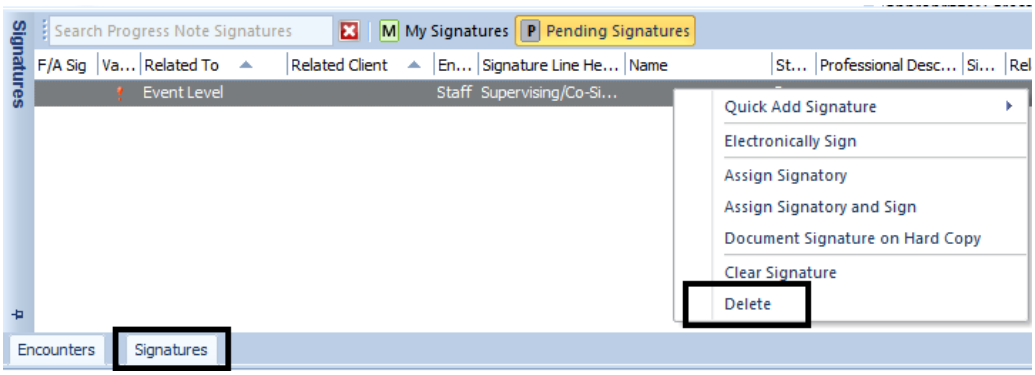
Progress Notes Signatures:

1. Select the “Signatures” pane at the bottom. This will automatically show all pending signatures.

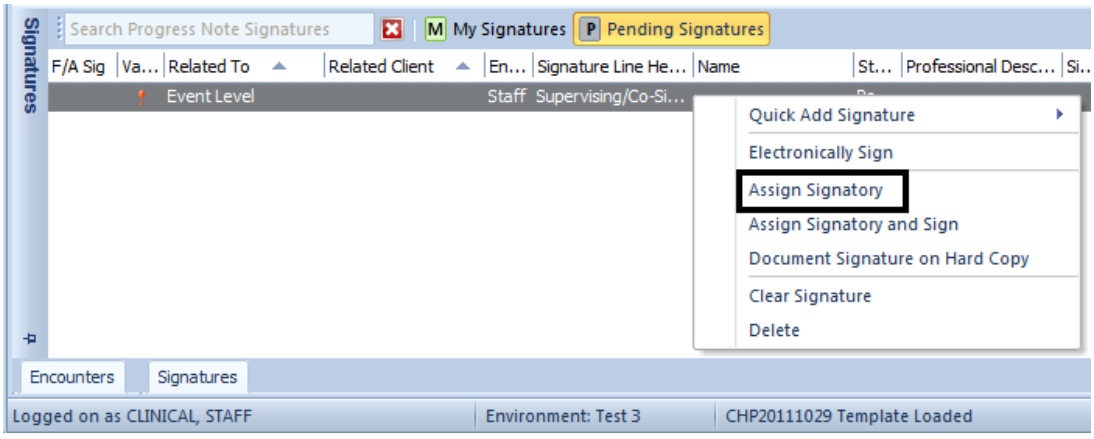
2. Right click on the first line, “Service Provider,” and choose “Electronically Sign”.



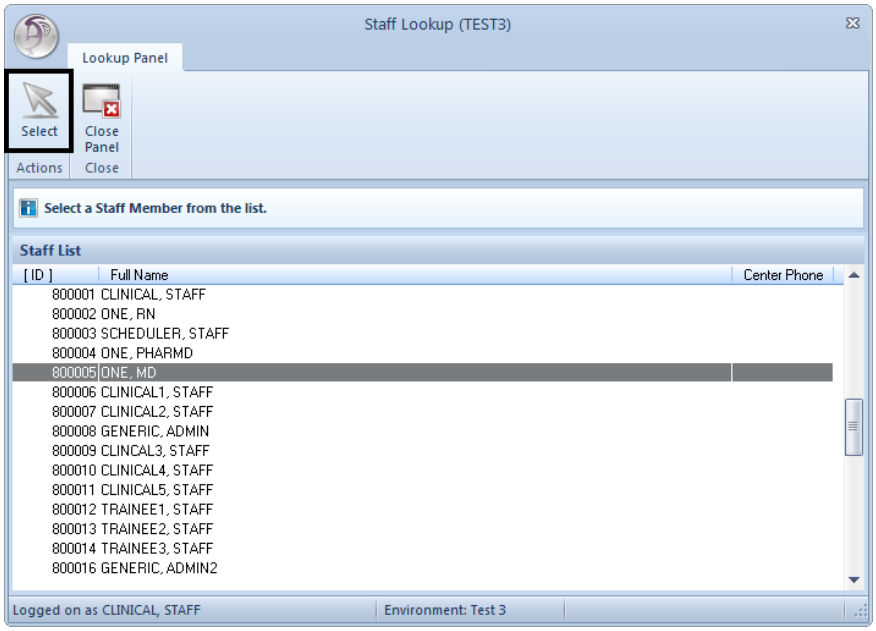
3. On the second signature line:
   a. If you do not need a co signature, right click and select “Delete.”



   b. If you do need a co-signature, right click and select “Assign Signatory”

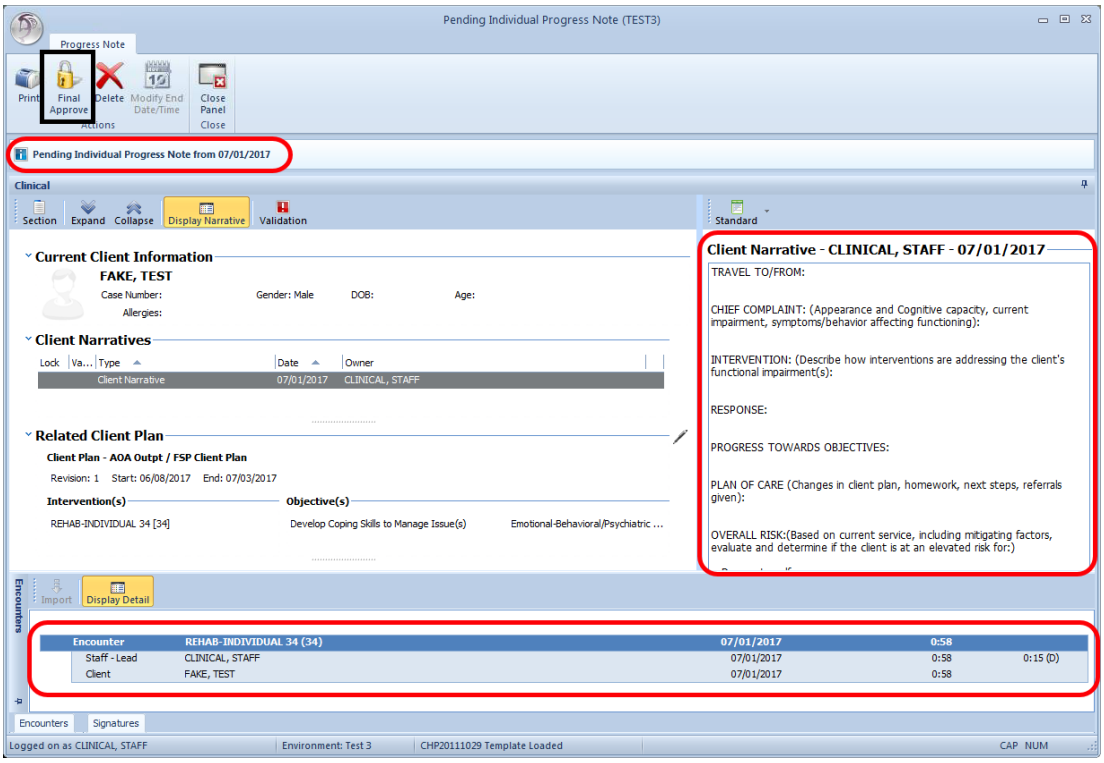


The Staff Lookup" window opens. If you know the CCBH number of the co-signer, begin typing it to search for the staff. If you do not know the number, single click in the "Full Name" column and begin typing, last name first. The "Search: [Full Name]" window appears. Select "OK" when you've completed typing the co-signer's name/staff ID. Click "Select" at the top once your desired staff is selected. The staff's name will populate. Close the panel so the co-signer may review the note.



Final Approve the Progress Note:

1. Once all signatures are complete, verify the date, encounter information, and narrative are **complete and correct**, select "Final Approve."



GROUP PROGRESS NOTES

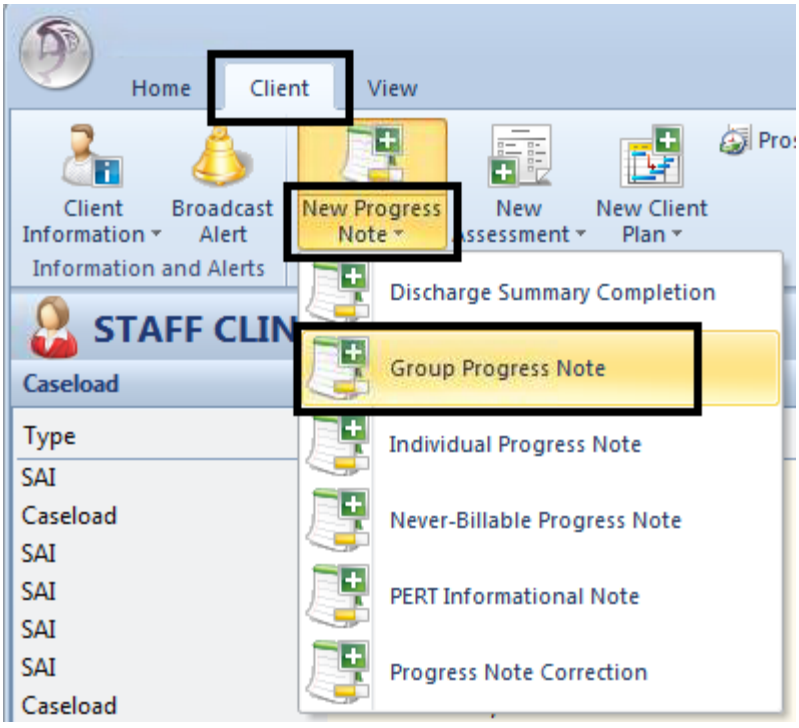
Group Progress Note:

Group progress notes are used for services that include multiple clients such as group psychotherapy, group rehab, collateral group, etc. Billing is generated from these types of notes.

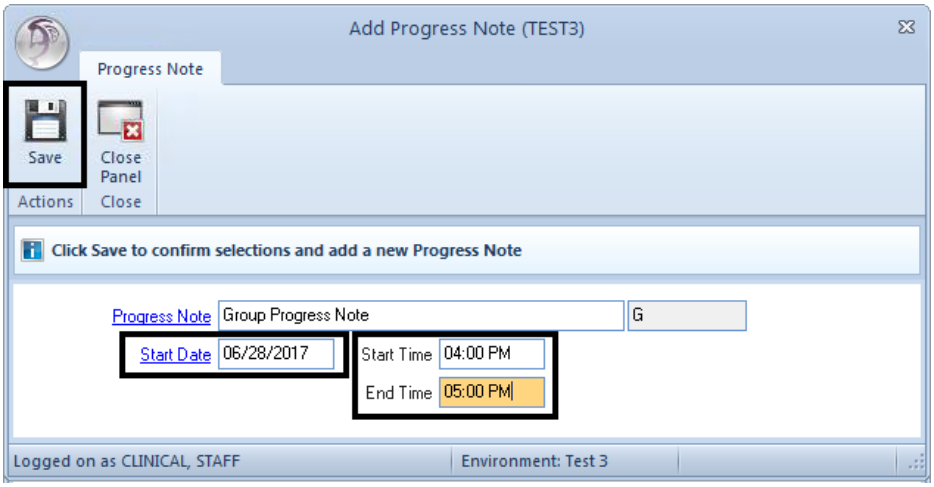
Note: A client plan type should be in place for **all** clients attending the group before you create a group progress note.

Accessing New Group Note

1. Click on the "Client" tab.
2. Click on the lower portion of "New Progress Note" button.
3. Select "Group Progress Note."

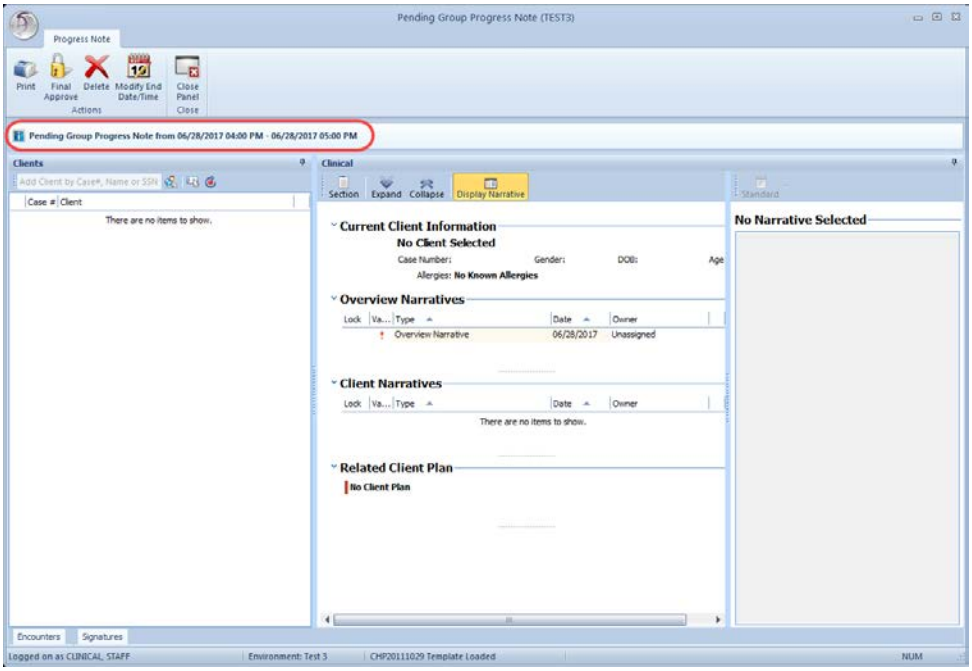


4. The begin date will automatically choose today's date. Be sure to change the date if the encounter took place on a different date. **Be mindful when entering this date, as it cannot be changed.** Enter in the start and end time of the group. The system defaults to the A.M., so add a "P" for P.M. time. **Be mindful when entering the time, as it cannot be changed.** After selecting the appropriate date and time, click on the "Save" button.



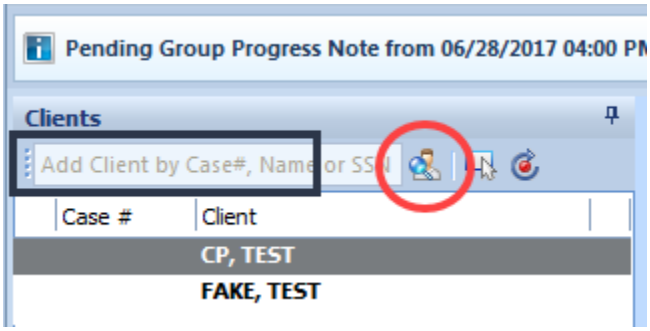
5. The empty note window displays ready for data entry.

6. In the "Pending Group Progress Note" window, verify the date and time are correct. If the date and or time are not correct, select "Delete" and start again.



Adding Clients:

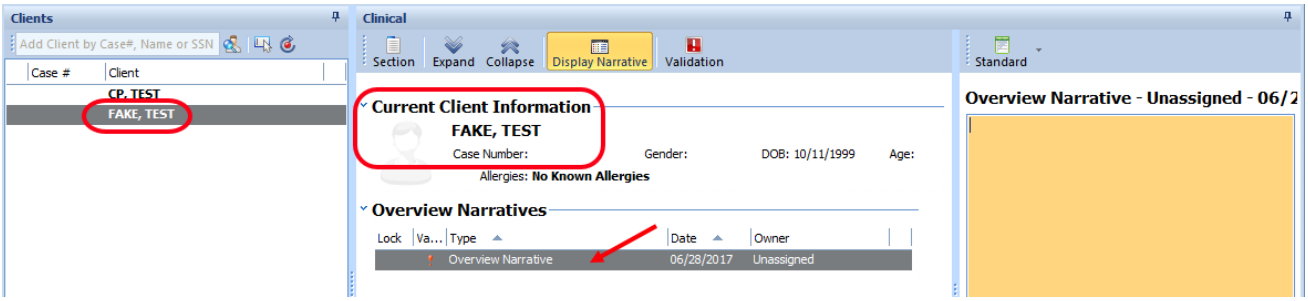
1. Add clients by entering the client's case number, and selecting "Enter" on your keyboard. If you do not have the case number(s) utilize the client search icon. When the client is successfully added to the group, their name will display.
2. Repeat this step for each client in the group.



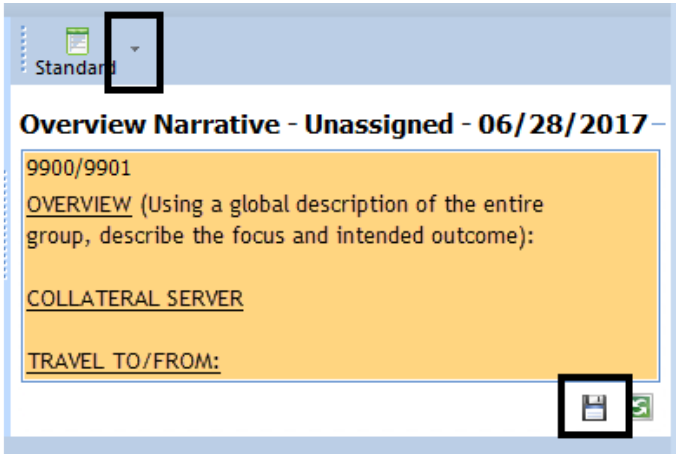
Adding Clinical Narratives:

There are two narrative sections in the Group Progress note. The Overview Narrative is for the overview of the group. The Client Narrative details the specific client's mood, safety issues, participation in group, progress towards individual goals, etc.

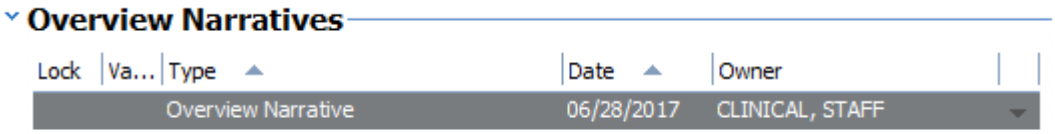
1. The client selected in gray on the list to the left indicates which client chart you are documenting in. The client's name will also be listed in the center of the note.
2. The "Overview Progress Note" section is where you provide a general description of the overall focus of the group for all participants. In this section, you would include the objective(s) for the group and the anticipated outcome(s). Double click anywhere on the "Overview Narrative" line to open the narrative for data entry. The yellow narrative section indicates you are ready to begin typing.



3. Import the standard text template for the Overview Narrative, by selecting the arrow. Based on your clinical judgment, clarify and complete all the prompts that have been populated in the narrative section. Select the save icon at the bottom of the narrative.

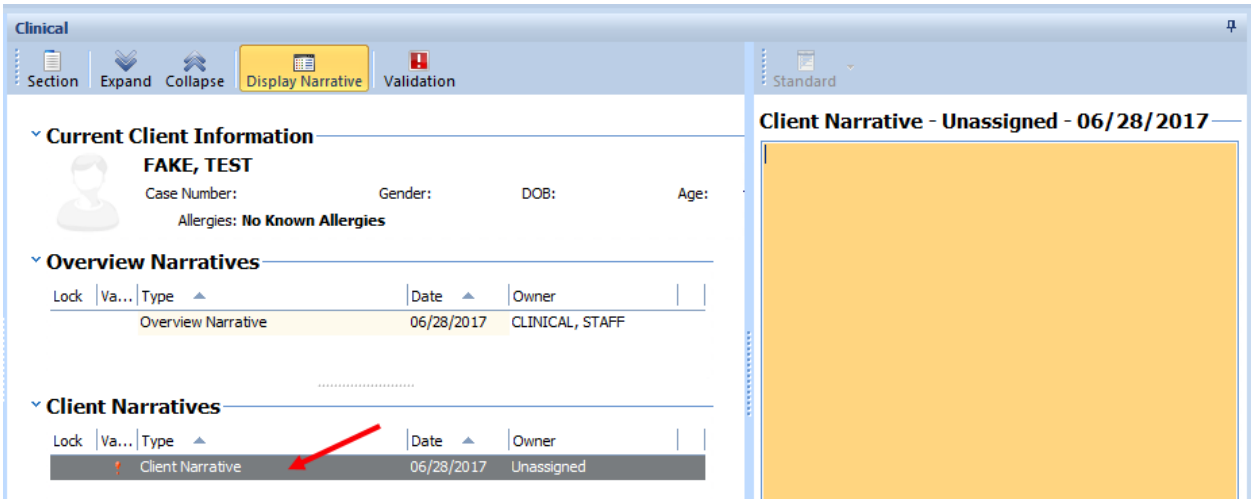


4. Your name will now show as Owner of the narrative.

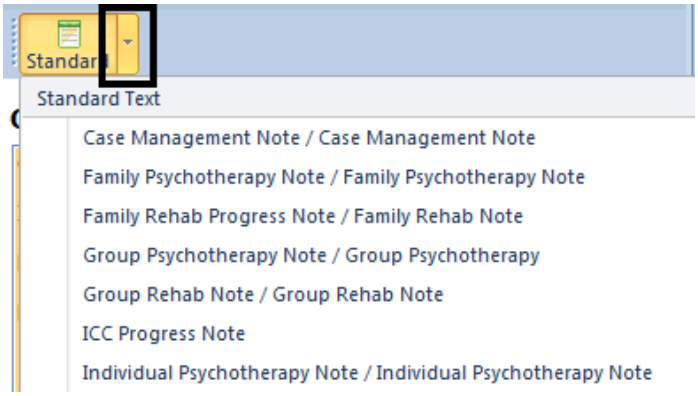


5. When the Group Overview has been written for one client and saved, it will pre-populate in the progress notes for all other clients in the group.

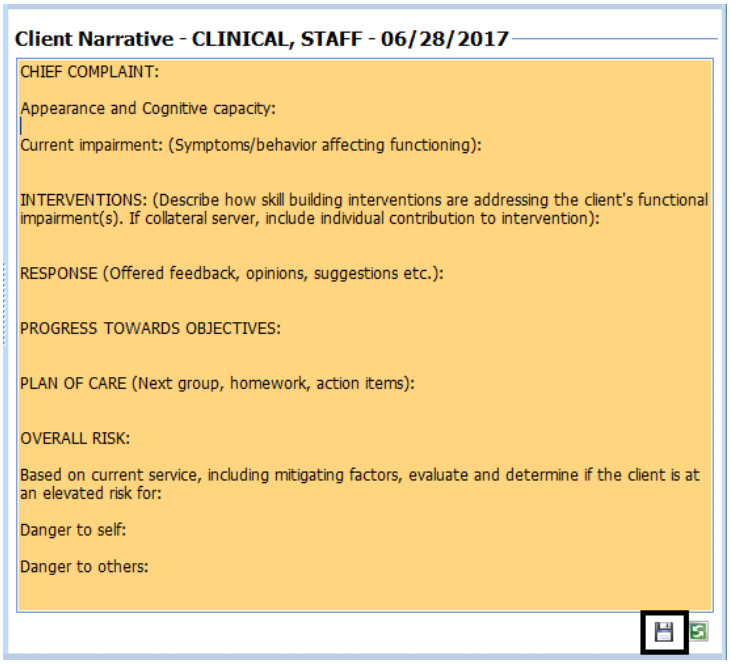
6. The “Client Narratives” section is where you document the specifics of the individual client’s participation in the group. Double click anywhere on the “Client Narrative” line to open the narrative for data entry. The yellow narrative section indicates you are ready to begin typing.



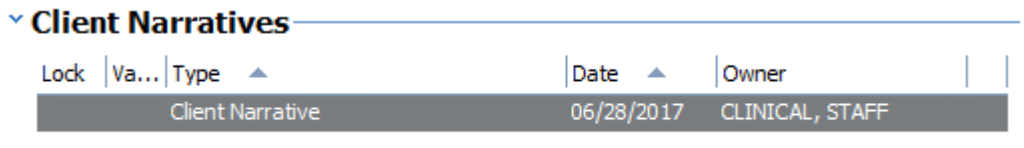
7. Import the “Standard Text” by selecting the arrow. Select the most appropriate option for help text on the type of information to include in your documentation.



8. Based on your clinical judgment, clarify and complete all the prompts that have been populated in the text window. Select the save icon at the bottom of the narrative.



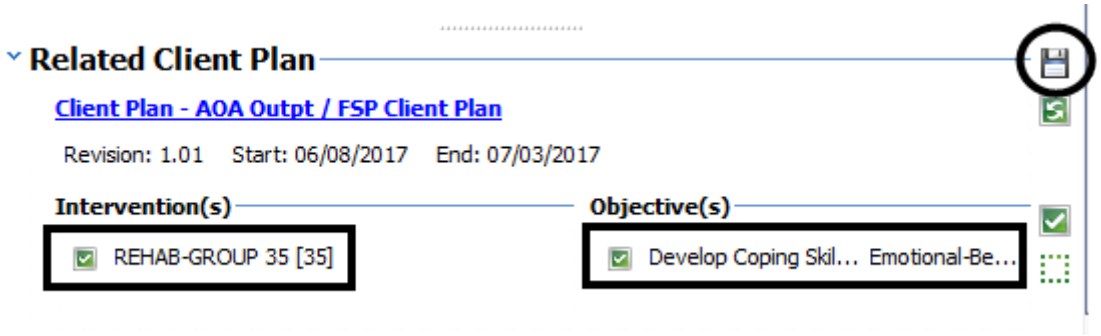
9. Your name will show as Owner of the narrative.



10. Select the green plus symbol, under “Related Client Plan” to select which *folder* you would like to store your note in. If there is only one option, it will be auto-selected it for you.

10. If this is a planned encounter, also select the Intervention and the linked Objective from the Client Plan. The green check box will indicate which are selected. Once the correct Client Plan type, Intervention, and Objective are populated, click the save icon. (*It will change to a pen icon once it is successfully saved).*

11. If this is an unplanned encounter, select the Client Plan and click the save icon. (*It will change to a pen icon once it is successfully saved).* The Interventions and Objectives shall be left blank.

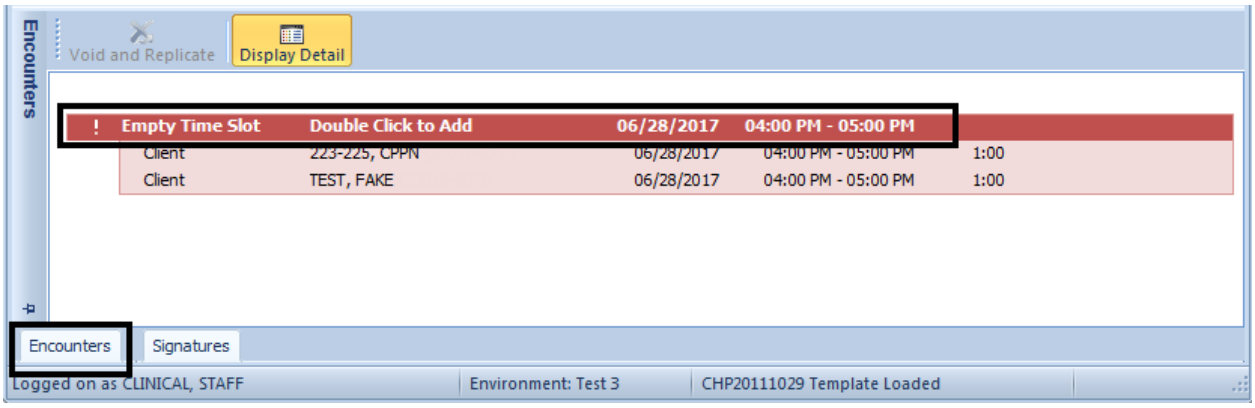


Note: If the intervention is on the Client Plan, but is not selected in the Progress Note, it will be considered ***Unplanned****.*

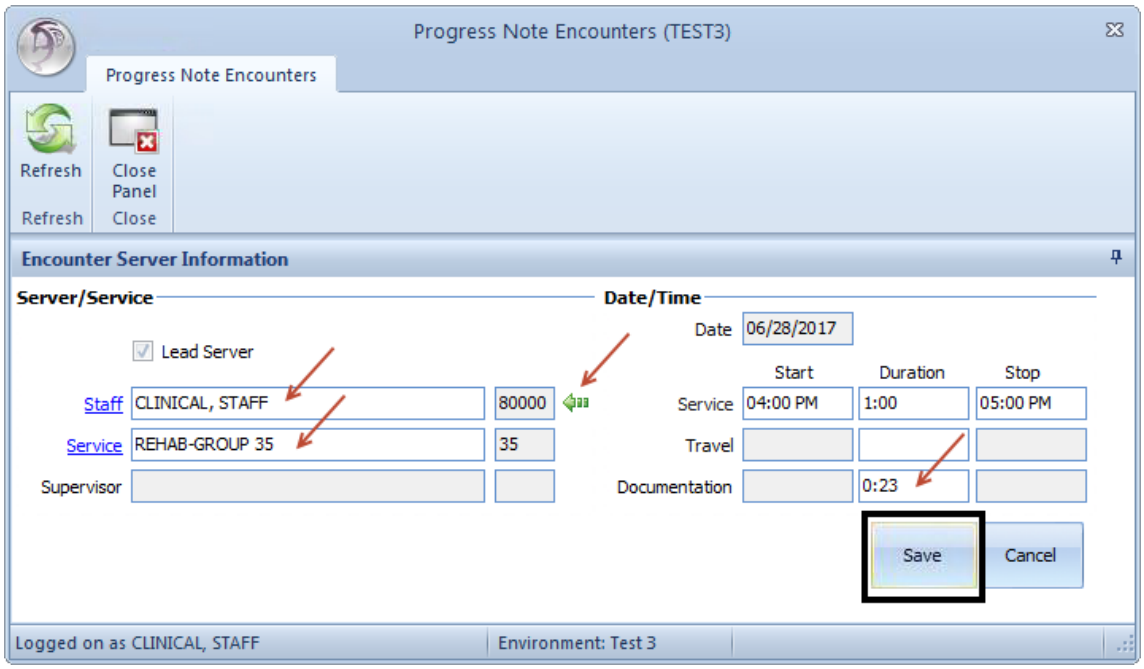
11. Select the next client in the group and repeat steps 6-10. Complete the documentation for each client in the group.

Enter/Edit the Client Encounter:

1. Select the “Encounter” pane at the bottom. Double click on the red line to add the server information.

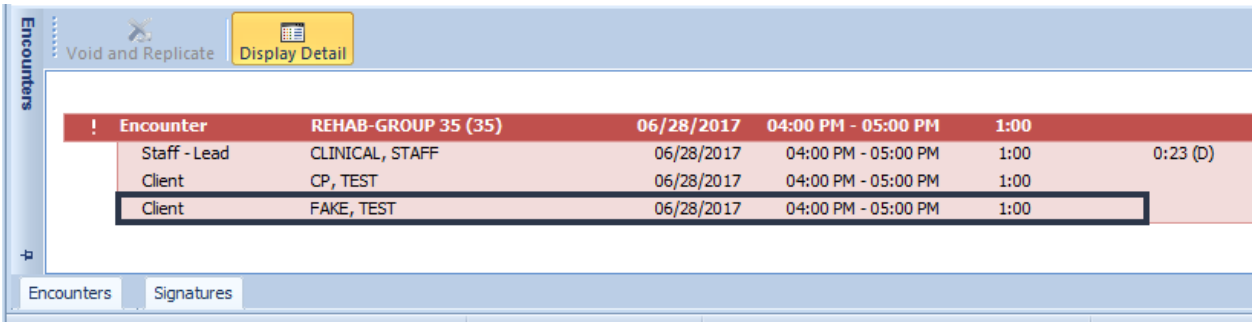


2. Click on the green arrow to populate yourself as the server. Enter in the service code. The Service time will prepopulate from the group start and stop time. Enter the Travel time and Documentation time (as applicable). Then select “Save.”

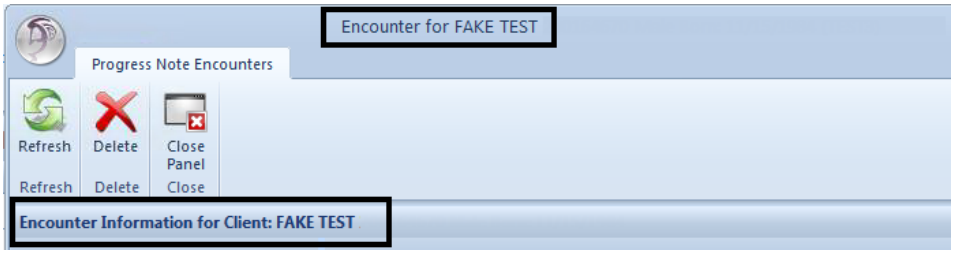


Note: If a collateral server was utilized, make sure there is a valid reason to have a collateral server and it is documented well. The billing information for the collateral server should be entered as an 815 service code, by the administrative staff.

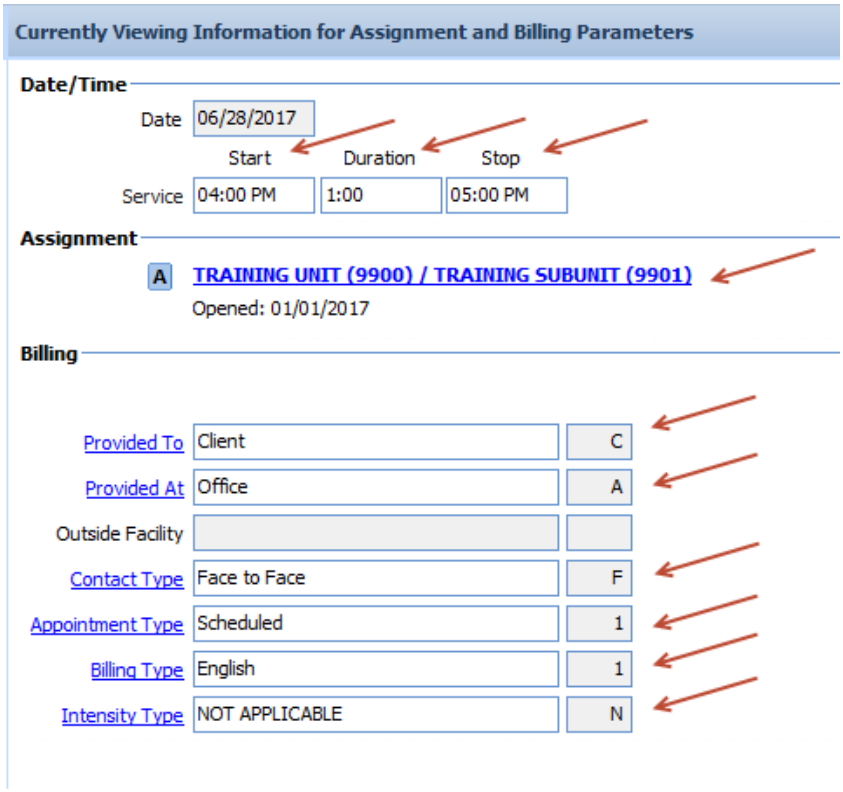
3. Double click on a client to add the client encounter.



4. You can verify which client chart you are working in by looking at the top of the encounter:

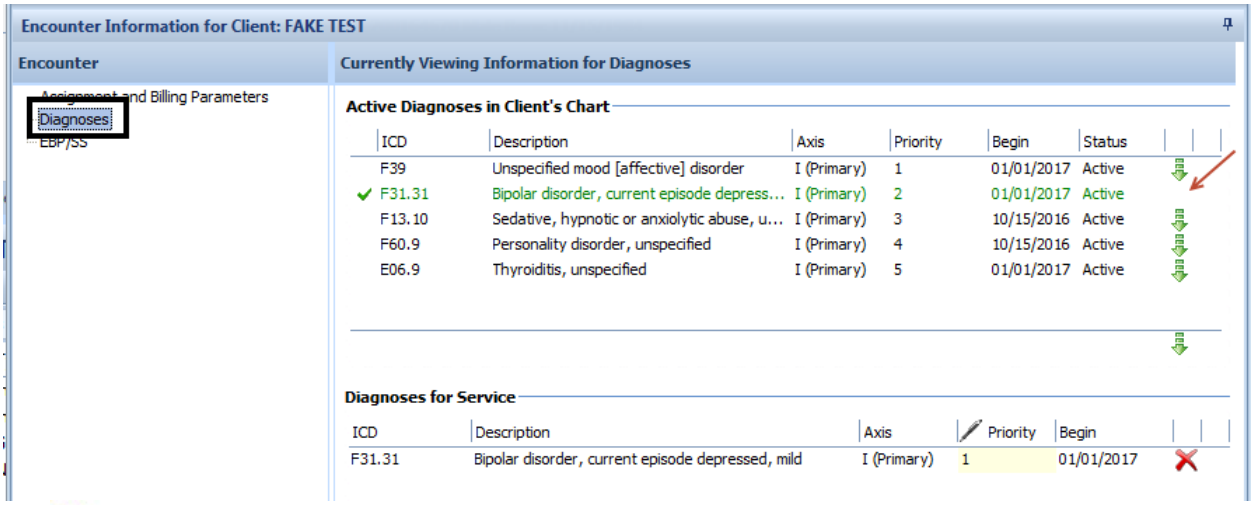


5. Billing information will appear. Check the service time, assignment, and billing indicators to ensure proper documentation, and adjust accordingly.
    a. In “Billing Type,” select the language utilized for the service delivery.
    b. In “Intensity Type,” select the type of interpreter utilized for service delivery.



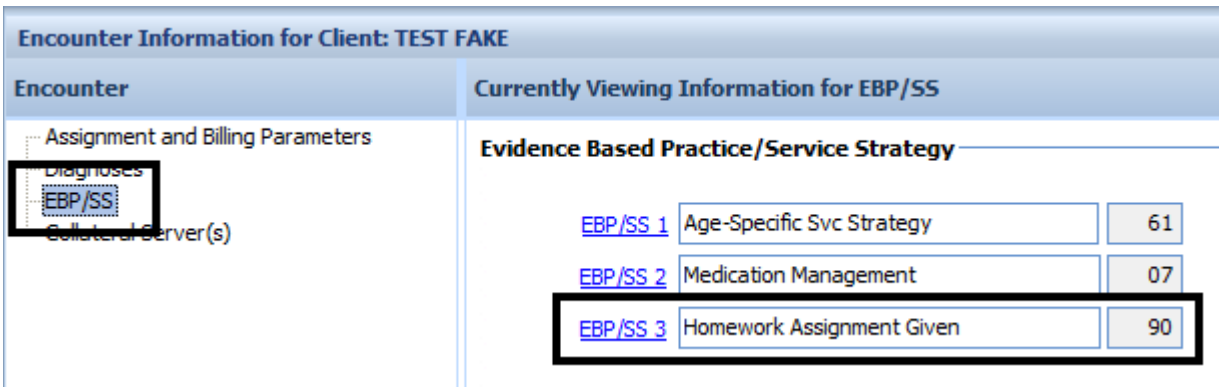
6. Click on “Diagnoses.” In the top portion, all of the client’s active diagnoses on that date of service will pull from the most recent final approved diagnosis assessment. Select the green arrow next to the diagnosis that was the focus of the treatment. The diagnosis will now display in green at the top and move to show in the lower portion of the screen. This indicates it is linked to the service.

Note: If a desired diagnosis is not on the list, a new Diagnosis Assessment must be entered. Only diagnoses that were active on the date of service will show.



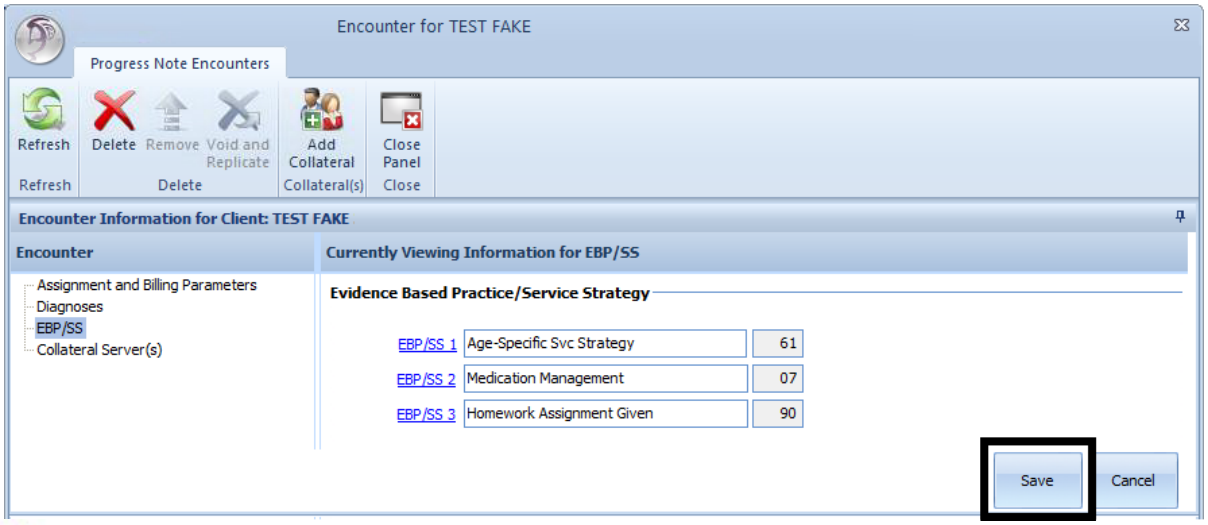
Note: To remove an attached diagnosis, click on the red “X” in the lower portion.

7. If homework was assigned or completed in the course of a mental health service, OR if a Child Family Team meeting was conducted for Pathways to Well Being clients, it must be indicated in the EBP (Evidence Based Practice). You may enter the selection on lines 2 or 3. If all 3 lines are already filled you may remove what populated on default in lines 2 or 3. Selection 1 should always remain what populated. If these 3 options do not apply, staff will skip this step.



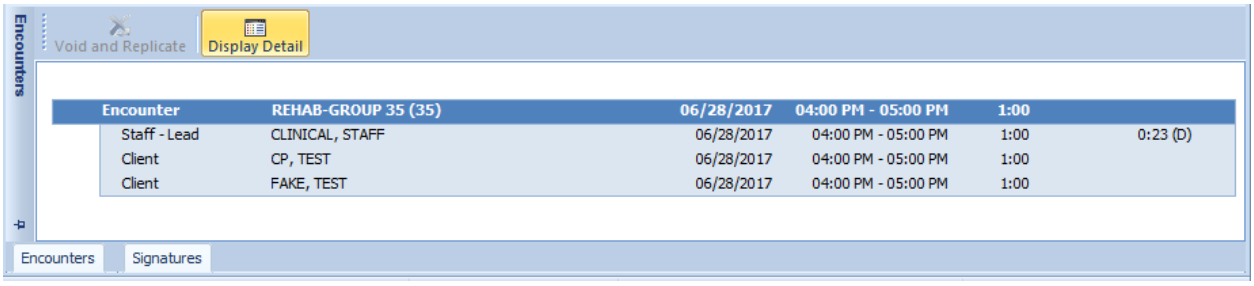
Note: Pay attention to the following things: A) Time for each client auto populates. "Start", "Duration", and "Stop" times can be changed as necessary. *B) Each client can have an individual start and end time. C) Verify billing indicators (Prov. To, Prov. At, etc.) D) Verify the correct diagnosis is linked to the service.*

8. When all the encounter information is added, select "Save".



Note: The "Cancel" button will eliminate all entry for re-entry.

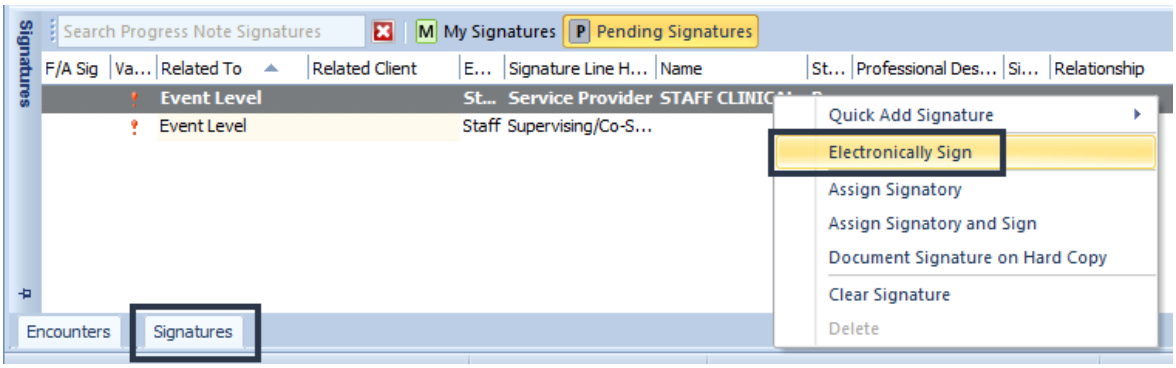
9. Repeat steps 3-8 until encounter information is added for each client. When all information has been added the encounter will display in blue.



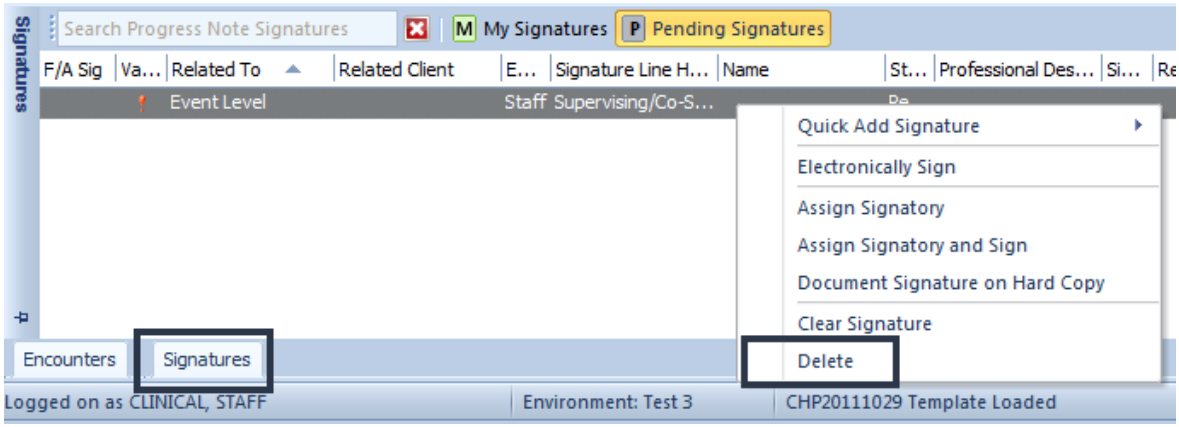
Progress Notes Signatures:

1. Select the “Signatures” pane at the bottom. This will automatically show all pending signatures.

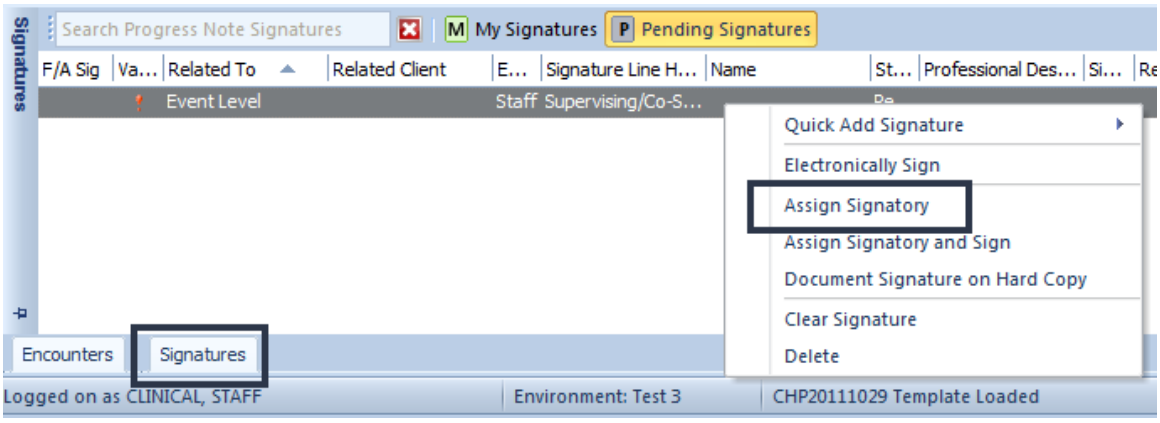
2. Right click on the first line, “Service Provider” and choose “Electronically Sign”.



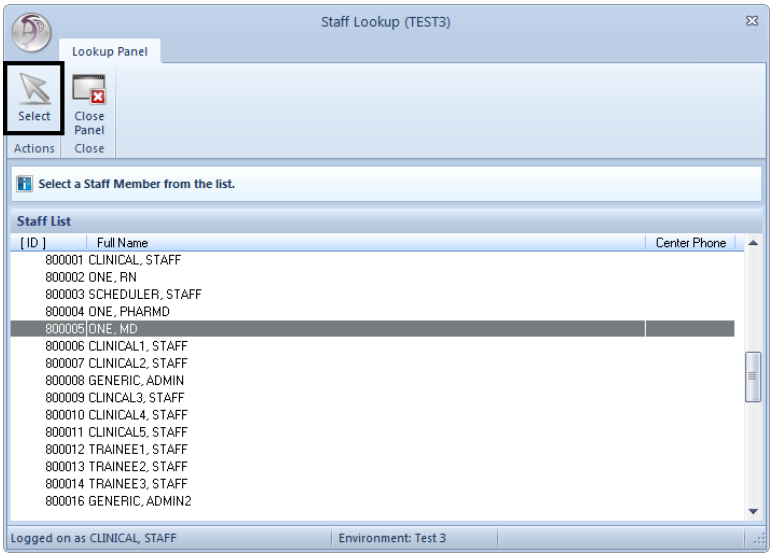
3. On the second signature line:
   a. If you do not need a co signature, right click and select “Delete.”



   b. If you do need a co-signature, right click and select “Assign Signatory.”

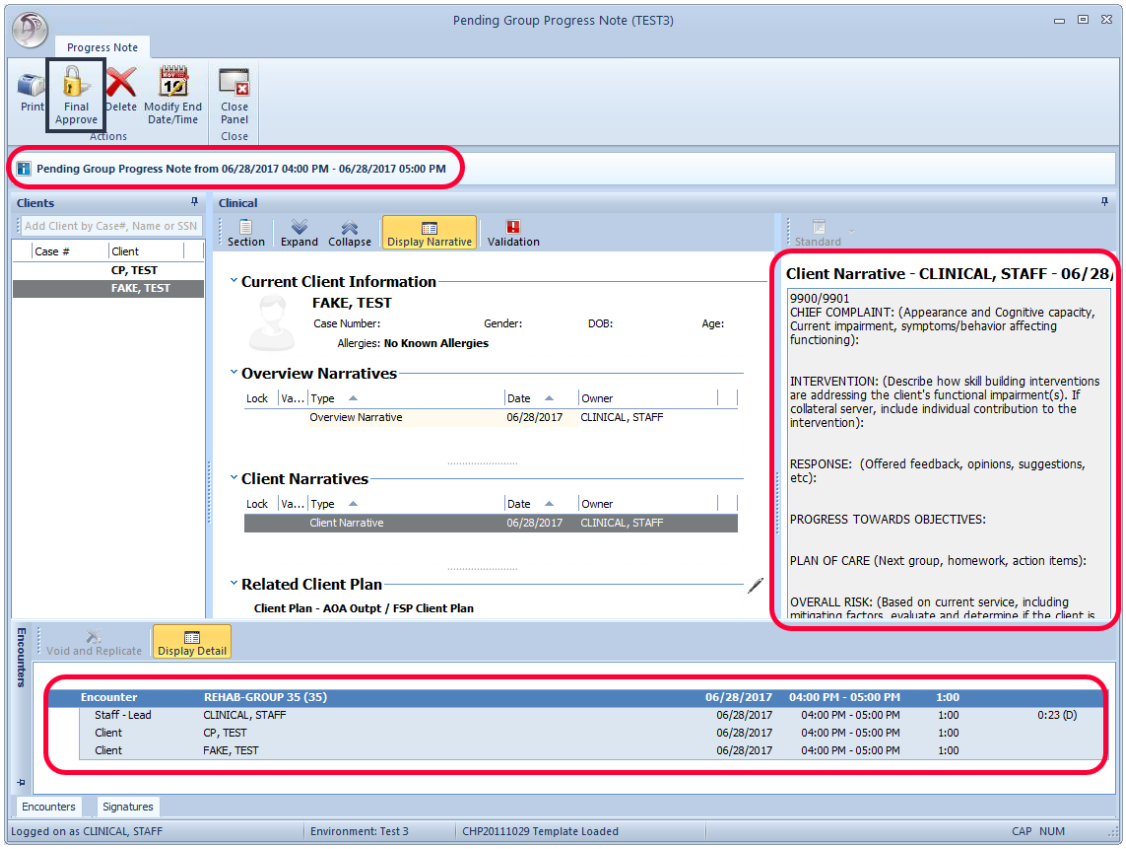


i. The Staff Lookup" window opens. If you know the CCBH number of the co-signer, begin typing it to search for the staff. If you do not know the number, single click in the "Full Name" column and begin typing, last name first. The "Search: [Full Name]" window appears. Select "OK" when you've completed typing the co-signer's name/staff ID. Click "Select" at the top once your desired staff is selected. The staff's name will populate. Close the panel so the co-signer may review the note.



Final Approve the Progress Note:

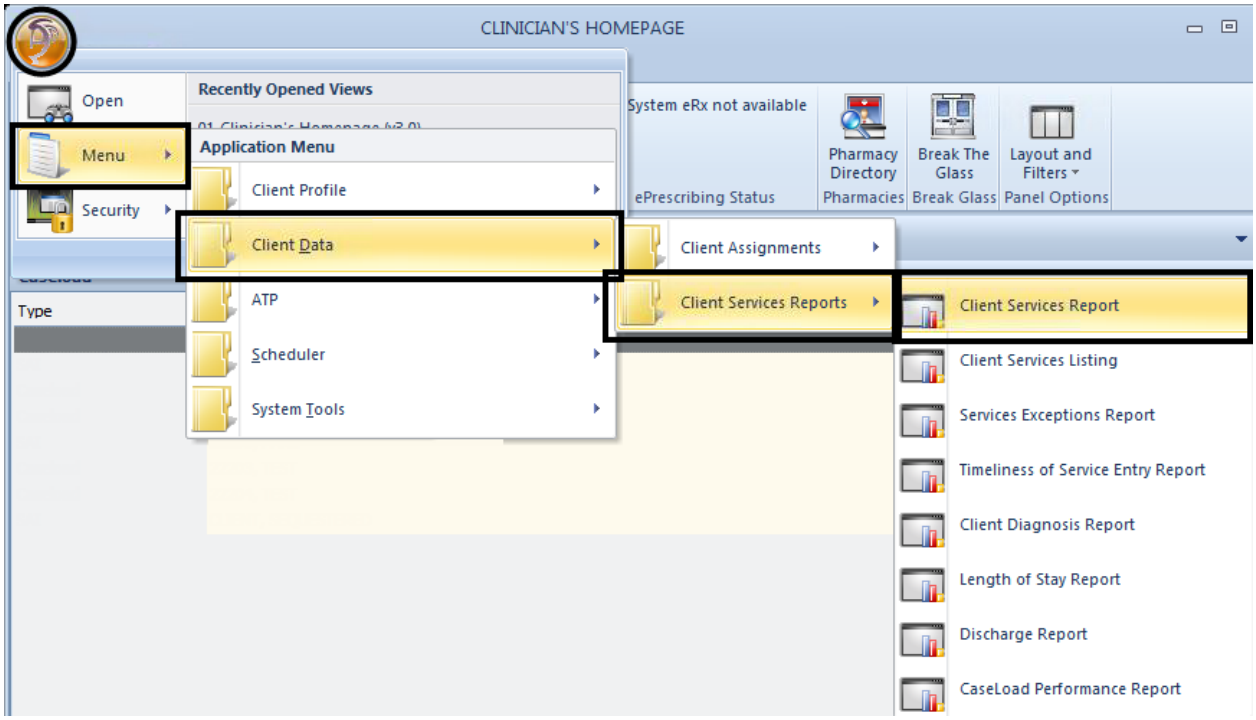
1. Once all signatures are complete, verify the date, encounter information, and narratives are **complete and correct**, select "Final Approve."



Report for Services

The report listed below may be utilized for monitoring and maintenance of and Services. Only designated staff in each program will have access to the reports that they are authorized to use. For additional assistance with approved template reports, please contact the Optum Support Desk at 1-800-834-3792.

SERVICES REPORT

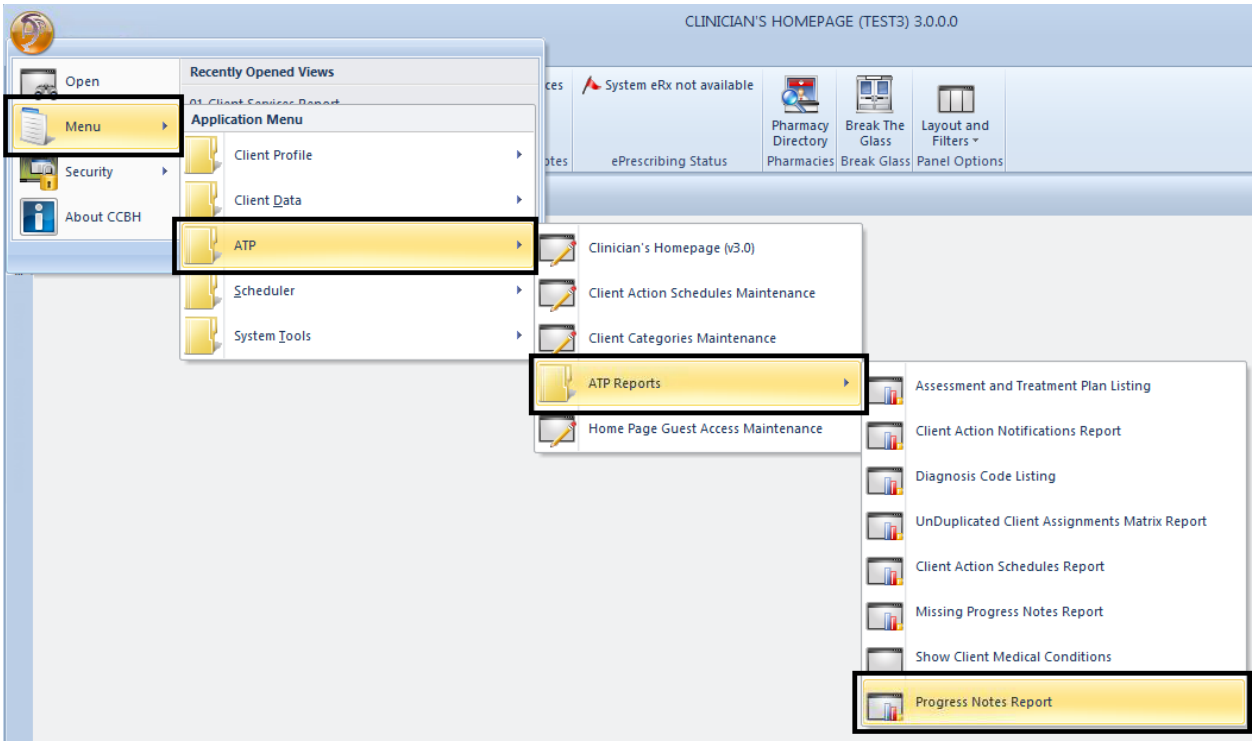


Productivity By Service Code And Server

This report captures the number of services and service hours listed by service codes and subtotaled by Server for a specific date range. It is run by the SubUnit and sorted by Server with a page break between Servers.

1. Locate Client Services Report on the menu toolbar.
2. Select “Load” on the Client Services Report screen.
3. Highlight “Productivity by Service Code and Server” from the template list and select “Load.”
4. On Selections 3 tab, enter Unit and SubUnit.
5. On Selections 5 tab, enter Unit and SubUnit.
6. On Selections 8 tab, enter a date range in the “Date Range” and “Thru” fields for the period of productivity desired.
7. Other tabs and fields are pre-set for the template.
8. Select “Print” to print the report.

PROGRESS NOTE REPORTS



Progress Notes Report

The Progress Note Report is a simple but effective way to identify progress notes that have not been final approved. All types of progress notes that are not final approved will populate on this report.

1. Locate Progress Notes Report on the menu toolbar.
2. Select “Load”.
3. Highlight “Non-Final Approved Progress Notes Report” from the template list and select “Load.”
4. On Selections 1 tab, enter a date range in the “Progress Note Start Dates” and “Thru” fields for the period desired. Enter in your staff ID in the “Staff Signature” field.
5. On Selections 2 tab, enter Unit and SubUnit.
6. Select “Print” to print the report.

EXPECTATIONS AFTER TRAINING

- Progress notes will be entered in CCBH immediately after training (per staff and not by program).

- Plan for the transition
    - When staff return from training, they need to have a lower number of client contacts initially so that they can begin using CCBH right away.
    - Review caseloads.
    - Allow time for clinicians to practice and receive needed technical support.
    - Use monitoring tools to support staff.

PROGRESS NOTE CORRECTION RESOURCES ON THE OPTUM WEBSITE

- The Progress Note Correction Request Form(s).

- The Progress Note Correction Materials for individual notes and group notes for both clinical staff and administrative staff.

- The matrix of the full correction process for both individual and group notes.

- Video tutorials of common correction processes from start to finish.

- Billing Correction Tutorials

If you have questions on progress note corrections, or need assistance in the correction process, call the Optum Support Desk

Support Desk Contact Information

sdhelpdesk@optum.com
1-800-834-3792

Monday through Friday (E-mail)

Hours	Services
6:00 am to 6:00 pm	All services except password resets or any service involving PHI

Monday through Friday (Telephone)

Hours	Services
4:30 am to 6:00 am	Resetting passwords (24 hour programs) and reporting system outages*
6:00 am to 6:00 pm	All services
6:00 pm to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*
11:00 pm to 4:30 am	Reporting system outages*

Weekends (Telephone)

Hours	Services
4:30 am to 11:00 pm	Resetting passwords (24 hour programs) and reporting system outages*
11:00 pm to 4:30 am	Reporting system outages*

* By definition, a system outage affects multiple users. Examples include when:
-The system does not respond and appears to be frozen
-No data can be entered or viewed

Support Desk Suggestions

- Please consult with your program manager and your resource packet prior to contacting the Support Desk.
- When calling for a password reset on weekdays between 4:30-6a or 6-11p, or calling weekends between 4:30a-11p, you must leave a message. Include your name, CCBH staff ID, phone number and the reason for your call.
- You may be given a ticket/tracking number if you call between 6:00a and 6:00p Monday through Friday. Remember to keep this number for future reference.

Additional Contacts

Questions	Where To Go
Clinical Documentation Questions	Documentation Manual/Your Program Manager
Duplicate Clients and Name/DOB/Gender/SSN Changes	Complete Form BHS-025 and Call Medical Records: 619-692-5700 x 3
Financial Questions (UMDAP/Insurance)	Billing Unit: 619-338-2612 Fax- 858-467-9682
Online User Manuals and Forms	www.optumsandiego.com
Service Codes	CCBH (Anasazi) User Manual/QM Unit