



State of California—Health and Human Services Agency
Department of Health Care Services

Mental Health Services Division
Medi-Cal Billing Manual

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CHANGES / UPDATES FROM PREVIOUS VERSION (JULY 2008)

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CHANGES / UPDATES FROM PREVIOUS VERSION (JULY 2008)

SECTION	DESCRIPTION OF CHANGE AND/OR UPDATE
3.1.3	Added MMEF description
3.1.4	Added information on MEDS eligibility status codes
3.2	Inserted section on Aid Codes
5.3	Added section on billing Other Health Care
5.4.2	Added coordination of benefits rules specific to Healthy Families
5.4.3	Clarified the description of gross billing
5.5	Added rules for claiming services for dual eligible clients
5.8	Added units definition and impact of voids on cost reporting
6.5	Extended the section on requests for and use of Delay Reason Codes
	Added recommendation on submitting authorized Over One-year Claims
6.6	Added clarification on Void and Replacement submission sequence
	Added information on warrants and payment timing
6.9	Extended the content on UMDAP
6.10	Added example on Share of Cost impact to eligibility
6.11.2	Clarified submitting Healthy Families claims and SED assessments
6.13	Added section on EPSDT-TBS
6.16.3	Clarified date restrictions on claims vs. those on claim files
6.16.4	Added a description on how void 835 timing differs from other 835 timing
6.16.5	Added reference to Federal regulation regarding claim certification authority
	Added instructions on certification for files that have to be renamed and resubmitted
6.17	Clarified use of the Disallowed Claim System
6.18	Added instructions on handling paper denials
6.19	Added a description of the difference between denials and rejections
7.4.6	Added instructions on handling Medicare crossover claims
7.4.7	Added instructions on handling out of state claims
7.4.8	Added instructions on use of pregnancy and emergency indicators
7.4.9	Added replacement claim matching restrictions
7.5.1	Added instructions on dealing with eligibility errors on MEDS
7.5.2	Added rules for claiming when a third party payer has not responded within 90 days

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CHANGES / UPDATES FROM PREVIOUS VERSION (JULY 2008)

SECTION	DESCRIPTION OF CHANGE AND/OR UPDATE
7.5.3	Described how to handle duplicates and lockouts caused by another MHP's claim
7.5.4	Added description of the rules used to determine EPSDT reimbursement
7.5.5	Added information on the disposition of unbalance claims
7.5.6	Described the provider appeal process
7.5.7	Added rules for claiming in a group setting with multiple providers
7.5.8	Added direction on PCCN to use when replacing claims with denied replacements
7.5.9	Added instructions for supplying supervising clinician NPI
7.5.10	Added clarification regarding claiming travel and documentation
7.5.11	Added rules for when admission and discharge dates are required

INTRODUCTION

1.0 Introduction

The Short-Doyle/Medi-Cal (SDMC) claim process system allows California's County Mental Health Plans (MHPs) to obtain reimbursement of funds for medically necessary specialty mental health services provided to Medi-Cal-eligible beneficiaries and also to Healthy Families subscribers diagnosed as Seriously Emotionally Disturbed (SED).¹ The Department of Health Care Services Mental Health Services Division (DHCS MHSD) oversees the SDMC claim processing system. This Billing Manual provides information about the system. This chapter includes:

[About This Billing Manual](#)

[Program Background](#)

[Authority](#)

[Medi-Cal Claims Customer Service Office \(MedCCC\)](#)

1.1 About This Billing Manual

This Mental Health Medi-Cal Billing Manual is a publication of the DHCS. DHCS administers the Mental Health Medi-Cal program (administered by the Dept of Mental Health until 6/30/12).

The scope of this Billing Manual is to provide stakeholders with a reference document that describes the processes and rules relative to SDMC claims for specialty mental health services. Stakeholders include MHPs, Billing Vendors of MHPs, etc.

1.1.1 Objectives

The primary objectives of this Billing Manual are to:

- Provide explanations, procedures and requirements for claiming
- Provide claiming system overviews and process descriptions
- Provide links and/or information related to:
 - State and Federal laws and regulations
 - Letters and Information Notices

¹ [W & I Code, Division 5, Part 2, Chapter 1, § 5600.3](#)

- Reference documents such as:
 - SDMC system user guides
 - X-12 Companion Guides
 - X-12 Companion Guide Appendix

This Manual is not intended to duplicate the content of the Companion Guides or the Companion Guide Appendix. However, key concepts from those documents have been included to help explain the SDMC claiming process.

1.1.2 Internet Addresses and Links

All internet addresses (URLs) and links in this document were current as of the publication date of this manual but are subject to change without notice.

1.2 Program Background

Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, and administrative and operating procedures.

Each Federally-approved State plan must designate a single State agency responsible for administration of its State Medicaid Program. In the case of California's Medicaid program (known as Medi-Cal), DHCS is the responsible State agency in California.

DHCS holds administrative responsibility for Medi-Cal specialty mental health services including but not limited to:

1. Determination of Aid Code²
2. Maintenance of eligibility information technology systems (e.g. Medi-Cal Eligibility Determination System [MEDS])
3. Adjudication of SDMC Mental Health claims
4. Processing of claims for Federal Financial Participation (FFP) payments

² [SDMC Aid Codes Master Chart](#)

5. Submission of expenditure claims to CMS to obtain FFP

For Medi-Cal specialty mental health services provided to a beneficiary by a certified provider, the cost of these services is paid by a combination of _____, State, and Federal funds.

The Federal Financial Participation (FFP) sharing ratio (the percentage of costs reimbursed by the Federal government) is determined on an annual basis and is known as the Federal Medical Assistance Program ([FMAP](#)) percentage.

County expenditures represent a combination of State realignment funds; State managed care allocations, State General Fund (SGF) [For services provided through 2010], Mental Health Services Act (MHSA) funds, local county funds and other sources such as grants. Counties submit claims to the State to obtain reimbursement of some or all of their costs based on FMAP and EPSDT eligibility and sharing ratios.

1.3 Authority

Authority for the Mental Health Medi-Cal program is governed by the following Federal and State of California statutes and regulations:

1.3.1 Social Security Act

Federal Social Security Act Title XIX, Grants to States for Medical Assistance Programs, 42 USD § 1396-1396v, Subchapter XIX, Chapter 7 (1965), provides the basis for development of each State's Medicaid plan.

1.3.2 Health Insurance Portability and Accountability Act of 1996

The Code of Federal Regulations (CFR) provides statutory authority for the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) 42 USC 1320d – 1320d-8, Public Law 104-191, § 262 and § 264; also 45 CFR, Subchapter C, Parts 160, 162 and 164.

1.3.3 Federal Regulations

Title 42 of the Code of Federal Regulations (42 CFR) Chapter IV Subchapter C Parts 430-456 – Medical Assistance Programs provides regulatory guidance for the Medicaid Program.

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Chapter 1: Introduction

1.3.4 Welfare and Institutions Code (W&I Code)

The California Welfare and Institutions (W&I) Code provides statutory authority for the Mental Health Medi-Cal program and implements legislation.

1.3.5 California Code of Regulations (CCR)

State regulations applicable to SMHS are found in the California Code of Regulations, CCR Title 9, Division 1, Chapters 1-14. Those applicable to DHCS that also affect SMHS are found in Title 22, Division 3, Subdivision 1, Chapter 3.

1.3.6 Companion Guides for the 837 Professional and Institutional Health Care Claims

1.3.7 Health Care Claim Payment/Advice (“837 Companion Guide” and “835 Companion Guide”)

1.3.8 Short-Doyle/Medi-Cal (SDMC) Companion Guide Appendix (Rev.10/7/11) (“Companion Guide Appendix)

1.3.9 ASC X12/004010X096A1 Health Care Claim: Institutional (837I) Implementation Guide

1.3.10 ASC X12/004010X098A1 Health Care Claim: Professional (837P) Implementation Guide

1.3.11 ASC X12/004010X091A1 Health Care Claim Payment/Advice (835) Implementation Guide

1.4 Medi-Cal Claims Customer Service Office (MedCCC)

[MedCCC](#) was created to provide MHPs a single point of contact to assist them with SDMC claim process questions and issues. MedCCC provides MHPs direct access to the state when they have questions regarding claim payment, need technical assistance with claim processing, have a question about policy, need assistance with accurate and timely submission and processing of claims or have other billing and/or claim-related issues. MedCCC also uses a proactive approach of delivering information to MHPs when a potential issue with a claim process or business rule has been identified. MedCCC assists MHPs with streamlining the claim process, resulting in improved processes and understanding of requirements at both the MHP and state levels.

What MHPs can expect when contacting MedCCC:

- An email response back within 24 hours, acknowledging receipt of the MHP's issue or concern
- The most current information on an MHP's Medi-Cal claims
- Assistance with troubleshooting claim and/or payment issues
- Helpful answers to policy and procedure questions

To ensure the accuracy of the inquiry and responses, MedCCC requests that MHPs email inquiries to: MedCCC@dhcs.ca.gov

MHPs may also call 916.650.6525 or Fax 916.440.7621

GETTING STARTED

2.0 Introduction

This chapter provides the requirements that must be met before submitting a claim, including:

[Enrolling in ITWS](#)

[Legal Entity, Provider Numbers and NPIs](#)

[Provider Enrollment and Medi-Cal Certification](#)

[Online Provider System](#)

[X-12 Companion Guide and Appendix](#)

2.1 Enrolling in ITWS

DHCS Information Technology Web Services ([ITWS](#)) are a collection of web applications that allow Mental Health Services Division business partners (e.g. MHPs, Contracted Providers, and authorized Vendors) to access information securely over the Internet. Requests for access to specific areas of ITWS are approved by ‘approvers’ appointed by each MHP director.³

For basic information related to ITWS enrollment and uploading claim files, a [Virtual Tour](#) is available. For further information, please call ITWS Support at (800) 579-0874 or go to [ITWS contact information](#).

2.2 Legal Entity, Provider Numbers and NPIs

All MHPs and providers wishing to bill Med-Cal for providing specialty mental health services must have:

1. a Legal Entity (“LE”) number
2. a State-assigned Provider number
3. an NPI (National Provider Identifier)

An LE can be a county, a corporation or an individual that owns one or more facilities providing mental health services. DHCS assigns unique 5-digit LE numbers for cost reporting purposes. To request and update Legal Entity numbers use the Legal Entity File Update (LFU) form.

³ [ITWS: Approver Certification Forms](#)

Provider numbers are unique 4-digit numbers used to distinguish one or more of an LE's facilities that provide both Medi-Cal and non-Medi-Cal mental health services. To request State-assigned provider numbers and to update information regarding provider numbers use the Provider File Update form (PFU).

Federal regulations require that individual health care providers and organizations obtain NPIs. DHCS maintains a website providing information about [obtaining an NPI](#).⁴ MHPs must identify, by NPI, the rendering provider and the billing and service facility provider locations in 837 health care claim transactions.

2.3 Provider Enrollment and Medi-Cal Certification

For a provider to be eligible to bill Medi-Cal for providing specialty mental health services, one of the steps a provider must take is to enroll in the ITWS Online Provider System (OPS – See **2.4**). Instructions for provider enrollment can be found on ITWS by clicking on the [Enroll](#) tab.

Another requirement is to have each provider who wishes to submit claims for providing specialty mental health services to beneficiaries of an MHP are Medi-Cal certified by the State. MHPs shall have completed, and submitted to DHCS, one Medi-Cal Certification and Transmittal form (aka "Transmittal") for each provider utilized by the MHP. The Transmittal form can be found on either 1) ITWS or 2) by emailing DMHCertification@dhcs.ca.gov. The purpose of the Transmittal is to "transmit" provider information, necessary to adjudicate claims, to the OPS.

Providers are assigned a 4-digit provider number by DHCS. Provider numbers are assigned with a separate number for each provider location and each MHP using that provider. Provider numbers are unique to each MHP with the exception of IMD and Skilled Nursing Facility (SNF) provider numbers. Many counties may use the same provider but each MHP will have its own unique provider number for that provider. Before being listed in the OPS, a provider must also have both an LE name and number listed in the Legal Entity File.

To obtain a new Provider Number and add a new provider to the OPS, counties must submit a PFU to ProviderFile@dhcs.ca.gov.

⁴ [DHCS NPI Overview](#)

2.4 Online Provider System

The [Online Provider System](#) is system located within ITWS and allows real-time access to information contained in the Provider File. To view information in the OPS, you must first enroll in ITWS (click on the **Request Additional Membership** link). Additional information about the OPS is included in Information Notice [07-15](#).

Since data contained on the Transmittal populates the Provider File on the OPS, SDMC Certification for specific combinations of Mode of Service and Service Function codes is required. Additionally, each and every time there is a change of any of the provider's information contained on the Transmittal, an updated Transmittal must be submitted to DHCS. When a provider's billing eligibility is checked during claim adjudication, a provider's Mode of Service and Service Function combinations are crosswalked to Healthcare Common Procedure Coding System (HCPCS) Procedure and Procedure Modifier codes.

Please submit Transmittals via: DMHCertification@dhcs.ca.gov or, Fax to 916-440-7620

2.5 X-12 Companion Guide and Appendix

X-12 (<http://www.x12.org/>) publishes both a Companion Guide and a Companion Guide Appendix for each HIPAA-compliant transaction type used by SDMC (e.g 835, 837).

The Companion Guide provides the detail on how to format HIPAA compliant claims.

The Companion Guide Appendix provides technical details about claim submission procedures, appropriate code usage, error codes, conversion tables, etc.

CLIENT ELIGIBILITY

3.0 Introduction

This chapter contains information about Medi-Cal eligibility including:

[Client Eligibility](#)

[Aid Codes](#)

3.1 Client Eligibility

Mental Health clients must be Medi-Cal-eligible in order for the MHP to be reimbursed through the SDMC Claim System. The sections in this chapter describe Medi-Cal Eligibility Determination and Medi-Cal Eligibility Review.

3.1.1 Medi-Cal Eligibility Determination

Procedures for establishing Medi-Cal eligibility criteria are the responsibility of DHCS. The determination of beneficiary eligibility and the collection of beneficiary eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding beneficiary eligibility criteria may be obtained through the DHCS website.⁵ [DHCS Provider Bulletins and Manuals](#) provide information for all Medi-Cal programs, including specialty mental health services.⁶

The following information regarding Medi-Cal eligibility is integral to the management of Mental Health Medi-Cal claiming.

Medi-Cal eligibility is established on a monthly basis. For this reason, Mental Health Medi-Cal claim processing requires frequent review and management of beneficiary Medi-Cal eligibility data.

Verification of beneficiary Medi-Cal eligibility can be reviewed by external auditors after the claimed month of service. For this reason, MHPs must maintain proof of how beneficiary Medi-Cal eligibility was verified.

Medi-Cal eligibility may require that a beneficiary's Share of Cost (SOC) be met before Medi-Cal will pay for any services. (Share of Cost is discussed in "[Medi-Cal Share of Cost \(SOC\)](#)" in Chapter 6.)

⁵ [DHCS MEDS Division Homepage](#)

⁶ [DHCS Provider Bulletins and Manuals](#)

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Chapter 3: Client Eligibility

Clients who are eligible for Supplemental Security Income (SSI) are Medi-Cal eligible. (Information on SSI may be obtained through the Federal Social Security Administration website.⁷)

Medi-Cal eligibility may be established retroactively through court hearings and/or decisions.

[Healthy Families](#)⁸ (HF) eligibility is based on the State Children's Health Insurance Program (SCHIP) which has been designed for children whose family income is below a State-established level but above the level qualifying for Medi-Cal.

California has incorporated HFP members into the Medi-Cal eligibility system through beneficiary [Aid Codes](#).

[HIPAA 270/271](#) transactions are available from DHCS to verify beneficiary Medi-Cal eligibility⁹.

MHPs must verify beneficiary Medi-Cal eligibility prior to submission of claims for reimbursement.

3.1.2 Eligibility Review

Once Medi-Cal eligibility is established, beneficiary eligibility information may be reviewed by authorized MHP staff. With few exceptions, the source of this eligibility verification information will always be from the DHCS Point of Service (POS) system¹⁰.

3.1.3 MMEF

The Monthly MEDS Extract File (MMEF) contains, among other data, all Aid Codes for which an individual is eligible at the date/time the file is created. The MMEF contains information for the current month and previous 15 months. A new MMEF is available at the end of each month and applies to the following month's eligibility. MMEF data is not used to determine eligibility during adjudication. The adjudication process queries the MEDS database for eligibility data at the time the claim is being adjudicated.

⁷ [US Social Security Admin Website](#)

⁸ [Information Notice 07-01: The Healthy Families Program](#)

⁹ [DHCS: HIPAA 4010/NCPDP 5.1 & 1.1](#)

¹⁰ [Medi-Cal Website: Transaction Services Available](#)

3.1.4 MEDS Eligibility Status Codes

For a claim to pass the Medi-Cal eligibility edit, the eligibility status code(s) received from MEDS and placed in the claim must be from 001 to 499 (except for Healthy Families: see below). For a particular month and year of service, if the eligibility is valid, then the approved Aid Code will be the highest-paying eligible SDMC Aid Code.

For HF claims which start with an eligibility status code of 6xx and include an HF Aid Code, the eligibility start date is also checked. HF claims will be denied if the service dates are before the eligibility establishment date.

Note: if a beneficiary is found in MEDS, but none of the Aid Codes for which the beneficiary is eligible are applicable to SDMC, the claim will be denied.

3.2 Aid Codes

During the Medi-Cal application and enrollment process, Aid Codes are codes assigned to Medi-Cal-eligible clients to indicate the program(s) under which the client qualifies for services.

The DHCS [Aid Codes Master Chart](#) (which includes both Mental Health and Drug Medi-Cal) can be found on the MedCCC website under Library. The Aid Codes Master Chart provides useful information for the following:

- Federal Financial Participation (FFP)
- Aid Codes
- Types of benefits
- Share of Cost
- Code description
- Indication of reimbursement through the DHCS Fiscal Intermediary Management Division, Alcohol and Drug Programs (DMC),¹¹ Mental Health Programs, and/or EPSDT¹² programs.

¹¹ [ADP Website](#)

¹² [County Interim RateTable FY12_13](#)

COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered services and limitations related to Mental Health Medi-Cal claiming. It also explains key concepts about the way a claim is processed. It includes:

[Covered Services](#)

[Mode of Service and Service Function Codes](#)

4.1 Covered Services

The specialty mental health services listed below are Medi-Cal covered services. Claims for reimbursement of specialty mental health services may be submitted to the SDMC Claim System via ITWS. Medi-Cal reimbursement for any other service (such as Administrative, QA/UR, etc) is through interim payment (using the paper or electronic forms MC1982B and/or MC1982C) or the Cost Reporting process.

4.1.1 Hospital Inpatient: CCR Title 9, § 1820.205

Hospital Inpatient services are provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital that is approved by DHCS to provide psychiatric services. Hospital Inpatient services must be medically necessary for diagnosis or treatment of a mental disorder. IP services are not billed through the SDMC Claim System; IP services are billed through the Fiscal Intermediary, which at the time of this publication, is Xerox.

4.1.2 Hospital Inpatient Administrative Day Services: CCR Title 9, § 1820.220

During a hospital stay, the beneficiary has previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. There is no appropriate, non-acute treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of 5 appropriate, non-acute treatment facilities per week subject to the requirements stated in CCR Title 9, Section 1820.220.

4.1.3 Psychiatric Health Facility: CCR Title 9, § 1810.236 & Title 22, § 77001

A Psychiatric Health Facility (PHF) is a facility licensed under the provisions of CCR, Title 22. For the purposes of this chapter, PHFs that have been certified by DHCS as

Medi-Cal providers of inpatient hospital services are governed by provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

4.1.4 Psychiatric Health Facility Services: CCR Title 9, § 1820.205 & 1810.237

Psychiatric Health Facility Services are therapeutic or rehabilitative services provided in a Facility other than a Psychiatric Health Facility as defined above. These services are provided on an inpatient basis to beneficiaries who need acute care (care that meets criteria outlined in CCR, Title 9) and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.

4.1.5 Crisis Residential Treatment Services: CCR Title 9, § 1810.208

Crisis Residential Treatment Services (CRTS) are therapeutic or rehabilitative services provided in a non-institutional residential setting. CRTS provide structured programs as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crises that do not have medical complications requiring nursing care.

CRTS offer a range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. CRTS are available 24 hours a day, seven days a week. Activities may include (but are not limited to) Assessment, Plan Development, Therapy, Rehabilitation, Collateral, and Crisis Intervention. CRTS are provided in Social Rehabilitation Facilities licensed under the provisions of CCR Title 22, and certified under the provisions of CCR Title 9.

4.1.6 Adult Residential Treatment Services: CCR Title 9, § 1810.203

Adult Residential Treatment Services are rehabilitative services provided in a non-institutional residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in a residential treatment program.

Adult Residential Treatment Services include a range of activities and services that support beneficiaries in their effort to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not

limited to Assessment, Plan Development, Therapy, Rehabilitation and Collateral. Adult Residential Treatment Services are provided in Social Rehabilitation Facilities licensed under the provisions of CCR, Title 22, and certified under the provisions of CCR Title 9.

4.1.7 Crisis Stabilization: Emergency Room: CCR Title 9, § 1840.338 and § 1840.348

Crisis Stabilization: Emergency Room is a service lasting less than 24 hours provided to (or on behalf of) a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include (but are not limited to) Assessment, Collateral, and Therapy. Crisis Stabilization differs from Crisis Intervention in that stabilization is delivered by providers who meet contact, site, and staffing requirements for Crisis Stabilization described in CCR Title 9, sections 1840.338 and 1840.348.

Crisis Stabilization must be provided onsite at a licensed 24-hour health care facility, as part of a hospital-based outpatient program, certified by the state to perform crisis stabilization.

The maximum allowance provided in CCR, Title 22 for 'Crisis Stabilization-Emergency Room' shall apply when the service is provided in a 24-hour facility, including a hospital outpatient department.

4.1.8 Crisis Stabilization: Urgent Care: CCR Title 9, § 1840.105

Crisis Stabilization: Urgent Care follows the same guidelines as 'Crisis Stabilization: Emergency Room' above, except that the maximum allowance for this category shall apply when the service is provided at an appropriate site other than an emergency room.

4.1.9 Day Treatment Intensive: CCR Title 9, § 1810.213

Day Treatment Intensive is a structured, multi-disciplinary program of therapy that may be an alternative to hospitalization, avoids placement in a more restrictive setting, or maintains the individual in a community setting where services to a distinct group of individuals is provided. Services are available for at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, Assessment, Plan Development, Therapy, Rehabilitation, and Collateral.

4.1.10 Day Rehabilitation: CCR Title 9, § 1810.212

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain, or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available for at least three hours and less than 24 hours each day the program is open. Service activities may include (but are not limited to) Assessment, Plan Development, Therapy, Rehabilitation, and Collateral.

4.1.11 Case Management/Brokerage: CCR Title 9, § 1810.249

Case Management/Brokerage is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include (but are not limited to) communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient's progress; placement services; and plan development.

4.1.12 Mental Health Services: CCR Title 9, § 1810.227

Mental Health Services are individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living, and enhanced self-sufficiency, and that are not provided as a component of Adult Residential Services, CRTS, Crisis Intervention, Crisis Stabilization, Day Rehabilitation, or Day Treatment Intensive services. Mental Health Service activities may include (but are not limited to) Assessment, Plan Development, Therapy, Rehabilitation, and Collateral.

4.1.13 Mental Health Services: Professional IP Visit

Mental Health Services: Professional IP Visit services are the same as Mental Health Services, except they are provided in a Fee-For-Service inpatient setting (IP) by professional staff.

4.1.14 Medication Support: CCR Title 9, § 1810.225

Medication Support is a service that can include the prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Med Support activities may include (but are not limited to) evaluating the need for medication; evaluating clinical effectiveness and side effects; obtaining informed consent; instruction in the use, risks and benefits of and alternatives for medication; and Collateral and Plan Development related to the delivery of the service and/or assessment of the patient.

4.1.15 Medication Support: Professional IP Visit

Medication Support: Professional IP Visit services are the same as Medication Support, except they are provided in a Fee-For-Service IP setting by professional staff.

4.1.16 Crisis Intervention CCR Title 9, § 1810.209

Crisis Intervention services last less than 24 hours and are provided to (or on behalf of) a beneficiary for a condition that requires more timely response than a regularly scheduled visit.

Service activities include but are not limited to one or more of the following: Assessment, Collateral, and Therapy. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site, and staffing requirements described in CCR Title 9 Section 1840.338 and 1840.348.

4.1.17 Crisis Intervention: Professional IP Visit

Crisis Intervention: Professional IP Visit services are the same services as Crisis Intervention except that the services are provided in a Fee-For-Service IP setting by professional staff.

4.2 Mode of Service and Service Function Codes

Mental Health Medi-Cal Mode of Service and Service Function (MS/SF) codes are mapped to HCPCS Procedure Codes, Procedure Modifiers, and Revenue codes for the 837 transaction. MHPs vary in the ways their staff code mental health services. Local coding may be in the form of HCPCS or CPT codes, DHCS MS/SF codes, are a unique

set of codes, which is linked to HCPCS, CPT, or MS/SF codes through crosswalk tables. In all cases, MHPs must conform or translate their local codes to those 837 transaction coding requirements found in the Companion Guide.

Critical to understanding the Mental Health SDMC claim process is the fact that the 837 health care claim transaction format does not use MS/SF codes. Instead, SDMC claim use different codes to represent similar information. These codes include Procedure, Procedure Modifier, Place of Service, Taxonomy and Revenue codes. Further discussion of this concept is found in Chapter 4 of this Manual.

837 transaction Procedure codes are required by National HIPAA 837 transaction code standards. The Companion Guide can be referenced to more fully understand the related and correct coding of Mental Health Medi-Cal claims.

Crosswalks provided herein describe how to convert MS/SF combinations to HIPAA-compliant HCPCS codes that are acceptable on an SDMC 837 transaction. All of these crosswalks have the same basic format: Columns A through D represent key Cost Report and/or CSI coding. Columns F through H represent key coding found in 837 transaction claiming.

4.2.1 Administration-Related Crosswalk

The Administration-related Crosswalk represents the MS/SF information related to MAA by an MHP. MAA activities cannot be claimed through Mental Health Medi-Cal. Chapter 5 of this Manual provides information regarding Medi-Cal reimbursement to Counties relative to administration and utilization review.

4.2.2 24-Hour Services Crosswalk

The 24-Hour Services Crosswalk represents the MS/SF information related to 24-Hour Service by an MHP. The 24-Hr Services Crosswalk demonstrates how a particular Mode of Service may have services that are both billable to SDMC as well as services not billable to Mental Health SDMC. This Crosswalk also shows how some MS/SF Codes were translated to the prior DHCS SDMC proprietary claim and how the same MS/SF Codes are represented as a Procedure Codes in the SDMC 837 transaction claim format.

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The following is an example showing 24-Hour Services billable to Mental Health Medi-Cal and the related Modes of Service. A description by row/column is used to explain table concepts.

Detail for Local Hospital Inpatient (Ages 21-64) SDMC 837 transaction claiming:

- Column B** Cost Reporting Mode of Service 05 (24-Hour Services)
- Column C** Service Function codes used by counties¹³ in Cost Reporting
- Column D** Types of Units of Service represented on the Cost Report
- Column F** Revenue code that must be supplied in the 837I claim
- Column G** HCPCS code (e.g. H2015) that must be supplied in the 837I claim
- Column H** No Procedure Modifier 2 is required for this service.
- Column I** Type of Cost Units upon which the costs are determined. Cost Units may be units of service or units of time

Line 8, Columns F and G indicate that there are no equivalent HIPAA codes in a SDMC 837 transaction for SNF Intensive Services.

4.2.3 Service Function: Detail Loss

The implementation of HCPCS codes in 837 transaction claims will affect the ability to directly relate Cost Reporting MS/SF codes to the SDMC adjudicated claim MS/SF data. This may occur because 837 transaction claims must currently be translated back to the prior SDMC proprietary claim format used by DHCS claim system. This is the role of the Translator. Since the 837 transaction claim does not have the original MS/SF descriptors, specific Service Function detail may be unavailable. Here is an example:

County A provides both an Assessment and a Collateral service to the same client in the same day. County A's computer system tracks this through internal codes representing MS 15 (Outpatient) with:

- Collateral local coding equal to SF 10
- Assessment local coding equal to SF 30

When the county creates an 837 transaction for each of these services, the result is that both of these services will be represented by Procedure code H2015.

Mode of Service (MS) and Service Function (SF) codes on their own are no longer used for claiming but are still used by the Client and Services Information system (CSI) and

¹³ Counties may use their own rationale for how or why they utilize Service Function codes for cost reporting but their choices must be within the allowable range and have no impact on the claiming system. For example, a county that has two separate Local Hospital Inpatient facilities might show costs for Facility 1 using Service Function 10 and Facility 2 using Service Function 11.

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Cost Reporting process. MS and SF codes allow similar mental health services to be grouped together for reporting purposes.

4.2.4 Mode of Service Codes

The Modes of Service used by Cost Reporting are:

- 00** Administration
- 05** 24-Hour Services
- 10** Less than 24-Hour Day Treatment Program Services
- 15** Outpatient Services
- 45** Outreach Services
- 55** Medi-Cal Administrative Activities ¹⁴
- 60** Client Support and Care

Direct Treatment Modes of Service used by both CSI and Cost Reporting are:

- 05** 24-Hour Services
- 10** Less than 24-Hour Day Treatment Program Services
- 15** Outpatient Services

For Mental Health Medi-Cal, Mode of Service (if used) must be mapped to Procedure codes and Revenue codes for the 837 transaction. Medi-Cal reimbursement in any other Mode of Service is through interim payment (MC1982B and MC1982C) or the Cost Reporting process. Modes of Service are grouped as follows:

- 05, 07, 08, and 09** 24-Hour Services
- 12** Outpatient Hospital Services
- 18** Non-Hospital Outpatient

24-HOUR SERVICES

These are services that provide a therapeutic environment of care and treatment within a 24-Hour setting.

05	Residential/Psychiatric Health Facility
07	General Hospital IP Services
08	Psychiatric Hospital IP Under Age 21
09	Psychiatric Hospital IP Over Age 64

NON 24-HOUR SERVICES

¹⁴ Medi-Cal Administrative Activities (MAA) are billed and paid through a paper claim (MC1982D)

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These services provide short-term or sustained therapeutic intervention for beneficiaries experiencing acute and/or ongoing psychiatric distress.

MS	SETTING
12	Hospital Outpatient Services
18	Non-Hospital Outpatient

4.2.5 Service Function Codes

Service Function codes are used in CSI and Cost Report information systems. They identify the specific type of service received under a Mode of Service. Service Function codes include any number from 01-99 (Exception: Codes 80 and 90 are not used). SF codes are necessary for classifying county-provided services and service cost data at a specific level.

Examples for MS 15 (Outpatient Services) are:

SF 60-69 Medication Support
SF 70-79 Crisis Intervention

Below is the list of **Short-Doyle** Mode of Service and **Short-Doyle** Service Function codes:

MODE OF SERVICE	24-HOUR SERVICES
05	Residential/Psychiatric Health Facility (PHF)
07	General Hospital IP
08	Psychiatric Hospital IP: Under Age 21
09	Psychiatric Hospital IP: Over Age 64
SERVICE FUNCTION	24-HOUR SERVICES
10 – 18	Hospital IP
19	Hospital IP: Administrative Day
20 – 29	Psychiatric Health Facility (PHF)
40 – 49	Adult Crisis Residential
65 – 69	Adult Residential

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MODE OF SERVICE	DAY SERVICES
12 or 18	12 Hospital Outpatient 18 Non-Hospital Outpatient
01–06, 08, 09	Case Management/Brokerage: Targeted Case Management (TCM)
07	Intensive Care Coordination (ICC)
10 – 18	Mental Health Services (MHS)
19	MHS: Professional IP Visit
20 – 24	Crisis Stabilization: Emergency Room (ER)
25 – 29	Crisis Stabilization: Urgent Care (UC)
30 – 38	MHS
39	MHS: Professional IP Visit
40 – 48	MHS

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MODE OF SERVICE	DAY SERVICES
49	MHS: Professional IP Visit
50 – 56	MHS
57	Intensive Home-Based Services (IHBS)
58	TBS
59	MHS: Professional IP Visit
MODE OF SERVICE	DAY SERVICES
60 – 68	Medication Support
69	Medication Support: Professional IP Visit
70 – 78	Crisis Intervention
79	Crisis Intervention: Professional IP Visit
81 – 84	Day Treatment Intensive: 1/2 Day

SERVICE FUNCTION	DAY SERVICES
85 – 89	Day Treatment Intensive: Full Day
91 – 94	Day Rehabilitation: 1/2 Day
95 – 99	Day Rehabilitation: Full Day

OTHER MENTAL HEALTH CLAIMING

5.0 Introduction

This chapter covers claiming performed outside the SDMC system:

[Inpatient Psychiatric Facilities \(Non-MHP Contracted\)](#)

[IMD Exclusion](#)

[Outpatient Claiming](#)

[Other Health Care](#)

[Coordination of Benefits and Gross Billing](#)

[Claiming for Dual Eligibles \(Medi-Medi\)](#)

[Non-Medicare Reimbursable: Specialty Mental Health Services](#)

[AB3632 Children's Services](#)

[Administrative, Utilization Review, and Medi-Cal Administrative Activities](#)

[Annual Year-end Cost Report and Fiscal Audit: Minutes and Units](#)

5.1 Inpatient Psychiatric Facilities (Non-MHP Contracted)

This section is related only to Inpatient Hospitals that do not contract with any MHP, and are not designated Short-Doyle hospitals.

Psychiatric IP managed care Medi-Cal claims continue to be processed through DHCS' Fiscal Intermediary (FI) Management Division. The process begins when a representative authorized by the MHP approves a mental health IP provider's Treatment Authorization Request (TAR). The FI's claim system matches the claim to the TAR and adjudicates the claim. This system supports the submission, approval and payment of claims for Mental Health Medi-Cal Psychiatric IP Fee-For-Service providers. TARs are governed by DHCS policy and procedures. (See: Inpatient Mental Health Services Program section under the Medi-Cal Inpatient/Outpatient Provider Manual¹⁵ for information on TARs¹⁶ and related billing.) Subsequently, the inpatient provider bills the FI Management Division for Medi-Cal reimbursement. This type of inpatient billing is never billed directly from an MHP through DHCS.

¹⁵ [Medi-Cal Provider Manual](#)

¹⁶ [TAR Manual](#)

5.2 IMD Exclusion

Services provided to individuals in Institutions for Mental Diseases or (IMDs), have different claiming rules than other Medi-Cal mental health services. Title 42, CFR, Section 435.1010 defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

A facility's license type is not a defining characteristic of an IMD; several types of facilities may meet the definition of an IMD, including but not limited to, acute psychiatric hospitals, mental health rehabilitation centers, psychiatric health facilities, and skilled nursing facilities with special treatment programs.

Title 42, CFR, Section 435.1009, in relevant part states that "FFP is not available in expenditures for services provided to ... Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter... The exclusion of FFP ... does not apply during that part of the month in which the individual is not ... a patient in an institution for ... mental diseases ... An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution."

MHPs are responsible for preventing the submission for claims to the State for services provided to individuals subject to the IMD exclusion. Inappropriate claiming of FFP must be prevented in both the SDMC claim system and the fiscal intermediary claim system.

5.2.1 IMD List by calendar year:

<http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>

5.2.2 Departmental Information Letters and Notices regarding IMDs:

[http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-ShortDoyleII\(SDII\).aspx](http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-ShortDoyleII(SDII).aspx)

5.3 Outpatient Claiming

Between November 1997 and July 1998 MHPs assumed responsibility for inpatient hospital and outpatient specialty mental health professional services. County representatives provide authorization for mental health outpatient services by external providers and bill DHCS Mental Health Medi-Cal for reimbursement. This billing must conform to all DHCS requirements.

5.4 Other Health Care

Because Medi-Cal is always the payer of last resort¹⁷, MHPs must first submit claims to other payers when the beneficiary has third party coverage. This means when a claim is submitted to Medi-Cal for payment, all third party payers must have either paid or denied the claim except as noted under Dual-eligibility Beneficiaries.

5.5 Coordination of Benefits and Gross Billing

5.5.1 Coordination of Benefits

The SDMC claiming system does not perform coordination of benefits through various payer sources. Each source must be billed separately by the MHP.

One example is Medicare/Medi-Cal dual-eligible beneficiaries (referred to as Medi/Medi beneficiaries). For eligible services that are not directly billed to Medicare, the MHP will bill Medicare prior to Medi-Cal. A Medicare intermediary processing the MHP's claim will not coordinate the subsequent billing to Medi-Cal. Instead, claim adjudication by the Medicare intermediary will result in claim payment information returned to the MHP. The MHP may then submit an 837 transaction to the Mental Health SDMC Claim system with the Medicare payment information included.

On occasion, MHPs will receive a denial from a third party insurer in paper. The SDMC claim should be coded as if the claim was submitted to the prior payer electronically with the adjudication date as the date of the paper denial. The Adjudication Date must be greater than or equal to the date of service. The paper denial should be retained for audit purposes.

¹⁷ [SSA.gov: State Plans for Medical Assistance](http://ssa.gov/StatePlansforMedicalAssistance)

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If payment is received from a prior payer after SDMC has adjudicated the claim, the MHP must submit a replacement claim correcting the transaction.

5.5.2 Coordination of Benefits for Healthy Families Program Enrollees

Coordination of Benefits rules apply to Healthy Families Program (HFP) as well as Medi-Cal. For an HFP beneficiary that has Other Health Coverage (OHC) and Medi-Cal, OHC would be the primary payer, HFP the secondary payer and Medi-Cal the payer of last resort. MHPs must continue to bill OHC before billing Medi-Cal or HFP. If the MHP does not bill to OHC, claims submitted to SDMC will be denied.

5.5.3 Gross Billing

Submitters are required to claim for the total amount billed for services rendered, including any amounts that have already been accepted to clear Share of Cost or paid by prior payers. After FY11-12, there is no requirement to submit claims in any particular sequence. For example, December claims can be submitted before November claims as long as the dates of service are correctly specified on each claim. Note that on claims where lockouts (see chapter 7) apply, the later submission will be the one that is denied.

If the claim has been adjudicated by a prior payer, submitters are required to accurately describe:

1. How the claim was adjudicated
2. What amounts were paid
3. Any adjustments that were made

MHPs should not submit Coordination of Benefits information that represents implied or inferred denials based upon an OHC's lack of action.

The amount SDMC will approve for any service line is the allowable reimbursement for the billed service reduced by any amounts paid by prior payers and any amount accepted by the provider to clear the beneficiary's Share of Cost. Examples of how the claim should be structured are located in the Companion Guide Appendix.

Example: A \$100 service is provided. The claim is sent to Medicare. Medicare adjudicates the claim and decides to pay \$20. Medicare provides adjustment detail

to explain why they did not pay the remaining \$80. The claim is submitted to SDMC indicating that the claim amount is \$100, that Medicare has already paid \$20 and the reason(s) that Medicare did not pay the remaining \$80. SDMC now adjudicates the claim and pays the claim as appropriate.

There can be more to this calculation for more complex billing scenarios. Additional information and examples of gross billing calculations are available in the Companion Guide Appendix.

5.6 Claiming for Dual Eligibles (Medi-Medi)

Some beneficiaries may be eligible for benefits under both Medicare (Federal) and Medi-Cal (CA) plans. These beneficiaries are often referred to as “Medi-Medi” beneficiaries. California statute¹⁸ requires that all other forms of coverage pay their portion of a claim before Medi-Cal pays its portion. In other words, Medi-Cal is always the payer of last resort. Generally, this means that after other forms of coverage have been billed, claims for reimbursement of Medicare-eligible services performed by Medicare-certified providers in a Medicare-certified facility must be submitted to Medicare before being submitted to Medi-Cal.

Medicare Coordination of Benefits (COB) information must be included on the claim when it is submitted to SDMC or the claim will be denied.

The following specialty mental health services *do not* require Medicare COB as specified in Information Notices [09-09](#) and [10-11](#):

1. **T1017** Targeted Case Management
2. **H2011** Crisis Intervention
3. **H2013** Psychiatric Health Facility
4. **H0018** Crisis Residential Treatment Services
5. **H0019** Adult Residential Treatment Services
6. **S9484** Crisis Stabilization
7. **H2012** Day Treatment Intensive / Day Rehabilitation
8. **H2019** Therapeutic Behavioral Services
9. **0101** Administrative Day Services

¹⁸ [W & I Code, Section 14124.795](#)

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As described in Information Notice [10-23](#), services under Mental Health Services (MHS) that meet certain conditions *do not* require Medicare COB. The following are those conditions:

1. 837P claims for Rehabilitation under MHS
2. 837P claims for Plan Development under MHS
3. 837P claims where place of service is School or Mobile Unit
4. 837P claims for services under MHS or Med Support provided over the telephone
5. 837P claims for services under MHS or Med Support provided in the community
6. 837P claims for services under MHS or Med Support where the rendering provider's taxonomy code indicates that they are a Psychologist, Social Worker, Physician, Nurse Practitioner, Physician Assistant, or Nurse Specialist¹⁹

The claim can be approved if any of the above conditions exist.

Please refer to The Companion Guide Appendix for explanations of the codes that should be reported in the claim.

Claims for services to Medi-Medi beneficiaries performed at facilities or by providers whose certification application has been denied by Medicare may be billed to SDMC as long as the requirements of Information Notice [11-04](#) have been met.

5.6.1 Inpatient Services and Crisis Stabilization

If a Medi-Medi beneficiary receives Inpatient Services and Crisis Stabilization services within 72 hours of an Inpatient stay, Medicare requires all of these services to be claimed on one claim (837I). Medicare reimbursement is not itemized. The MHP is paid the same Diagnostic-Related Group (DRG) rate whether or not Crisis Stabilization is provided when occurring within 72 hours of the Inpatient stay.

The MHP should claim Medi-Cal for the hospital Inpatient Services on the 837I and Crisis Stabilization on the 837P.

All Medicare reimbursement should be applied to the Medi-Cal 837I for hospital Inpatient Services.

If a Medi-Medi beneficiary receives Crisis Stabilization services with no Inpatient Services, or no Inpatient Services within 72 hours and the MHP claims portions of what

¹⁹ MHS and Med Support services processed prior to April 1, 2011, will not be denied if the taxonomy code is missing from the claim as long as the MHP indicates that the code is unavailable.

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DHCS recognizes as Crisis stabilization to Medicare (e.g. physician services), the MHP should claim Medi-Cal for the balance of the claim not paid by Medicare for Crisis Stabilization on the 837P.

The MHP must submit the Medicare reimbursement as a Coordination of Benefits (COB) amount so it can be applied to the SDMC payment.

5.6.2 MHS: Rehabilitation: HCPCS H2015 & H2017

The following should be claimed directly to Medi-Cal without claiming Medicare first: The service activity “Rehabilitation” (Title 9, CCR § 1810.243) is under Mental Health Services. When claiming Rehabilitation under Mental Health Services, MHPs will use procedure code H2017.

Please note that some “Rehabilitation *Option*” services *are* Medicare reimbursable. The service activity “Rehabilitation” (Title 9, CCR, § 1810.243) should not be confused with all services included under the rehabilitation option. See: Info Notice [10-23](#)

MHPs are reminded that the service activity “Rehabilitation” (Title 9, CCR, § 1810.243) under Mental Health Services can already be claimed directly to Medi-Cal per Info Notice 10-23 using procedure code H2017 for Medi-Medi clients. Rehabilitation is a service activity under Mental Health Services that is not Medicare reimbursable regardless of where it is provided or who provides it. See: Info Notice [11-06](#)

5.6.3 Services Provided in the Community

Specialty mental health services provided in the community are not Medicare reimbursable and should be claimed directly to Medi-Cal. When a service is provided in the “community” and no other appropriate Place of Service code applies, Place of Service code indicated should be 99 (“Other”). Use modifier “HQ” with Procedure Codes H2010 and H2015 to specify that the service was provided in the community.

Medi-Medi claims with Place of Service code 99 but no modifier will be denied as requiring Coordination of Benefits.

Medi-Medi claims for Procedure Codes H2010 or H2015 with the procedure modifier “HQ” that do not include Place of Service 99 will be denied.

5.6.4 Services Provided by Telephone

Specialty mental health services provided over the telephone (e.g. Collateral) are not Medicare reimbursable and should be billed directly to Medi-Cal. When services are delivered by telephone, indicate the appropriate Place of Service code and use the modifier “SC” with procedure codes H2010 and H2015. This specifies that the service was provided by telephone. For example, if a telephone service is provided in an office, use modifier “SC” with Place of Service code 11 (“Office”). Leaving a telephone message, scheduling an appointment, or other clerical functions are neither Medicare nor Medi-Cal reimbursable activities.

Services provided by telephone differ from telemedicine services. Telemedicine services are Medicare reimbursable when provided from a clinic through interactive voice and visual interface between the provider and the beneficiary and when provided in specific, eligible geographic regions. Services provided via telemedicine should be claimed to Medicare prior to Medi-Cal unless another exception to prior Medicare claiming exists.

5.6.5 Place of Service

Place of Service 03 (“School”) is defined as a facility whose primary purpose is education.

Place of service 15 (“Mobile Unit”) is defined as a facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

5.6.6 MHS: Plan Development

Plan Development (CCR Title 9, §1810.232 and CCR Title 9, §1810.227) is a service activity under Mental Health Services that is not Medicare reimbursable regardless of where it is provided, or who provides it.

When claiming Plan Development, MHPs may use procedure code H0032 to bill Medi-Cal directly for Medi-Medi beneficiaries.

5.6.7 Assessment, Therapy & Collateral

“Assessment” (CCR Title 9, §1810.204), “Therapy” (CCR Title 9, §1810.250) and “Collateral” (CCR Title 9, §1810.206), under Mental Health Services (CCR Title 9, §1810.227), must be claimed to Medicare prior to Medi-Cal, using Procedure Code H2015, unless an exception to Medicare billing exists. For example, the service is provided over the telephone or in the community, it is provided by a non-Medicare reimbursable provider, or in a non-Medicare reimbursable place of service. Federal and state law requires the Medicaid (Medi-Cal) program to be the payer of last resort. Providers are required to bill payers, including Medicare, for services provided to dual eligible beneficiaries prior to billing Medi-Cal. However, most of the Medi-Cal Specialty Mental Health is authorized by the Rehabilitation Option, which provides significant staffing and service flexibility to assure beneficiary access to appropriate community based services that may be provided in community based settings by multi-disciplinary teams and are therefore not covered by Medicare. Medicare will not reimburse for the provision of specialty mental health services whenever one or more of the following three conditions exist:

1. The service, or service activity, is not covered as a Medicare benefit
2. The location where the service is provided or the method by which it was delivered renders the service ineligible for Medicare reimbursement
3. The provider does not meet Medicare provider qualifications

5.7 Non-Medicare Reimbursable: Specialty Mental Health Services

For specialty mental health services provided to dual eligible beneficiaries, the following Healthcare Common Procedure Coding System (HCPCS) codes do not meet Medicare requirements, do not require Medicare Coordination of Benefits (COB) and should be claimed directly to Medi-Cal:

1. **0101** Administrative Day Services
2. **H0019** Adult Residential Treatment Services
3. **H2011** Crisis Intervention
4. **H0018** Crisis Residential Treatment Services
5. **S9484** Crisis Stabilization
6. **H2012** Day Rehabilitation

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7. **H2012** Day Treatment Intensive
8. **H2012** Psychiatric Health Facility
9. **T1017** Targeted Case Management Services
10. **H2019** Therapeutic Behavioral Services

5.7.1 Non-Medicare Reimbursable: Specialty Mental Health Services Service Activities

For services provided to dual eligible beneficiaries (e.g. Medi-Medi), the following specialty mental health service activities (as defined in CCR Title 9, §1810.245) and HCPCS codes do not meet Medicare requirements and as such do not require Medicare coordination of benefits. The following service activities should be claimed directly to Medi-Cal:

1. **H2017** Rehabilitation (CCR Title 9, §1810.243) is provided as a service activity under Mental Health Services (CCR Title 9, §1810.227)
2. **H0032** Plan Development (CCR Title 9, §1810.232) is provided as a service activity under Mental Health Services
3. **H0034** Medication Training and Support (CCR Title 9, §1810.225) is provided as a service activity under Medication Support Services

MHPs may use procedure code H0034 to claim the following non-Medicare reimbursable service activities directly to Medi-Cal:

To obtain informed consent linked to providing Medication Support Service activities

Instruct in the use, risks and benefits of, and alternatives for, medication

Plan Development-related to Medication Support Services

5.7.2 Non-Medicare Reimbursable: Places of Service or Method of Service Delivery

Claims for services that are otherwise Medicare reimbursable with place of service code 03, 15, and 99 with modifier HQ, and claims with procedure codes H2010 and H2015 with modifier SC do not meet Medicare requirements and as such do not require Medicare COB and should be claimed directly to Medi-Cal.

1. Place of service code **03** (school) is defined as a facility whose primary purpose is education.

2. Place of service code **15** (mobile unit) is defined as a facility/unit that moves from place-to-place equipped to provide preventive, screening diagnostic, and/or treatment services.
3. When a service is provided in the “community” and no other appropriate place of service code applies, the place of service code should be indicated as 99 (other) and the modifier “HQ” should be used with procedure codes H2010 and H2015 to specify that the service was provided in the community. Claims for dual eligible beneficiaries with procedure codes H2010 or H2015 with place of service code 99, but no modifier, or claims with the procedure modifier “HQ” that do not include place of service 99 will be denied as requiring coordination of benefits.
 - a. When a service is provided by telephone, the appropriate place of service code should be indicated and the modifier “SC” should be used with procedure codes H2010 and H2015 to specify that the service was provided by telephone. For example, if a telephone service is provided in an office use modifier SC” with place of service code 11 (office).

Claimed services provided by telephone must be actual, Medi-Cal reimbursable services. Leaving a telephone message, scheduling an appointment, or other clerical functions are not Medicare or Medi-Cal reimbursable activities.

Services provided by telephone differ from those delivered via telemedicine. Telemedicine benefits are Medicare reimbursable when provided from a clinic through interactive voice and visual interface between the provider and the client and when provided in specific, eligible geographic regions. Services provided via telemedicine should be claimed to Medicare prior to Medi-Cal unless another exception to prior Medicare claiming exists.

5.7.3 Non-Medicare Reimbursable: Rendering Providers

Claims with taxonomy codes representing rendering provider types which are not Medicare eligible may be claimed directly to Medi-Cal without seeking a denial from Medicare. Rendering provider types which are not Medicare eligible are those represented by taxonomy codes which do not begin with any of the following three-digit prefixes:

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1. **363** Nurse Practitioner/Physician Assistant*
2. **364** Clinical Nurse Specialist*
3. **207** Physician
4. **208** Physician
5. **103** Psychologist
6. **104** Social Worker

*A registered nurse (RN) who is not a nurse practitioner (NP) or a clinical nurse specialist (CNS) is not a Medicare reimbursable provider. MHPs are advised that claims for services rendered by a NP or a CNS must be submitted using the appropriate taxonomy code starting with prefix 363 or 364 respectively and may not be submitted using a RN taxonomy code (those with prefix 163).

5.7.4 Non-Medicare Reimbursable: Clinics or Organizational Providers

See Information Notice [11-04](#) for information on claims processing for services provided by MHPs, clinics, or organizational providers that have applied for but have been denied Medicare program certification. In the event that the information provided in Information Notice 11-04 is updated, this section of the Billing Manual will be revised to reflect policy changes and a new information notice will be issued.

5.8 AB3632 Children's Services

Assembly Bill 3632 (AB3632) Children's Services is relevant to this manual since counties must compile related AB3632 Medi-Cal statistics for use in Cost Reporting through FY10-11 to DHCS.

AB3632 information reported may be used to support an MHP's SB90 claims.

5.9 Administrative, Utilization Review, and Medi-Cal Admin Activities

Administrative (Admin), Utilization Review (UR), and Medi-Cal Administrative Activities (MAA) claiming are part of overall county Medi-Cal claim functions. However, they are not claimed through the SDMC claim system.

Admin and UR costs are not included in rate setting calculations for maximum Mental Health Medi-Cal reimbursement rates. Neither does the 837 transaction claim provide a

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vehicle for interim funding of these costs. They are treated as separate costs to process apart from the actual SDMC 837 transaction claim.

DHCS provides counties interim funding for Admin and UR costs related to service delivery through paper claim form submission. These paper claim forms are the [MC1982B](#) (Admin) and [MC1982C](#) (UR). Letters [11-01](#) and [05-11](#) contain directives on Admin and UR claiming.

An MHP can choose whether or not to submit MC1982B and MC1982C forms during a fiscal year in order to receive interim funding. In either case, settlement of actual Admin or UR costs occurs during the fiscal end of year Cost Reporting process.

Activities claimed under MAA are those that are necessary for the proper and efficient administration of the Medi-Cal program. These activities are found under Mode of Service 55 and are never part of an SDMC 837 transaction. Invoices for are submitted quarterly through a paper claim submission using the [MC1982D](#) (MAA) claim form. Instructions and requirements for MAA planning, development and claiming are found in the DHCS MAA Instruction Manual maintained by the DHCS Cost Reporting and Financial Support Unit.

5.10 Annual Year-end Cost Report and Fiscal Audit: Minutes & Units

The annual year-end DHCS Cost Report is required to be completed by all Legal Entities that contract with the MHP to provide community mental health services (both Medi-Cal and non-Medi-Cal). The Cost Report serves multiple purposes including establishment of the MHP's cost settlement basis and serves as the focus of the subsequent DHCS fiscal audit. The basis for both cost settlement and fiscal audit is established in the Cost Report process by determining the allowable costs and allocating them among direct services (i.e. unit cost by Mode of Service and Service Function code), Administrative, Utilization Review, Research and Evaluation and MAA cost centers.

While the cost report requires the use of minutes for specific services, the SDMC claim requires units for many services. Units are 15 minutes long, so one minute equals $\frac{1}{15}$ of a unit. The Companion Guide Appendix has a table that shows how to convert between minutes and units.

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Note: A denied claim has no SDMC monetary value. Denied claims do affect cost reporting, cost settlement, and/or the audit processes because they reduce the potential for the County to earn FFP.

Annual training is provided by DHCS on the Cost Report process. In order to access complete instructions for the Cost Report process found in the Cost and Financial Reporting System Instruction Manual,²⁰ counties must enroll with DHCS Information Technology Web Services (ITWS). An enrollment link and overview of the Cost and Financial Reporting System is available at:

<https://itws.dhcs.ca.gov/systems/cfrs/docs/public/default.asp>

For claims that have an indication that there is "Support Data for the Claim," MHPs must retain supporting paperwork for review during audit. Examples of paperwork that might support a claim are:

1. Medi-Cal Letter of Authorization for Provider Late Billing
2. MHP's Good Cause Certification for Over-One-Year Claims

²⁰ https://itws.dhcs.ca.gov/systems/cfrs/docs/private/cfrs_manual.asp

CLAIM PROCESSING OVERVIEW

6.0 Introduction

This chapter provides an overview to Mental Health Medi-Cal claim processing and includes:

[Claim Processing Overview](#)

[High-level Mental Health Medi-Cal Claim Overview](#)

[Funding Sources](#)

[Mental Health Medi-Cal Claim Stages](#)

[Submission Timeliness](#)

[Voids and Replacements](#)

[Uniform Method of Determining Ability to Pay \(UMDAP\)](#)

[Medi-Cal Share of Cost Eligibility](#)

[Title XXI: Enhanced Services for Children](#)

[Healthy Families](#)

[Early and Periodic Screening, Diagnosis and Treatment \(EPSDT\)](#)

[Mental Health Medi-Cal Service Claim Rates](#)

[Federal Funding Ratios](#)

[Mental Health Medi-Cal Claim Processing](#)

[Disallowance and Void Transactions](#)

[Paper Claims, Error Correction and Replacement Transactions](#)

[Denials vs. Rejections](#)

[Mental Health Medi-Cal Reports](#)

6.1 Claim Processing Overview

Mental Health Medi-Cal claiming is a reimbursement system where counties (MHPs) are reimbursed an amount of Federal funding (pending cost settlement and audits) on a 'claim-in,' 'payment-out' basis for [certified public expenditures \("CPEs"\)](#) incurred by an MHP. Funding is made available through the Federal Medicaid entitlement program²¹.

In order for counties to obtain reimbursement for a percentage of their costs, allowing counties to continue providing services to Mental Health Medi-Cal beneficiaries, MHPs must meet claim requirements. Based on approved claims, the State Controller's Office

²¹ [42 USC §1396-1396v, Subchapter XIX, Chapter 7 \(1965\) Grants to States for Medical Assistance Programs](#)

will make payments to County Treasurer's Offices for providing approved services. MHPs must certify that claims submitted to DHCS for specialty mental health services meet all the conditions that qualify them as a CPE by submitting a completed, signed [MC1982A](#) form along with each claim file uploaded to ITWS.

Mental Health Medi-Cal is impacted by/integrated into other Federal/State/County fiscal and IT operations in many ways. The following sections provide an overview of various relationships to claim processing and provide information on claiming requirements.

6.2 High-level Mental Health Medi-Cal Claim Overview

The amount claimed by an MHP reflects an interim rate per unit of service based upon either the actual cost incurred by the MHP based on a payment to a contract provider or the estimated cost of a County-operated provider. The MHP incurs the CPE prior to submission of the claim to DHCS for adjudication. (*Date of Service* prior to FY11-12.)

Figure 6-1 provides a visual perspective example of a claim as it relates to a broader funding process. Below is a description of Figure 6.1:

1. **Example: Approved Non-EPSDT** This type of claim is reimbursed based on the appropriate FMAP. This percentage represents the percentage of a claim for which the Federal government will pay Federal Financial Participation (FFP). An expenditure for the entire amount of the claim by the MHP using state and/or county funds must be incurred before the claim can be submitted. The MHP is then reimbursed FFP for a percentage of this expenditure. The example uses an FMAP of 50% so that an expenditure/claim in the amount of \$100 of State and/or county funds would be reimbursed with \$50 of FFP. State and/or county funds used to incur the expenditure may include funding from:
 1. State Realignment Funds (see description below)
 2. Mental Health Services Act (MHSA) funds
 3. Local county monies
 4. Other sources (grants, etc.)
2. **Example: Approved EPSDT** An approved claim that is eligible for EPSDT reimbursement is also reimbursed based on the FMAP of 50% so that an approved claim in the amount of \$100 would be reimbursed with \$50 of FFP and

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Chapter 6: Claim Processing Overview

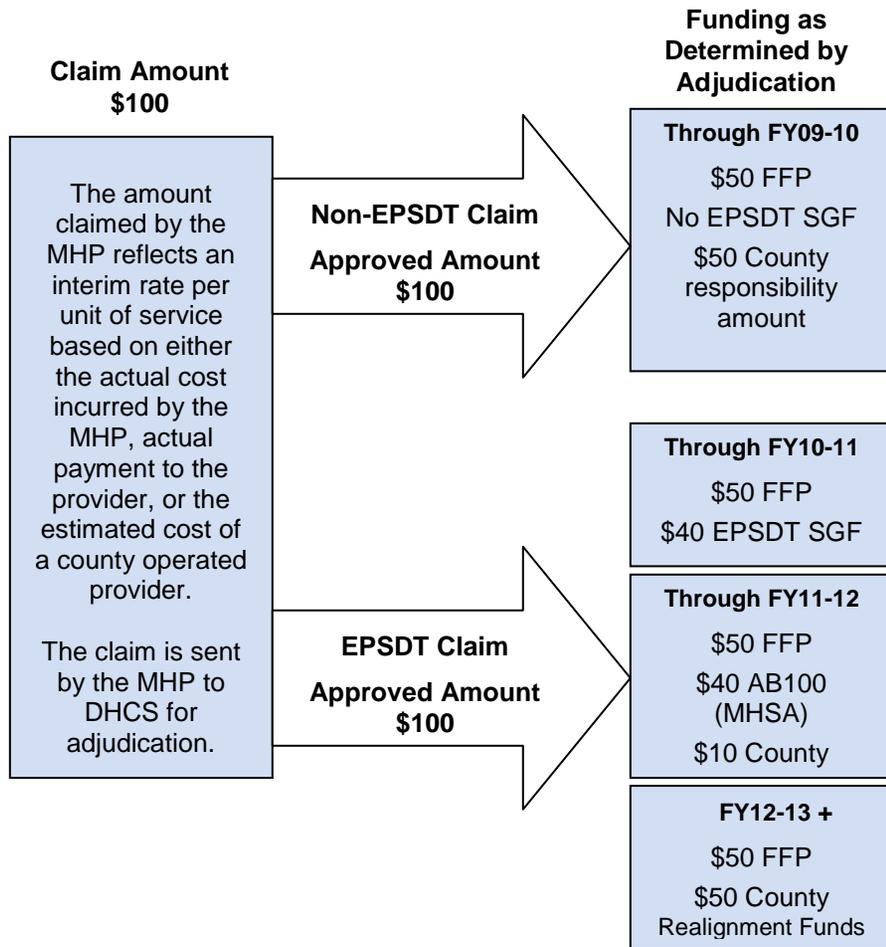
a percentage of the balance based on the county-specific EPSDT reimbursement percentage. State and/or county funds used to incur the expenditure may include funding from:

5. State Realignment
6. Allocated in FY2011/12
7. N/A in FY2012/13
8. State Managed Care
9. Allocated through FY10/11
10. AB100, including:
 - a. Managed Care FY2011/12
 - b. EPSDT Quarterly Distributions FY2011/12
 - c. State General Fund (SGF)
 - d. Distributed for services through FY10/11
 - e. Mental Health Services Act (MHSA)
 - f. Local county monies
11. Other eligible sources such as grants, etc

Figure 6-1 shows that Mental Health Medi-Cal funding is comprised of both Federal and non-Federal funds. Federal funds are reimbursements to the State under the Federal Medicaid program. Non-Federal funds may be any non-Federal funds not otherwise limited by matching restrictions. Federal funds may not be used to match other Federal funds.

Examples of non-Federal funds used by counties include local county funds established by local taxes and other income. Other non-Federal funds include: State Realignment Funds, State Managed Care Allocations, SGF monies distributed for EPSDT, and MHSA funds.

Figure 6-1: Example of Mental Health Medi-Cal Claim Payments



Through FY10-11:

Payment Determination

FFP and SGF amounts are determined by DHCS during claim adjudication and the results are sent to DHCS Accounting for payment. The amount of SGF paid out is determined by each MHP's EPSTD Percentage, which includes factors for the MHP EPSTD baseline and growth.

Funding Sources

- Federal funds are drawn by DHCS based on the FFP requested by DHCS accounting and paid by the State Controller's Office on behalf of DHCS
- EPSTD SGF is paid by the SCO on the same warrant as FFP and come from the department's EPSTD budget allocation
- County funds come from State Realignment Funds, State Managed Care Allocation, county expenditure budgets, local taxes, and other income such as grants

Distribution

- State Realignment Funds are paid monthly to the MHP by the State Controller's Office
- State Managed Care Allocations are paid to the MHP by DHCS as an advance in accordance with Section 5778 of the Welfare and Institutions Code and the contract between DHCS and the MHP
- FFP and EPSTD SGF are paid based on the approved claim amount from claims for actual provider expenses submitted to DHCS by the MHP for reimbursement

6.3 Funding Sources

6.3.1 State Realignment Funds

State Realignment Funds (Sales tax and vehicle license fees) are paid monthly to the county by the State Controller's Office. In FY91-92, California's State budget was 'realigned', placing the responsibility and a greater share of the risk for social services, physical health, and mental health programs on the counties. Under realignment, the county's share of the cost for the realigned programs was funded by new sales tax revenue sources and vehicle license fees.

6.3.2 The Local Revenue Fund

The Local Revenue Fund contains a Sales Tax Account, Sales Tax Growth Account, Vehicle License Fee Account, Vehicle License Fee Growth Account, and several sub-accounts. The revenues deposited into these accounts are distributed by the State Controller's Office to all counties on a monthly basis according to various formulas found in statute.

6.3.3 FFP

FFP is paid based on claims for actual provider expenses submitted to DHCS by the MHP for reimbursement. Claims submitted by the MHP must be represented by CPE incurred by the MHP.

6.3.4 EPSDT/SGF Effective FY11-12

EPSDT/SGF payments will not be paid out of the SDMC system. Pending Legislation for FY12-13, counties will receive payment with 2011 Realignment.

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Chapter 6: Claim Processing Overview

⇒ Arrows from counties to the Department** indicate HIPAA 837 transaction claim submissions.

⇒ Arrows from the Department** to counties indicate HIPAA 835 health care claim payment/advice transactions.

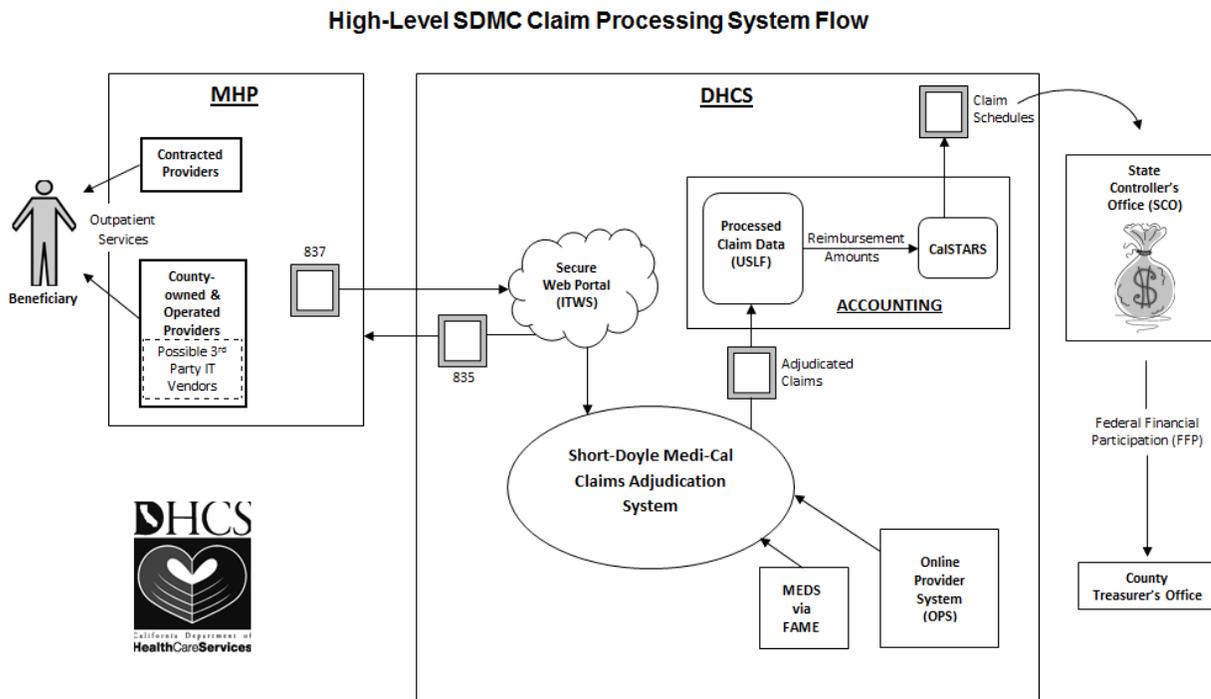
① Mental Health Medi-Cal claims submitted by MHPs to DHCS include both mental health outpatient and inpatient service-related claims. Background information on specialty mental health Medi-Cal is described on the [DHCS website](#).

**Please note that effective July 1, 2012, the DMH portion of the claim process has been transitioned to the Dept of Health Care Services (www.dhcs.ca.gov)

Figure 6-2 (next page) represents another high-level view of the SDMC Claim Processing System and illustrates the following:

- Claim submission by MH Medi-Cal Provider to MHP
- Claim submission by MHP to DHCS
- DHCS claim adjudication and processing
- State Controller's Office (SCO) claim payment to the County Treasurer's Office

Figure 6-2: High-Level SDMC Claim Processing System Flow



A claim in the Short-Doyle Medi-Cal (SDMC) Claim System is a request from a County Mental Health Plan for the reimbursement of costs for specialty mental health services provided to an eligible Medi-Cal beneficiary. DHCS receives SDMC claims from the MHP in an electronic file (837) via secure web portal (ITWS). DHCS validates that the 837 is accompanied by a valid Certification of Public Expenditure (1982A) and forwards the claim for adjudication by the SDMC system. The SDMC system performs various edits, including validating service provider certification and beneficiary eligibility, to determine the reimbursement due to the MHP. Claims processed in the SDMC system are either approved for payment or denied. For denied claims, a Claim Payment Advice (835) file is returned immediately to the MHP. For approved claims, an 835 is returned to the MHP once payment has been made by the State Controller's Office (SCO).

A claim in the **Short-Doyle Medi-Cal (SDMC) Claim System** is a request from a County Mental Health Plan for the reimbursement of costs for specialty mental health services provided to an eligible Medi-Cal beneficiary. DHCS receives SDMC claims from the MHP in an electronic file (837) via secure web portal (ITWS). DHCS validates that the 837 is accompanied by a valid Certification of Public Expenditure (1982A) and forwards the claim for adjudication by the SDMC system.

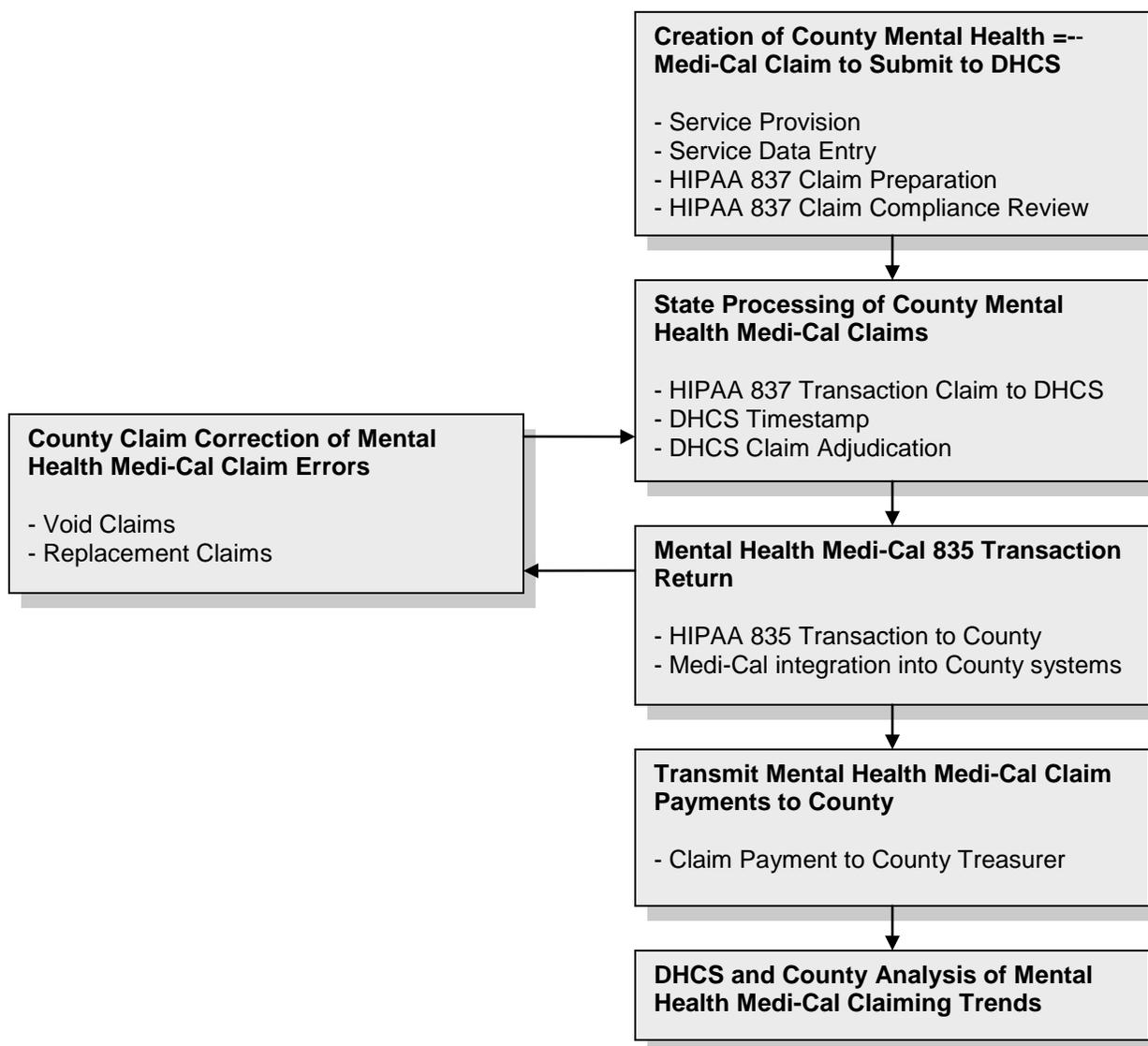
The SDMC system performs various edits, including validating service provider certification and beneficiary eligibility, to determine the reimbursement due to the MHP.

Claims processed in the SDMC system are either approved for payment or denied. For denied claims, a Claim Payment Advice (835) file is returned immediately to the MHP. For approved claims, an 835 is returned to the MHP once payment has been made by the State Controller's Office (SCO).

6.4 Mental Health Medi-Cal Claim Stages

Mental Health Medi-Cal claims are categorized by stages of the claim process. Each stage may be monitored or analyzed for efficiency and improvements. The following chart summarizes the various claim stages:

FIGURE 6-3: MENTAL HEALTH MEDI-CAL CLAIM STAGES



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FFP and SGF are paid in a single warrant for all claims submitted beginning July 2009. Due to the realignment of funds to Counties, payments of FFP & SGF in a single warrant have ceased for claims with Dates of Service through June 30, 2011.

To change the destination that your MHP's warrants are sent to, please send your request on official letterhead and signed by the Director of your MHP to:

Dept of Health Care Services
Accounting Section, MS 1101
PO Box 997415
Sacramento, CA 95899-7415

6.5 Submission Timeliness

The timeline for initial submission of a Mental Health Medi-Cal claim is critical.

In accordance with AB1297 (effective July 1, 2012) MHPs will have 12 months from the month of service to submit a timely claim.

- Replacement claims may be submitted up to 15 months from the month of service without a DRC so long as the initial claim was submitted prior to one year from the date of service
- An MHP may void a claim at any time without a DRC
- A claim denied by DHCS cannot be voided
- A DRC submitted with timely initial or replacement claims will not cause a denial

Initial submission of a claim after 12 months from service month will result in claim denial. Exceptions to the 12 month deadline may occur in the case of court or State hearing decisions. If approval has been granted by DHCS to submit claims over one year from the date of service MHPs may submit those claims using their normal electronic submittal process. Although not required, it is highly recommended that over one year claims be submitted in a different file from other claims. This will help to ensure that if there are any adjudication, processing, or payment delays due to the age of the claim, those delays will not impact other claims.

6.6 Voids and Replacements

- Denied claims cannot be voided
- Only approved claims may be voided
- Denied claims can be replaced

If the replacement claim is approved, the replacement claim can be voided if necessary.

If an original claim is submitted containing multiple service lines spanning multiple service months, the claim will be denied. In this situation, the MHP needs to break this single claim into multiple claims – each claim with service lines belonging to the same service month. These new broken down claims cannot be submitted as replacements to a single original claim because their new structure does not match with the original. So these new claims will have to be submitted as originals.

In the sequence of an original claim and its replacements, only the last valid transaction can be voided or replaced. For example, if Claim A is denied and replaced by Claim B which is later replaced by Claim C, neither Claim A nor Claim B can be replaced or voided; only Claim C can be replaced or, if approved, voided.

Exception: when there are errors in the void/replacement transaction, the claim is denied with an adjustment reason code of CO129 (prior processing information incorrect)

In the example above, if Claim B was denied with a CO129 then Claim C should reference Claim A. The same exception applies if Claim B was a void and was denied with a CO129: Claim C (either a void or replacement) should reference Claim A.

For more examples and technical information on this exception can be found in the Companion Guide Appendix.

Voided claims cannot be replaced at any time. Voided claims cannot be voided to “undo” the void.

For more information please refer to the Companion Guide Appendix.

6.6.1 Deadlines: Voids

Void claims are transactions submitted to completely reverse a previously submitted and approved claim. There are no time restrictions on voiding approved claims since FFP must be returned to CMS regardless of the age of the claim.

6.6.2 Deadlines: Replacements

Replacement claims are claims that correct previously submitted claims. There are no deadlines for submitting replacement claims for approved claims. However, there is a 24-month window for drawdown of FFP. DHCS allows 22 months for processing approved claims. Claims submitted outside of the 22 months will be processed at Cost Settlement.

When a claim for service filed by an MHP is denied due to an error in the claim or due to incomplete information, the MHP may submit one or more replacement claims no later than 15 months after the month of service.

If the original claim included a DRC, resubmit the same DRC on the replacement claim.

6.7 UMDAP: Uniform Method of Determining Ability to Pay

Uniform Method of Determining Ability to Pay or UMDAP determines the SOC amount collected from a beneficiary that may be applied to the beneficiary's UMDAP liability. If the SOC is not cleared at the time the claim is adjudicated, the beneficiary is deemed ineligible and the claim will be denied. For more information on UMDAP, see Information Notice 98-13.

6.8 Medi-Cal Share of Cost Eligibility

Beneficiaries may have what is known as Medi-Cal Share of Cost (SOC).

Some Medi-Cal beneficiaries must meet a specified SOC for medical expenses before Medi-Cal will pay claims for services provided in that month.

A beneficiary's SOC is usually determined by the County Department of Social Services and is based upon the beneficiary's or family's income and living arrangement (See: UMDAP). Members of the family may have the same or different Share of Cost amounts.

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The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.

Mental Health IT systems are required to indicate Medi-Cal SOC payments per guidelines found in the 837 Companion Guide. These guidelines are used to calculate the claim net billed amount, which is the basis for payment determination.

If a beneficiary is obligated to pay a portion of the service being billed, the provider should clear the SOC before submitting the claim. "Patient Amount Paid" on the claim would be the amount that the beneficiary paid or was obligated to pay. The SDMC system will deny any claim submitted where the beneficiary has an outstanding SOC for the month of service at the time of adjudication. Consider this example:

- Transaction 1 - Service \$200, Patient pays \$200, Balance \$0
- Transaction 2 - Service \$200, Patient pays \$0, Balance \$200

If the beneficiary's current unmet SOC is \$200, then transaction 1 gets denied. If the provider applies the beneficiary payment from transaction 1 to their SOC (a separate process), the beneficiary becomes eligible and transaction 2 can be payable. If the beneficiary payment is not applied, both transactions will be denied.

Providers may clear SOC for any valid Medi-Cal services even if they are not claimable to SDMC. Providers do not need to send in claims for services delivered that are used to clear SOC if the claim has already been paid in full from other sources,

Note that clearing SOC immediately updates Medi-Cal's files and more than one provider can clear Share of Cost without interfering with each other, but the SDMC eligibility source is only updated daily. Counties may choose to wait until the day after SOC clearance to submit claims for that beneficiary.

DHCS Inpatient/Outpatient Medi-Cal Manual contains SOC information.²² This DHCS manual provides additional information about:

- Who determines SOC
- How to determine if a beneficiary must pay SOC
- Obligating SOC payment
- Certifying SOC
- Eligibility Verification Confirmation (EVC) numbers

²² http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

6.9 Title XXI: Enhanced Services for Children

The State Children's Health Insurance Program (SCHIP)²³ was established under Title XXI of the Social Security Act. The purpose of this program is to enable States to initiate and expand child health assistance to uninsured, low-income children. The FFP provides an enhanced match for all services funded under Title XXI. In California, assistance is provided primarily through either or both of two methods:

1. Healthy Families Program (HF). HF provides a basic health benefit package (provided by HF health plans) that includes a mental health benefit for children assessed with serious emotional disturbances (SED)²⁴. HF is provided by County Departments of Mental Health (see 6.10).
2. Expanding eligibility for children under the State's Medicaid (Medi-Cal) Child Health Plan (known in California as MCHIP). MCHIP provides an enhanced Medicaid match under Title XXI for physical health and mental health service expenditures for 'optional targeted low-income children.' These beneficiaries are defined in Federal law as targeted low-income children who would not qualify for Medicaid.

Title XXI MCHIP and HF Aid Codes are enhanced (65%) Federal Funds match as shown in the [Aid Codes Master Chart](#) on the MedCCC Library website.

6.10 Healthy Families

Established in 1998, Healthy Families provides low-cost insurance for children under the age of nineteen whose families do not have insurance, do not qualify for no-cost Medi-Cal, and whose income is at or below 250% of the Federal poverty level. Eligible children may be U.S. citizens, U.S. non-citizen nationals, or eligible-qualified immigrants. HF insurance covers health, dental, and vision services. Most covered services are provided by health plans under contract with the Managed Risk Medical Insurance Board (MRMIB), the State agency that administers HF.

²³ <http://www.cms.hhs.gov/home/schip.asp>

²⁴ [W & I Code, Division 5, Part 2, Chapter 1, § 5600.3](#)

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HF provides 'basic' mental health services per CCR, Title 10.²⁵ However, if a child is thought to be SED, the HF beneficiary is referred to his or her local MHP for an SED assessment. If the MHP determines that the child meets SED criteria, the MHP assumes responsibility for the provision and payment of treatment of the SED condition(s). The exception being the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HF. When an MHP assumes responsibility for the treatment of an HF beneficiary's SED condition, the MHP claims those services through the SDMC Claim System. SDMC will reimburse the MHP for SED assessment services performed regardless of whether the assessment results in an SED determination or not.

HF claims are distinguished by the beneficiary's Aid Code. SDMC Phase 1 allowed for MHPs to indicate that a claim was for HF and specify that the HF Aid Code be used for adjudication. SDMC Phase 2 uses a different methodology, a detailed description of which can be found in Section 2 of the Companion Guide Appendix. The reason for the change is that SDMC determines the Aid Code used during adjudication by evaluating all eligible Aid Codes for the beneficiary and selecting the Aid Code with the highest FFP percentage.

Consider the following two examples:

1. If a claim comes in for an SED HF beneficiary, and this beneficiary also has other regular Medi-Cal Aid Code eligibility, the claim would be adjudicated using the enhanced HF Aid Code with 65% FFP.
2. If the beneficiary has both HF *and* Refugee Medi-Cal, the claim would be adjudicated based on the 100% FFP Refugee rate rather than HF (65% FFP reimbursement) because edits that normally deny claims when a prior payer has not been billed are not applied when the prior payer is HF.

For further information on HF, including applicable FFP Rates and Inpatient Provider Numbers, see Information Notice No. [07-01](#) and the Companion Guide Appendix.

²⁵ [CCR, Title 10, Chapter 5.8, § 2699.6700](#)

6.11 EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

EPSDT is Medicaid's benefit for individuals under 21 years of age. EPSDT was included as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation²⁶ and became a part of the Medicaid Program at that time. In California, the EPSDT benefit includes comprehensive health, mental health, dental, hearing, and vision care services for Medi-Cal eligible children/youth under 21 years of age.

EPSDT mental health services were expanded in 1995 by DHCS in accordance with federal regulations and statutes that require States to not only provide and pay for any medically-necessary health treatment services, but also provide and pay for any mental health treatment services needed to correct or ameliorate the mental health condition of a full-scope Medi-Cal-eligible beneficiary under 21 years of age. Part of the impetus for this expansion was a lawsuit, *T.L. vs. Belshé*,²⁷ which put forth the position that California had not fully complied with Federal regulations and statutes applicable to EPSDT benefits.

In order to fund the expansion of EPSDT specialty mental health services, DHCS estimated the amount of additional SGF dollars and FFP dollars needed after a county baseline was established. This baseline represented the county's responsibility to maintain their mental health services funding levels prior to EPSDT expansion, and was derived from the FY1994/95 Mental Health Medi-Cal Cost Report settlement amounts adjusted for cost of living.

As a result of this expansion, funding for EPSDT specialty mental health services was governed by a complex set of rules applicable to each MHP's program funding that historically included baseline funding, expansion funding above the baseline, and a 10% county match for growth in the SGF matching requirement for the cost of EPSDT services above the FY01-02 level.

Estimation of statewide EPSDT claiming data requires access to relevant data for EPSDT services claimed through Mental Health Medi-Cal. EPSDT services may be delivered to a beneficiary by the county of origin (the MHP where Medi-Cal eligibility is established) or by another county.

²⁶ [Omnibus Budget Reconciliation Act of 1989, P.L. 101-239](#)

²⁷ [T. L. v. Belshé, No. CV-S-93-1782 LKKPAN, \(E. D. Cal., 1995\)](#)

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EPSDT services are restricted to full-scope Medi-Cal beneficiaries under 21 years of age who meet the medical necessity criteria. Full-scope Medi-Cal eligibility is indicated by the Medi-Cal Aid Code assigned during the Medi-Cal application and eligibility intake and/or renewal processes conducted by County Social Service Departments. These Aid Codes may be found in the [Aid Codes Master Chart](#) (located online in the MedCCC Library).

For EPSDT services rendered through FY10-11, the MHP's EPSDT SGF settlement is based on information from settled Cost Report data for Mental Health Medi-Cal, Mental Health Medi-Cal and EPSDT approved claims data and paid claims information. Each MHP receives a final EPSDT settlement letter that includes the calculations used to generate the final settlement amount.

As indicated above, funding for EPSDT specialty mental health services was historically a combination of SGF (approximately 40%), FFP reimbursements (50%), and county funds (approximately 10%). Reimbursement was, and continues to be, based on approved and certified claims for services.

Pursuant to AB100, Mental Health Services Act (MHSA) funds were appropriated in the budget and allocated to MHPs for reimbursement for EPSDT services in place of SGF for FY11-12 only.

Effective FY12-13, the non-Federal share of reimbursement for EPSDT specialty mental health services will be fully "re-aligned" to the MHPs and paid with a funding source generated through taxes and/or vehicle license fees.

6.11.1 EPSDT: Supplemental Specialty Mental Health Services - Therapeutic Behavioral Services (TBS)

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) supplemental specialty mental health services are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need, diagnostic and treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additionally medically necessary services. These additional services are known as EPSDT Supplemental Services and include: private duty nursing services from

a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN), Case Management, Pediatric Day Health Care, and Nutritional and Mental Health Evaluations and Services.

In July 1999, following the preliminary injunction in the Emily Q. vs. Belshé lawsuit, Therapeutic Behavioral Services (TBS) was established as an EPSDT supplemental specialty mental health service. MHPs became responsible for providing, or arranging for the provision of TBS. TBS is an intensive, one-to-one service designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term, measurable goals based on the beneficiaries needs. TBS may be provided to beneficiaries under age 21 (with full-scope Medi-Cal), serious emotional challenges, as determined medically necessary and needed to address the beneficiaries mental health needs. TBS is provided in conjunction with other specialty mental health services but not as stand-alone services. To qualify for TBS, beneficiaries must be also under consideration for placement in a Rate Classification Level (RCL) 12 or higher facility or group home, or at risk of hospitalization in an acute care psychiatric facility.

6.12 Mental Health Medi-Cal Service Claim Rates

Until July 1, 2012, local MHPs and contract providers have set their usual and customary charges. Statewide Maximum Allowance (SMA) rates were set and published annually by DMH via DMH Letters and Information Notices.

Effective July 1, 2012, DHCS has established County Interim Rates (CIR) of reimbursement for specialty mental health services provided by each MHP's county-owned and operated providers and also their contracted providers. These interim rates are intended to approximate each county legal entity's actual cost of providing each Medi-Cal mode of service and service function that it is certified as eligible to bill to Medi-Cal. These rates will have been entered into the SDMC system. The payments made from these interim rates will be settled to the lower of cost or charges through the cost report.

6.13 Federal Funding Ratios

Mental Health Medi-Cal and HF services are paid through Federal, County and State funding. However, Federal and State sharing ratios are subject to change.

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Federal regulations 42CFR 447.50 through 447.59 describe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.²⁸

Federal reimbursement is determined annually and released as FMAP.^{29,30} Subsequently, DHCS notifies MHPs of FMAP changes through correspondence such as Letter No. [06-06](#).

Mental Health Medi-Cal claim payments are settled by county-submitted Cost Reports and subsequent DHCS audits.

Historical FMAP data may be found on the United States Assistant Secretary for Planning and Evaluation (ASPE) website.³¹

6.14 Mental Health Medi-Cal Claim Processing

To submit a Mental Health Medi-Cal claim, MHPs and their billing service vendors must fulfill certain requirements. These requirements include obtaining ITWS usage authorization/enrollment; certifying providers as eligible to bill Medi-Cal; converting local data sets into DHCS-approved claim data sets; processing 837 and 835 transactions; and completing any related claim certification forms, such as the MC1982A, MC1982B, or MC1982C.

6.14.1 Mental Health Medi-Cal Claim Submission

All Mental Health Medi-Cal claims submitted to ITWS are time stamped at DHCS and are considered for adjudication. This process described below is available to authorized submitters 24 hours a day/ seven days a week.

6.14.2 Mental Health Medi-Cal 837 Claim Transactions

Mental Health Medi-Cal 837 claim transactions are submitted electronically via ITWS, the portal for online DHCS applications, by selecting **Short-Doyle/Medi-Cal Claims**

²⁸ http://www.access.gpo.gov/nara/cfr/waisidx_10/42cfr447_10.html

²⁹ http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=69209

³⁰ <http://edocket.access.gpo.gov/2006/E6-20264.htm>

³¹ <http://aspe.hhs.gov/health/fmap.htm>

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from the **Systems** menu. To upload a file or files, select **Transfer Files (Upload and Download)** under **Function** and follow the prompts. Hard copy submittal is not allowed.

There is no restriction on claim submission requiring that all claims submitted in a single claim file to be from the same fiscal year. The only date restriction is at the claim level, where all service lines for a particular claim must be in the same month and year.

The structure and contents of 837 transactions are defined in the 837 Companion Guide. Additional requirements are outlined by Departmental Information Notices and Letters. For example, Letter [07-05](#) details the requirement that 837 transactions include gross cost of service and related other payer payments and/or adjustments. Figure 6-4 illustrates this process.

The Companion Guide and Companion Guide Appendix should be consulted for specific details on processing 837 transactions.

6.14.3 Mental Health Medi-Cal 835 Payment Advice

Counties can download their 835 payment advice records from ITWS by selecting **Short-Doyle/Medi-Cal Claims** from the **Systems** menu. The 835 Companion Guide should be consulted for specific details on the contents of the 835 transaction.

DHCS will process voids separately from Original or Replacement claims. This applies to voids explicitly submitted by the MHP and the implicit voids generated automatically when the MHP submits a replacement claim. That means that voids will be returned on a separate 835 that will only contain voided claim information. They will be balanced with a Provider Adjustment. The MHP will be invoiced for the amount of the void and the 835 will contain a tracking number that will tie to the invoice. From a timing standpoint, the void 835 associated with a replacement claim will be returned before the 835 for the replacement claim itself.

6.14.4 MC1982A: Short-Doyle/Medi-Cal Monthly Claim for Reimbursement: Treatment Cost

A completed copy of the MC1982A form (Short-Doyle/Medi-Cal Monthly Claim for Reimbursement: Treatment Cost, formerly MH1982A) must accompany each claim file. Information Notice No. 03-10 outlines this requirement. A .pdf of the signed MC1982A form must be included in the zipped claim file before it is uploaded to ITWS. The

MC1982A is available on ITWS for authorized users.³² After logging on to ITWS, select **Systems**, select **Short-Doyle/Medi-Cal Claims**, select **SDMC**, and select **Claim Forms**.

Federal regulations define who is allowed to certify that submitted claims represent a CPE.³³ These regulations must be followed when gathering signatures for the MC1982A (a .pdf of which is submitted along with claim files).

MC1982As show the file name of the claim file that is being certified. Occasionally, a claim file is rejected and must be resubmitted using a new file name. The original MC1982A can be used when the total dollar amount being claimed in the new file is unchanged from the original. (There is a place on the MC1982A to indicate that the same file was resubmitted under a new name.) However, when the total dollar amount being claimed in the new file is different, a new MC1982A must be signed and submitted with the new claim files. Technical information relating to the resubmission of rejected claim files can be found in the Companion Guide Appendix.

6.15 Disallowance and Void Transactions

The ITWS Disallowed Claim System (DCS) remains operational for disallowing only SDMC Phase 1 claims as described in Information Notice [09-09](#). The DCS will be available indefinitely for SDMC Phase 1 claims, however SDMC Phase 1 claims disallowed through the DCS after June 30, 2010 will not be eliminated from the audit sample.

MHPs must not submit new claims in SDMC Phase 2 for any claims disallowed in the DCS. For SDMC Phase 2 claims, MHPs must use the Void or Replace functionality to reverse or correct claims instead of using the DCS.

6.16 Paper Claims, Error Correction and Replacement Transactions

Paper claims, paper claim error correction, and the electronic Edit Error Correction Report process are no longer available for SDMC Phase 1 or SDMC Phase 2 claims for direct services under Mental Health Medi-Cal. SDMC Phase 1 claims that were suspended were eligible to be resubmitted in SDMC Phase 2 as new original claims

³² http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/MC_1982_A%20Rev_07_24_12.pdf

³³ [42 CFR 438.606](#)

(using DRC 9 when approved by MedCCC). If those claims were denied, they must be corrected using Replacement claims.

There are limits on what may be changed on a replacement transaction. The Client Index Number (CIN) must be the same on the Replacement claim as the Original. Further, two of the following fields must be the same for the Replacement to be adjudicated:

1. Procedure Code
2. Date of Service
3. Place of Service
4. Provider ID

Only if these conditions are met, will the SDMC Claim Processing System allow the claim to be adjudicated.

6.17 Denials vs. Rejections

When any portion of a claim file does not meet the Workgroup for Electronic Data Interchange Strategic National Implementation Process HIPAA Transaction and Code Sets Final Rules (“SNIP edits”) the entire claim file is rejected and the original submittal date is not preserved. The claims contained in that file are not considered denied claims and must be corrected and submitted as new Original claims, not Replaced. This creates a scenario where it is possible that even if all the claims were timely when originally submitted, submitting the claims again at a later date might cause them to be denied as late submissions if the resubmission date is outside the timely Original submittal period. Since it may take a day or longer to apply the necessary corrections, DHCS strongly recommends that MHPs do not wait until the last day of the timely submittal period to submit a claim.

6.18 Mental Health Medi-Cal Reports

6.18.1 Mental Health Medi-Cal 835 Payment Advice

Currently, as required by HIPAA, DHCS is providing counties with 835 payment advice transactions that indicate approval or denial of claims submitted via 837 health care

claim transactions. This data is provided so that counties can update their proprietary billing systems.

6.18.2 Approved Claims Report

DHCS provides each MHP with a monthly approved claims reports for each fiscal year since FY02-03 via Excel workbooks on ITWS.³⁴ This report contains a claim approval summary and detail information including total approved amounts by program for FFP and SGF.

³⁴ <http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>

CLAIM LIMITS AND SPECIAL CONDITIONS

7.0 Introduction

This chapter provides an overview to edit, lockouts, and repeat procedures and includes:

[Overview](#)

[Duplicate Claims and Scenarios](#)

[Maximum Service Time and Lockouts](#)

[Duplicate Service Error Messages](#)

[Special Claiming and Denial Situations](#)

7.1 Overview

Claims that have passed all edits in the SDMC system and are eligible for payment are edited against other incoming claims and the history file of approved claims. Table 75 provides billing scenarios depicting sequences of service claims and the resulting claim approval or denial, depending on the values of the eight duplicate criteria fields, duplicate override code, and admission date. Below are the definitions of Duplicate Claims and Maximum Service Time and Lockouts.

7.2 Duplicate Claims and Scenarios

A duplicate claim in SDMC is defined as the second and all subsequent claims that match all of the following criteria:

1. Same Beneficiary (CIN)
2. Same Submitting County
3. Same Facility Location NPI
4. Same Rendering Provider NPI
5. Same Date of Service
6. Same Procedure Code
7. Same Units
8. Same Amount Billed

Subsequent claims will be denied for being a duplicate unless the claim has a duplicate service procedure modifier.

7.2.1 Duplicate Service Procedure Modifier Codes

The duplicate service procedure modifier code is used by the MHP to certify that the MHP has verified that the identified service was distinctly different or was actually performed again for valid clinical reasons

Allowable duplicate service procedure modifier codes are listed below and in 'Table-B – Duplicate Billing Edit Procedure Modifiers' of the Companion Guide Appendix.

59 Distinct Procedural Service

76 Repeat Procedure by Same Person (i.e. Rendering Provider)

77 Repeat Procedure by Different Person (i.e. Rendering Provider)

7.2.2 Units

The Units field on the 837 corresponds to the units of time for all but 24-Hour Services, in which case it corresponds to Units of Service. See the 837 Companion Guide for more information on the Units field and the Companion Guide Appendix for related calculations/conversion.

7.2.3 Line Item Charge Amount

The Line Item Charge Amount field on the 837 may not match the Line Item Charge Amount field on the 835 because the gross amount on the 837 is adjusted to create the Net Billed Amount in the SDMC system. The Net Billed Amount is reported in the Line Item Charge Amount field on the 835. The Net Billed Amount is the value used as one of the criteria in the SDMC Claim System Duplicate Service evaluation. Refer to the Companion Guide for the calculations used to create the Net Billed Amount.

7.3 Multiple Services and Lockouts

Multiple Services are claims for services for the same day and recipient that are approved for reimbursement, up to the maximum accumulation of units of time for each Service Category and subject to the CIR or maximum payment allowed per unit of time for each Service Category. For inpatient claims, the discharge day (the day the patient leaves the hospital) will not be counted since there is no service on that day. Services for the same day for the same recipient may be approved for reimbursement if the claim contains an appropriate repeat procedure code.

Lockouts (L) are claims for mutually exclusive activities. Lockouts are also services that should never occur on the same day for the same recipient and will not be approved for reimbursement. Some claims for services may occur on the day of admission (AD) but are lockouts on other days.

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Table 7-1: Multiple Services and Lockouts

HCPCS	H2015	H0046	H2013	H0018	H0019	H2012	H2012	H2012	H2012	T1017	T1017	H2015	H2019	H2010	H2011	S9484	H2015
CR Mode / SDMC Mode of Service	05 / 07-09	05 / 07-09	05 / 05	05 / 05	05 / 05	10 / 12, 18	10 / 12, 18	10 / 12, 18	10 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18	15 / 12, 18
Service Function	10-18	19	20-29	40-49	65-79	81-84	85-89	91-94	95-99	01-06, 08-09	07	10-19, 30-56, 59	58	60-69	70-79	20-29	57
HCPCS/ Procedure Codes	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF	Adult Crisis Residential	Adult Residential	Day Tx Intensive Half Day	Day Tx Intensive Full Day	Day Rehab Half Day	Day Rehab Full Day	CM / Brokerage (4)	ICC (4)	MHS (5)	TBS (5)	Med Support (1)	Crisis Intervention (2)	Crisis Stabilization ER & UC (3)	IHBS (5)
H2015 Hospital Inpatient	L	L	A	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0046 Hospital Inpatient Admin Day (6)	L	L	L	L	L	L	L	L	L	I	I	L	L	L	L	L	L
H2013 PHF	A	L	L	A	A	A	A	A	A	I	I	A	A	A	A	A	A
H0018 Adult Crisis Residential	A	L	A	L	A	A	A	A	A			A	A		A	A	A
H0019 Adult Residential	A	L	A	A	L							I	I				T
H2012 Day Treatment Intensive: Half Day	A	L	A	A		L	L	L	L			T	T				T
H2012 Day Treatment Intensive: Full Day	A	L	A	A		L	L	L	L			T	T				T
H2012 Day Rehabilitative: Half Day	A	L	A	A		L	L	L	L			T	T				T
H2012 Day Rehabilitative: Full Day	A	L	A	A		L	L	L	L			T	T				T
T1017 Case Mgmt/Brokerage (4)	I	I	I							O							
T1017 ICC (4)	I	I	I								O						
H2015 MHS (5)	A	L	A	A	I	T	T	T	T			O					T
T2019 TBS (5)	A	L	A	A	I	T	T	T	T				O				T
H2010 Medication Support (1)	A	L	A											O			T
H2011 Crisis Intervention (2)	A	L	A	A											O		T
S9484 Crisis Stabilization ER & UC(3)	A	L	A	A	T	T	T	T	T			T	T	T	T	T	T,O
H2015 IHBS (5)	A	L	A	A	T	T	T	T	T								T

I Institutional Limitations: Audit
L Lockout: Services that may not occur on the same day
A Lockout: Except for day of admission and day of discharge
T Lockout: During actual time service is provided - audit, not a computer edit
O Override allowed for duplicate services with procedure modifier code
 Multiple services may be allowed on the same day, limited by the maximum time allowed.

(1) Maximum of 4 hours (240 Minutes) per day
 (2) Maximum of 8 hours (480 minutes) per day
 (3) Maximum of 20 hours per 24 hour period
 (4) Maximum of 24 hours (1440 minutes) per day
 (5) Maximum of 2878 minutes per day
 (6) An Administrative Day may not be billed on the day of admission

7.4 Duplicate Service Error Messages

For 4010, Duplicate Service Error Messages and Codes are listed in 'Table E – Denial Reason Codes' of the Companion Guide Appendix.

For 5010, please see the Companion Guide.

7.4.1 Lockouts

In cases where services are listed as a lockout ('AD' or 'L') in the SDMC Table of Multiple-Service Billing Edits, the service on the claim may only be corrected so that the claim no longer meets the lockout condition. **Adjustment Reason Code 18 with Health Remark Code M80** indicates the SDMC system has found a duplicate service that cannot be overridden with a duplicate service procedure modifier.

7.4.2 Duplicate Services

Adjustment Reason Code 18 with Health Remark Code M86 indicates the SDMC system found a duplicate service that may be corrected by using a duplicate service procedure modifier code, if appropriate.

7.4.3 Excessive Units

There is no override possible for this error. Correct the appropriate fields in this or other claims as needed. **Adjustment Reason Code A1 with Health Remark Code M53** indicates the SDMC system has found a service, when added to previously approved claim(s), exceeds the maximum amount of time allowed.

7.4.4 Institutional Limitation

Targeted Case Management (TCM) services are limited when a beneficiary is receiving inpatient services. TCM must be performed within 30 days of the beneficiaries discharge date. For a claim for TCM services to be approved, a discharge date must be present on the claim.

7.4.5 Time of Service Limitation

Services that should never occur during the same time may be found and disallowed during audit(s).

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7.4.6 Medi-Medi / Palmetto

Regarding Medicare/Medi-Cal claiming, MHPs must coordinate their claiming with Palmetto so that SDMC claims are returned to MHPs (Provider-to-Payer-to-Provider model) instead of forwarded to DHCS (Provider-to-Payer-to-Payer model), as may be done with physical health claims. The SDMC system accepts certified claims only from MHPs.

7.4.7 Out of State: Outpatient Services

Out-of-state specialty mental health services are not billable to SDMC³⁵ except when it is customary practice for a California beneficiary to receive services in a border community in another state. Title 9, CCR, § 1810.205.1 **Border Community** means a community located outside the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHPs because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.

7.4.8 Out of State: Inpatient Services

Out-of-State TARs are handled by the San Francisco Field Office.

The correct number to refer providers is 415-9054-9608. Other numbers may get a menu with a very long wait time.

It will help the provider to know the following:

1. Medi-Cal pays for emergency psychiatric admissions only at a campus with an emergency psychiatric facility
2. There is no coverage for free-standing facilities
3. In order for the provider to get paid, they must be a Medi-Cal provider
4. Because of #2 above, it may be necessary to contact provider enrollment at <http://www.medi-cal.ca.gov/>
5. Where the provider is not Medi-Cal enrolled, payment will involve a retrospective review.
6. The San Francisco Field Office will give the provider a TAR, and the provider must give progress notes, hospital face record sheet, etc. (SF Field Office rep will provide this information)
7. The address for the SF Field Office is:
185 Berry Street, Ste. 290
San Francisco, CA 94119-3704

³⁵ CCR, Title 9, Section 1810.355(b)

7.4.9 Pregnancy Indicator and Emergency Indicator

The Pregnancy Indicator and/or the Emergency Indicator must be supplied if relevant. When the Pregnancy Indicator is required by a restricted aid code, the Pregnancy Indicator is required or the service line will be denied during adjudication. In order to ensure that SDMC will use the appropriate aid code, the Pregnancy Indicator should always be included if the beneficiary is pregnant. Auditors do not consider whether or not SDMC used a pregnancy-restricted aid code for adjudication during the audit. When including the Emergency Indicator, the field should be populated based upon the circumstances surrounding the service.

7.4.10 Replacement Claim Matching Rules

In addition to meeting other business rules (such as timeliness and completeness), SDMC must be able to determine that a replacement is both valid and reasonably similar to the original. The first step in this determination is to ensure that the following fields match the claim being replaced:

1. Billing Provider EIN
2. Subscriber CIN

In addition, any two of the following four elements must also be the same as the claim being replaced:

1. Procedure Code
2. Date of Service
3. Place of Service
4. Provider ID

Since the CIN cannot be changed using a Replacement claim, CIN corrections must be made by voiding the incorrect claim and submitting a new Original claim. This restricts the correction period for incorrect CINs to the timeliness window for new Original claims, currently twelve months from the month of service. MHPs who feel they have good cause for submitting CIN corrections after that may request use of a DRC.

7.5 Special Claiming and Denial Situations

This section covers a number of special situations that may occur, describes the reasons for them and, where appropriate, the actions that should be taken in response.

7.5.1 Eligibility Errors

When a claim is denied due to lack of eligibility and the MHP has proof of eligibility, the MHP must correct the eligibility issues in MEDS before submitting a Replacement claim. There is no claim eligibility override in SDMC. DHCS cannot approve claims denied for eligibility reasons during audits. The DHCS Medi-Cal Help Desk³⁶ can assist with questions on the eligibility shown in the MEDS screens or POS eligibility verification system (Internet or POS device).

If a claim is denied for lack of Other Health Coverage (OHC) Coordination of Benefits (COB) information but the MHP has proof that the OHC has terminated, the MHP must correct the OHC issue in MEDS to avoid denial of replacement claims for future claims for that beneficiary. As long as MEDS shows the presence of OHC, SDMC requires Payer Amount Paid to show the results of third party billing.

Medi-Cal beneficiaries in Foster Care often appear in MEDS as if they have OHC. If the MEDS OHC indicator is "A", providers may request the removal of the OHC indicator by contacting the DHCS Third-Party Liability and Recovery Division³⁷. Otherwise, prior billing information must be included on the 837. MHPs must continue to bill OHC, if it exists, prior to billing Medi-Cal. Without COB information indicated, SDMC claims will be denied.

7.5.2 Third Party Response

If a third party (e.g. Kaiser, et al) has been billed but no response has been received by the MHP within 90 days, then the MHP is allowed to submit the claim without the usual COB information³⁸. Details on the appropriate codes to use can be found in section 2.3 of the Companion Guide Appendix. Please refer to [TPLR Division's website](#) for further information on Third Party Liability / Other Healthcare.

7.5.3 Duplicate Claims, Lockouts, and Maximum Units

If an MHP submits a claim with a service line that contains units over the maximum allowed, the allowable units are not approved: the service line is denied. The MHP may replace the denied claim with a service line that has fewer units.

³⁶ <http://www.medi-cal.ca.gov/contact.asp>

³⁷ http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_10724.asp.

³⁸ [W & I Code Section 14023.7](#)

Occasionally a claim will be denied because it is a duplicate claim, locked out, or over the maximum allowable units due to an approved claim from another county. Unfortunately, there is no place on the 835 to indicate which prior claim caused the denial. If the MHP is unable to make this determination themselves, the MHP should contact MedCCC to find out information about the conflicting claim or claims. One reason that this may happen is that the claim causing the problem may have been submitted by a different MHP and one MHP cannot view another MHP's claims. If that is the situation, the MHPs must work together to coordinate claim submission so that claims for beneficiaries receiving services in multiple MHPs have the intended adjudication results.

If a claim is denied due to exceeding the units approved by another MHP, the MHPs must reconcile any resulting payment issues.

7.5.4 EPSDT Reimbursement

Prior to July 1, 2011, State General Funds were available to reimburse MHPs for costs covered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In order to receive those funds, a beneficiary must have met all of the following criteria:

1. The claim must be approved
2. The beneficiary must be eligible for a full-service Aid Code
 - a. A full service Aid Code is one that is not restricted to a specific population of beneficiaries, such as refugees or pregnant women
 - b. The [Aid Codes Master Chart](#) is posted online in the [MedCCC Library](#)
3. Minor consent is not required
4. Beneficiary must be under 21 years of age at the time of the service
5. The beneficiary is not eligible under an HF Aid Code
6. The service is not a hospital Inpatient service

The amount of reimbursement is calculated starting with the claim approved amount (usually the lesser of the claimed amount or the State Maximum Allowance). The FMAP is applied to the approved amount and the non-FFP amount is used as the basis for the EPSDT calculation. The non-FFP amount is multiplied by the MHP's EPSDT percentage and the result is the amount of SGF paid to the MHP. Any residual amount after subtracting the FFP and the SGF from the approved amount is the MHP's responsibility. Each of these amounts is returned in the applicable 835 transaction record relating to that claim. EPSDT

percentages are recalculated each year. A table of EPSDT percentages can be found on the MedCCC web site.

7.5.5 Group Settings with Multiple Providers

Divide the number of minutes by the number of beneficiaries, and prorate that number by the amount of time spent by each provider at the group session. For example, a 100-minute session for 10 beneficiaries with two counselors present for the entire session: each counselor should bill five minutes for each beneficiary:

100 minutes / 10 beneficiaries / 2 counselors = 5 minutes per beneficiary per counselor

The progress note should clearly indicate length of group session with documentation time included (or documentation time clearly recorded separately). Both the number of group participants and the number of staff group facilitators also need to be documented.

7.5.6 PCCNs and Void and Replacement Claims

The MHP must refer to specific Payer Claim Control Numbers (PCCNs) when submitting replacement claims. Here are some examples:

Replacements - Post Adjudication Denied

- For 1st Replacement, use Original PCCN

1st Replacement Status: “CO129” (Original status remains unchanged), or “Denied Replaced”

- For 2nd Replacement, use Original PCCN

Voids – Post Adjudication Denied

- For 1st Void, Use Original PCCN

1st Void status: Void Denied” (Denied Claims may not be voided, original status remains unchanged)

- For 2nd Void – N/A

7.5.7 Supervising Clinician NPI

The MHP must identify both the rendering and supervising providers by NPI when applicable.

7.5.8 Travel and Documentation Time

Travel and documentation time is to be included in the service time and must not be claimed separately.

7.5.9 Admission and Discharge Dates

The Discharge Day for an inpatient hospital day is not Medi-Cal reimbursable unless the Discharge Date and the Admission Date are the same.

The Implementation Guide describes the requirements related to Admission Date and Discharge Date for professional claims:

Admission Date Required on all ambulance claims/encounters when the patient was known to be admitted to the hospital. The Admission Date is required on inpatient medical visits claims/encounters.

Discharge Date Required for inpatient claims when the patient was discharged from the facility and the discharge date is known.

For an 837P claim where the Place of Service is:

- Inpatient Hospital
- Inpatient Psychiatric Facility
- Comprehensive Inpatient Rehabilitation Facility

Admission Date is required.

If the Admission Date is missing, the 837 transaction will be rejected.

Although the Discharge Date is not required for most 837P claims, to ensure that a claim meets regulatory requirements for reimbursement of Targeted Case Management (TCM) in Inpatient facilities,³⁹ the Discharge Date is required.

Since the Discharge Date is not a required field for all claims, TCM claims will be denied, not rejected, when the claim does not contain a Discharge Date.

The ASC X12/004010X096A1 Health Care Claim: Institutional (837I) Implementation Guide describes the requirements related to institutional claims:

Admission Date This segment is required on all Inpatient claims (See: Note 2, page 164)

All 837I files containing claims without the Admission Date will be rejected.

³⁹ CCR, Title 9, Section 1840.374

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Table 7: Duplicate and Multiple Service Billing Scenarios

7-1: Duplicate services without repeat or distinct procedure codes

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Minutes	Billed Amount	Comments
C1234567A	12345678901	2/2/2011	H2015	HE	50	\$122.00	
C1234567A	12345678901	2/2/2011	H2015	HE	50	\$122.00	Failed the duplicate edit

7-2: When two distinct services that fall into the same procedure category are performed on the same day, the second service must be designated as distinct by including a distinct service procedure modifier. Likewise, when a specific procedure is performed a second time by the same provider (or a different one) a repeat procedure modifier must be included. Note that there are separate procedure modifiers depending on whether the same provider repeated the service or if it was performed by someone else.

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Minutes	Billed Amount	Comments
C1234567A	12345678901	2/2/2011	H2015	HE	50	\$122.00	
C1234567A	12345678901	2/2/2011	H2015	HE, 59	50	\$122.00	Distinct procedure modifier
C1234567A	12345678901	2/2/2011	H2015	HE, 76	50	\$122.00	Repeat procedure by the same person

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7-3: Any number of claims for service may be approved for the same recipient on the same day up to the maximum time allowed for that type of service. Note that the first and any claim that causes the limit to be exceeded will be denied, even if it is the first claim received. This is an example with several claims from different providers, with the fifth one exceeding the maximum. Even though the fifth claim was denied, the sixth claim was approved because it does not cause the cumulative number of minutes to exceed the daily maximum.

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Minutes	Billed Amount	Comments
C7654321A	12345678901	4/3/2011	H2010	HE	30	\$135.30	Approved. Cumulative Minutes = 30
C7654321A	12345678902	4/3/2011	H2010	HE	120	\$541.20	Approved. Cumulative Minutes = 150
C7654321A	12345678903	4/3/2011	H2010	HE	30	\$135.30	Approved. Cumulative Minutes = 180
C7654321A	12345678901	4/3/2011	H2010	HE	40	\$180.40	Approved. Cumulative Minutes = 220
C7654321A	12345678902	4/3/2011	H2010	HE	30	\$135.30	Denied. The cumulative number of minutes exceeded the 240 minute maximum per day for this service
C7654321A	12345678904	4/3/2011	H2010	HE	10	\$45.10	Approved. Cumulative Minutes = 230

7-4: Claims that exceed the Statewide Maximum Allowance (SMA) for the fiscal year in which the service was performed will be adjusted to reflect the SMA. (County Interim Rate [CIR] for services provided effective 7/1/12)

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Minutes	Billed Amount	Comments
C1234567A	12345678901	2/2/2011	H2015	HE	100	\$290	Exceeded the SMA/CIR per minute rate. Approved amount will reflect the SMA/CIR of \$2.61 per minute for a total approved amount of \$261.00

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7-5: Only one Day Treatment service may be provided to the same beneficiary on the same day.

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Units	Billed Amount	Comments
C1234567A	12345678901	4/6/2011	H2012	HE TG	1	\$134.81	
C1234567A	12345678902	4/6/2011	H2015	HE TG	1	\$134.81	Failed the edit that allows only one Day Treatment service per beneficiary per day

7-6: Only one Hospital Inpatient or Hospital Inpatient Administrative Day service may be provided to the same recipient on the same day

Client	Provider	Date of Service	Procedure Code	Procedure Modifiers	Units	Billed Amount	Comments
C1234567A	12345678901	4/6/2011	H2015	HE	1	\$913.58	
C1234567A	12345678902	4/6/2011	H0046	HE TG	1	\$236.82	Failed the edit that allows only one Day Treatment service per beneficiary per day

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Chapter 7: Claim Limits and Special Conditions

7-7: Outpatient services are allowed on the day of admission (subject to other edits such as the State Maximum Allowance/CIR and maximum time allowed). Inpatient services are not paid for on the date of discharge.

Client	Provider	Service Start Date	Procedure Code	Procedure Modifiers	Revenue Code	Units	Billed Amount	Admission Date	Discharge Date	Comments
C1234567A	12345678900	4/11/2011	H2015	HE	0100	9	\$8,222.22	4/10/2011	4/21/2011	Hospital Inpatient 4/10-18
C1234567A	12345678900	4/19/2011	H0046	HE TG	0101	2	\$473.64	4/10/2011	4/21/2011	Hospital Admin Days 4/19-4/20
C1234567A	12345678901	4/10/2011	H2015	HE		2	\$73.20			Mental Health Service
C1234567A	12345678906	4/10/2011	H2010	HE		3	\$202.95			Medication Support
C1234567A	12345678911	4/10/2011	H2012	HE TG		1	\$134.81			Day Tx Intensive 1/2 Day
C1234567A	12345678981	4/10/2011	S9484	HE TG		1	\$353.02			Crisis Stabilization
C1234567A	12345678902	4/10/2011	T1017	HE		3	\$85.05			Targeted Case Management

APPENDICES

MHSD MEDI-CAL BILLING MANUAL

Procedure Code Crosswalk for Short-Doyle Medi-Cal

Procedure Code Crosswalk for Short-Doyle Medi-Cal

	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
General Hospital Inpatient (IP)	24-Hr	05	10 - 18	Day	H2015	HE	None	0100	Cost	Day	N/A	N/A	07	10 - 18	Day
Psychiatric Hospital IP: Under Age 21	24-Hr	05	10 - 18	Day	H2015	HE	HA	0100	Cost	Day	N/A	N/A	08	10 - 18	Day
Psych Hospital IP: Over Age 64	24-Hr	05	10 - 18	Day	H2015	HE	HC	0100	Cost	Day	N/A	N/A	09	10 - 18	Day
General Hospital IP: Administrative Day	24-Hr	05	19	Day	H0046	HE	None	0101	Cost	Day	N/A	N/A	07	19	Day
Psych Hospital IP: Admin Day Under Age 21	24-Hr	05	19	Day	H0046	HE	HA	0101	Cost	Day	N/A	N/A	08	19	Day
Psych Hospital IP: Admin Day Over Age 64	24-Hr	05	19	Day	H0046	HE	HC	0101	Cost	Day	N/A	N/A	09	19	Day
Psychiatric Health Facility (PHF)	24-Hr	05	20 - 29	Day	H2013	HE	None	None	Cost	Day	N/A	N/A	05	20 - 29	Day
Skilled Nursing Facility (SNF): Intensive	24-Hr	05	30 - 34	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Institutions for Mental Diseases (IMD): Basic (No Patch)	24-Hr	05	35	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
IMD: Patch	24-Hr	05	36 - 39	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None

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Procedure Code Crosswalk for Short-Doyle Medi-Cal

	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
Adult Crisis Residential: Geriatric	24-Hr	05	40 - 49	Day	H0018	HE	HC	None	Cost	Day	N/A	N/A	05	40 - 49	Day
Adult Crisis Residential: Non-Geriatric	24-Hr	05	40 - 49	Day	H0018	HE	HB	None	Cost	Day	N/A	N/A	05	40 - 49	Day
Jail Inpatient	24-Hr	05	50 - 59	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Residential: Other	24-Hr	05	60 - 64	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Adult Residential: Geriatric	24-Hr	05	65 - 79	Day	H0019	HE	HC	None	Cost	Day	N/A	N/A	05	65 - 79	Day
Adult Residential: Non-Geriatric	24-Hr	05	65 - 79	Day	H0019	HE	HB	None	Cost	Day	N/A	N/A	05	65 - 79	Day
Semi - Supervised Living	24-Hr	05	80 - 84	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Independent Living	24-Hr	05	85 - 89	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Mental Health Rehab Centers (MHRC)	24-Hr	05	90 - 94	Day	N/A	N/A	None	None	None	None	N/A	N/A	None	None	None
Crisis Stabilization: Emergency Room	Day	10	20 - 24	Hour	S9484	HE	TG	None	Cost	Hour	23	282N00000X, 283Q00000X	12 or 18	20 - 24	Hour
Crisis Stabilization: Urgent Care	Day	10	25 - 29	Hour	S9484	HE	TG	None	Cost	Hour	20	282N00000X, 283Q00000X	12 or 18	25 - 29	Hour
Vocational Services	Day	10	30 - 39	None	N/A	N/A	None	None	None	None	None	None	None	None	None
Socialization	Day	10	40 - 49	None	N/A	N/A	None	None	None	None	None	None	None	None	None

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	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
SNF: Augmentation	Day	10	60 - 69	None	N/A	N/A	None	None	None	None	None	None	None	None	None
Day Treatment Intensive: Half Day	Day	10	81 - 84	1/2 Day	H2012	HE	TG	None	Cost	Hour: Half day rate used when Units ≥ 3 and Units < 4	None	282N00000X, 283Q00000X	12 or 18	81 - 84	1/2 Day
Day Treatment Intensive: Full Day	Day	10	85 - 89	Day	H2012	HE	TG	None	Cost	Hour: Full day rate used when Units ≥ 4	None	282N00000X, 283Q00000X	12 or 18	85 - 89	Day
Day Rehabilitation: Half Day	Day	10	91 - 94	1/2 Day	H2012	HE	None	None	Cost	Hour: Half day rate used when Units ≥ 3 and Units < 4	None	282N00000X, 283Q00000X	12 or 18	91 - 94	1/2 Day
Day Rehabilitation: Full Day	Day	10	95 - 99	Day	H2012	HE	None	None	Cost	Hour: Full day rate used when Units ≥ 4	None	282N00000X, 283Q00000X	12 or 18	95 - 99	Day

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Procedure Code Crosswalk for Short-Doyle Medi-Cal

	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
Linkage (TCM) / Brokerage	Outpatient	15	01 - 06, 08	Mins	T1017	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	01 - 09	Mins
Intensive Care Coordination (ICC)	Outpatient	15	07	Mins	T1017	HK	None	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	N/A	Mins
Linkage (TCM) / Brokerage: Professional IP Visit	24-Hr	15	09	15 Mins	T1017	HE	GT	None	Cost	Minutes	21 or 51	282N00000X, 283Q00000X	12 or 18	09	15 Mins
Collateral	Outpatient	15	10 - 18	Mins	H2015	HE	N/A	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	10 - 18	Mins
Collateral: Professional IP Visit	Outpatient	15	19	Mins	H2015	HE	N/A	None	Cost	Minutes	21 or 51	282N00000X, 283Q00000X	12 or 18	19	Mins
MHS: Professional IP Visit	Outpatient	15	19, 39, 49, 59	Mins	H2015	HE	GT	None	Cost	Minutes	21 or 51	282N00000X, 283Q00000X	12 or 18	19, 39, 49, 59	Mins
Mental Health Services (MHS)	Outpatient	15	30 - 56	Mins	H2015	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	30 - 38	Mins
MHS: Plan Development	Outpatient	15	30 - 56	Mins	H0032	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	30 - 38	Mins
MHS: Rehabilitation	Outpatient	15	30 - 56	Mins	H2017	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	30 - 38	Mins

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Procedure Code Crosswalk for Short-Doyle Medi-Cal

	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
Intensive Home-Based Services (IHBS)	Outpatient	15	57	Mins	H2015	HK	None	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	N/A	Mins
Therapeutic Behavioral Services (TBS)	Outpatient	15	58	Mins	H2019	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	58	Mins
Medication Support	Outpatient	15	60 - 68	Mins	H2010	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	60 - 68	Mins
Med Support: Training & Support	Outpatient	15	60 - 68	Mins	H0034	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	60 - 68	Mins
Med Support: Care Plan Development & Documentation	Outpatient	15	60 - 68	Mins	G8437	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	60 - 68	Mins
Med Support - Professional IP Visit	Outpatient	15	69	Mins	H2010	HE	GT	None	Cost	Minutes	21 or 51	282N00000X, 283Q00000X	12 or 18	69	Mins
Crisis Intervention	Outpatient	15	70 - 78	Mins	H2011	HE	None or SC or GT or HQ	None	Cost	Minutes	None	282N00000X, 283Q00000X	12 or 18	70 - 78	Mins
Crisis Intervention: Professional IP Visit	Outpatient	15	79	Mins	H2011	HE	N/A	None	Cost	Minutes	21 or 51	282N00000X, 283Q00000X	12 or 18	79	Mins
Administration Support	Administrative Support	20	None	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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Procedure Code Crosswalk for Short-Doyle Medi-Cal

	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
Research & Evaluation	Research & Evaluation	25	None	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Formal Training Programs	Formal Training	40	None	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Contract Administration	Contract Administration	41	None	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization Review	Utilization Review	42	None	None	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health Promotion	Outreach	45	10 - 19	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community Client Services	Outreach	45	20 - 29	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medi-Cal Outreach	MAA	55	01 - 03	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medi-Cal Eligibility Intake	MAA	55	04 - 06	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medi-Cal Contract Administration	MAA	55	07 - 09	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Crisis Referral	MAA	55	11 - 13	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MHS Contract Administration	MAA	55	14 - 16	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Discounted MH Outreach	MAA	55	17 - 19	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Skilled Professional Medical Personnel (SPMP) Case Management	MAA	55	21 - 23	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
SPMP Program Planning	MAA	55	24 - 26	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
SPMP Medi-Cal Administrative Activities (MAA) Training	MAA	55	27 - 29	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Non-SPMP Case Management	MAA	55	31 - 34	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Non-SPMP Program Management	MAA	55	35 - 39	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Conservatorship: Investigation	Support	60	20 - 29	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Conservatorship: Administration	Support	60	30 - 39	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Life Support: Board and Care	Support	60	40 - 49	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Case Management: Support	Support	60	60 - 69	Hour	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Housing: Support Expenditures	Support	60	70	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Housing: Operating Expenditures	Support	60	71	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Client Flexible Support Expenditures	Support	60	72	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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	Cost Reporting				SDMC 837 Transaction								SDMC Proprietary Claim		
Service Name	Service Type	Mode of Service	Service Function	Cost Units	Procedure Code	Procedure Modifier 1	Procedure Modifier 2	Revenue Code	Basis for Measure	Unit of Measure	Place Of Service	Taxonomy Code	S/D Mode of Service	Service Function	Cost Units
Non Medi-Cal: Capital Assets	Support	60	75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Non Medi-Cal: Client Support Expenditures	Support	60	78	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

FREQUENTLY ASKED QUESTIONS

What are the Specialty Mental Health Services that are eligible for Federal Financial Participation (FFP)?

Rehabilitative Mental Health Services:

- Mental Health Services
- Medication Support
- Day Treatment Intensive
- Day Rehabilitation
- Crisis Intervention
- Crisis Stabilization
- Adult Residential Treatment Services
- Crisis Residential Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- EPSDT Supplemental Specialty Mental Health Services (Incl. TBS)

Can staff claim travel and documentation time at whatever service function rate, e.g., Mental Health Service (MHS), Case Management, etc., of the service provided?

Yes. Travel and documentation time must be linked to the service provided.

Can staff claim Federal Financial Participation (FFP) for Case Management Services provided while a beneficiary is in an IMD?

FFP cannot be claimed if the beneficiary is between the ages of 21-64. Yes, if the beneficiary is 65 or older. Yes, if the beneficiary is under 21 and is a patient in a hospital or another accredited facility.

Can staff claim FFP for a parenting group that includes parents whose children have open cases at the clinic?

Yes, if the services are directed at the mental health needs of the children, rather than based upon the needs of the parents. In addition, there must be documentation in the child's chart to show the need for this activity.

How should time be divided when beneficiaries and their parents are seen together in a group setting? Should the time be claimed as mental health services or collateral?

Time should be divided equally among the beneficiaries being represented. The time should be treated as if this were a group setting composed only of the beneficiaries being represented (the parents themselves would not count as group members).

Only the time for beneficiaries who are Medi-Cal-eligible may be claimed as a Medi-Cal service. For example, a staff meets with three Medi-Cal-eligible beneficiaries, five parents of these three beneficiaries, and two parents of a Medi-Cal-eligible beneficiary who was not present for a total of ten people in a group setting for 120 minutes.

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Since four beneficiaries were represented, the time is divided by four, and 30 minutes is claimed for each beneficiary.

If there was an additional beneficiary who was not Medi-Cal eligible and that beneficiary's parents, the time would be divided by five, and 24 minutes would be claimed for each Medi-Cal eligible beneficiary.

Claims for FFP submitted to DHCS would be for Mental Health Services, whether the activity claimed is Collateral or a direct service to the beneficiary or some other allowable service activity.

Chart documentation should justify the activities involved; however, each minute need not be assigned to a discrete activity.

In the example above, time with the parent of the beneficiary is clearly collateral for that beneficiary, but time with the beneficiaries who are present with their parents would generally serve both Collateral and direct treatment purposes. See below:

§ 1810.227: Mental Health Services Those individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, and collateral.

§ 1810.206: Collateral A service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's treatment plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

When a treatment group contains both Medi-Cal and non Medi-Cal clients, how is staff to divide the time? For example, if a group of six clients containing three Medi-Cal and three non-Medi-Cal clients lasts 120 minutes (group time plus documentation), how is the time divided? By three or by six?

It depends. If a provider is delivering services to a group composed of both Medi-Cal and non-Medi-Cal eligible individuals, the provider must determine if the rate for the services is different for the Medi-Cal and the non-Medi-Cal eligibles.

If the rate is the same, the provider would prorate his or her time for all individuals who participated.

If services for a group of individuals are reimbursed at different rates, the provider must prorate the Medi-Cal and non-Medi-Cal individuals separately, e.g. if a provider

delivers 63 minutes of services to a group consisting of 5 Medi-Cal and 2 non-Medi-Cal eligibles who are reimbursed at different rates, they would:

Calculate reimbursement by prorating their time (63 minutes divided by 7 = 9 minutes): Multiply 9 minutes by 5 and apply the Medi-Cal rate to 45 minutes; Multiply 9 minutes by 2 and apply the non-Medi-Cal rate to 18 minutes

*See [Information Notice 07-03](#) Collateral for Group Settings.

Can FFP be claimed for assisting beneficiaries to obtain their medication by preparing an authorization request?

Yes. FFP can be claimed for completing an authorization request for a prescription as it relates to the provision of medication support services. Only physicians, RNs, LVNs, psychiatric technicians, or pharmacists within their scopes of practice may provide medication support services.

Can staff claim FFP for photocopying, faxing, and other clerical type activities as specialty mental health services?

No. However, the cost of such activities can be included in determining the cost of delivering specialty mental health services.

Can staff claim FFP for payee-related activities?

No. FFP cannot be claimed for time spent performing the fiscal responsibilities of a payee. For example, staff cannot claim FFP for time spent writing checks to pay the beneficiary's bills. However, it is possible to claim for payee related services when such activities are necessary to address impairment in an important area of life functioning. For example, staff can claim FFP for time spent providing training on money management skills.

Can staff claim FFP for telephone assessments?

Yes. Assessments can be completed face-to-face or over the telephone. However, MHPs are strongly encouraged to complete face-to-face assessments when determining medical necessity.

How long can staff claim FFP for services provided after a beneficiary has died?

FFP cannot be claimed for any services provided once the beneficiary has died. All services claimed to Medi-Cal on behalf of a beneficiary must be provided to meet the mental health needs of that beneficiary. Therefore, claims must be submitted in a timely manner as specified in CCR Title 9.

Can staff claim FFP for court-related assessments, e.g., conservatorship investigations?

It depends.

Yes, if an assessment is completed for clinical, treatment-related purposes, FFP can be claimed if the purpose of that assessment is court-ordered in order to determine medical necessity for Medi-Cal.

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No, if the assessment is completed per request of the court for a purpose other than determining medical necessity for Medi-Cal. For example, FFP cannot be claimed if a court-ordered assessment is narrowly defined for establishment of conservatorship and the MHP limits its assessment to this purpose.

Please note that the use of realignment dollars is limited in this area, as well as the use of Medi-Cal dollars. See below:

W&I Section 5714 To continue county expenditures for legal proceedings involving mentally disordered persons, the following costs incurred in carrying out Part 1 (commencing with Section 5000—LPS Act) of this division shall not be paid for from funds designated for mental health services.

- a. The costs involved in bringing a person in for 72-hour treatment and evaluation.
- b. The costs of court proceedings for court-ordered evaluation, including the service of the court order and the apprehension of the person ordered to evaluation when necessary.
- c. The costs of court proceedings in cases of appeal from 14-day intensive treatment.
- d. The cost of legal proceedings in conservatorship other than the costs of conservatorship investigation as defined by regulations of the State Department of Mental Health.
- e. The court costs in post certification proceedings.
- f. The cost of providing a public defender or other court-appointed attorneys in proceedings for those unable to pay.

What are the 24-Hour claiming limitations listed by service type?

10/20, 10/25 Crisis Stabilization "The maximum number of hours claimable for Crisis Stabilization in a 24-Hour period is 20 hours." CCR Title 9, Chapter 11, §1840.368(c)

15/60 Medication Support "The maximum amount claimable for Medication Support Services in a 24-Hour period is 4 hours." CCR Title 9, Chapter 11, §1840.372

15/70 Crisis Intervention "The maximum amount claimable for Crisis Intervention in a 24-Hour period is 8 hours." CCR Title 9, Chapter 11, §1840.366(b)

Regarding medication support services, can staff claim FFP for med support e.g. in a group setting as long as the following conditions are met:

Time is prorated per CCR Title 9, Chapter 11, §1840.316(a)(2)

The medication support services provided meet the definition of medication support services in CCR Title 9, Chapter 11, §1810.225

The service is provided by staff qualified to provide such services.

Yes. For example: An RN facilitates a weekly group discussion on medication education, e.g., the side effects of the medication, overcoming resistance to taking medications, etc. This intervention and its goals should be addressed in each client's plan.

Are there any special lockouts on claiming FFP while a beneficiary is in Rate Classification Level (RCL) 12-14 facilities (group homes that specialize in serving children with mental illness)?

No. There are no special lockouts outside those listed in CCR Title 9 while a beneficiary resides in RCL 12-14 facilities because the RCL 12-14 rates do not include treatment services. The duplicate payment issues that exist when a beneficiary is in a 24-hour facility that is receiving reimbursement for treatment services do not exist when the beneficiary is in an RCL 12-14 facility.

Can FFP be claimed for travel time from one provider site to another provider site? From a staff's residence to a provider site? From a staff's home to a beneficiaries home?

It depends.

To claim FFP, travel time must be from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered.

FFP cannot be claimed for travel between provider sites or from a staff member's residence to a provider site.

It is possible to claim for travel time between a staff's home and the beneficiaries home as long as the MHP permits such activity and MHP travel guidelines are adhered to.

NOTE: A "provider site" is defined as a site with a provider number, this includes affiliated satellite sites and school sites.

How long and what types of services can be claimed to Medi-Cal prior to a determination of medical necessity?

It depends.

In urgent, crisis, or emergency situations, the MHP can/should provide whatever services are needed prior to establishing that all medical necessity criteria are met. If not an urgent, crisis, or emergency situation, the MHP should only claim those assessment services necessary to establish medical necessity.

It is understood that MHPs have established 30-90 day intake periods (or longer, if need is documented) during which time the provider is to establish medical necessity, set up the client plan, and coordinate the arrangement of necessary services. However, the intake period is not exempt from the medical necessity requirements for claiming Medi-Cal.

How should staff claim time when services with two different rates are in the course of a single client session, e.g., 30 minutes of Mental Health Services and 30 minutes of Case Management? Should staff claim the whole time to the dominant service provided, or claim 30 minutes to MHS and 30 minutes to Case Mgmt? Can staff write one progress note and break out the claim by each service, or must a separate progress note be written for each service?

Staff should claim for each service separately or claim the entire time to the lower cost center, e.g., case management. Staff may write two separate progress notes or write one progress note that clearly delineates the time spent providing each service.

While it is not required that staff document the actual number of minutes claimed in each progress note, a clear audit trail must still be maintained, including documentation of actual minutes using the forms and/or procedures established by the MHP or provider.

Can an MHP charge Medi-Cal beneficiaries a co-payment?

Yes.

Per CCR Title 9, §1810.365, "Beneficiary Billing," specifies certain situations when an MHP can collect reimbursement from a beneficiary:

Other Health Insurance/Other Health Care (OHC)

Medi-Cal Share-of-Cost (SOC)

Co-payments in accordance with W&IC §14134

W&IC §14134 allows the MHP to collect a co-payment, generally \$1.00 per outpatient visit, as long as no beneficiary is denied services because the co-payment is not collected. W&IC §14134 also lists specific beneficiaries who may not be charged a co-payment, including beneficiaries who are 18 years of age or younger or who are inpatients in hospitals or psychiatric health facilities. The MHP must ensure that any system established to collect co-payments is in compliance with the limits of W&IC §14134. Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars (\$10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:

- a. Co-payment of five dollars (\$5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.
- b. Co-payment of one dollar (\$1) shall be made for each drug prescription or refill.
- c. Co-payment of one dollar (\$1) shall be made for each visit for services under subdivisions (a) and (h) of §14132.
- d. The co-payment amounts set forth in subdivisions (a), (b), and (c) may be collected and retained or waived by the provider.
- e. The department shall not reduce the reimbursement otherwise due to providers as a result of the co-payment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.
- f. This section does not apply to emergency services, family planning services, or to any services received by:
 - 1. Any child in Foster Care, as defined in §11400.
 - 2. Any person who is an inpatient in a health facility, as defined in § 1250 of the Health and Safety Code.
 - 3. Any person 18 years of age or under.

- 4. Any woman receiving perinatal care.
- g. Subdivision (b) does not apply to any person 65 years of age or over.
- h. A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. An individual shall, however, remain liable to the provider for any copayment amount owed.

When can FFP be claimed for treating undocumented aliens?

According to by the beneficiaries' aid category, the MHP needs to deliver services to beneficiaries who are undocumented aliens based on what is covered.

Undocumented aliens are eligible for aid categories that cover emergency and/or pregnancy services only. The MHP would be responsible only after the eligibility had been determined. (For more information, see the [Master Aid Codes Chart](#) available online in the MedCCC Library)

Per CCR Title 9, §1810.216:

'Emergency Psychiatric Condition' means a condition that meets the criteria in §1820.205 when the beneficiary with the condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

What this means is that only emergency psychiatric inpatient hospital services and related psychiatric inpatient hospital professional services are covered for Medi-Cal beneficiaries who are only covered for emergency services. Crisis Intervention and Crisis Stabilization are not emergency services under the Medi-Cal managed mental health care program. Pregnancy-related services, when covered, are broader than emergency services. These services involve treatment of a mental illness that might affect the outcome of the pregnancy.

While an "Emergency Psychiatric Condition" for inpatients is defined in regulations, there is no separate definition for outpatients. DHCS intends to revise the regulations to include outpatient crisis stabilization, crisis intervention, and medication support. The other conditions in the regulation (current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing) will apply to outpatient as well as inpatient situations for SDMC claiming purposes.

If a beneficiary is admitted to an acute care setting for a medical condition, what specialty mental health services are eligible for FFP?

There is nothing in the regulations that prohibits claiming FFP for the provision of medically necessary specialty mental health services while a beneficiary is on a medical unit.

CCR Title 9, §1840.215 and §1840.360 through §1840.374 only addresses lock-out requirements for specialty mental health services.

Since the per diem rates for Medi-Cal inpatient hospital services cover routine hospital services and hospital-based ancillary services, only those mental health services that are not routine hospital services or hospital-based ancillary services may be separately reimbursed by Medi-Cal. Psychotherapy and medication support services by psychiatrists are eligible for FFP and must be delivered if medically necessary.

Other services should be evaluated to determine whether or not they would be considered routine hospital services or hospital-based ancillary services if provided as a part of a psychiatric inpatient hospital service. MHPs may decide who provides such services and whether or not authorization is required prior to providing the services.

Can FFP be claimed for administrative hospital days if FFP was not claimed for the days of acute status? For example, a patient who otherwise meets medical necessity criteria but is ineligible for Medi-Cal because of his/her legal status, e.g., in jail custody. The court later releases him/her, but the patient remains in the hospital pending suitable placement.

Yes, as long as medical necessity for acute psychiatric inpatient hospital services had been established at some point during the patient's stay in the hospital and the administrative days meet criteria specified in CCR Title 9, §1820.220(j)(5).

What are the rules around claiming FFP for services provided by students, volunteers, and paid consumers?

As long as all Medi-Cal requirements and any supervision and scope of practice requirements are met, MHPs and their providers may claim FFP for Medi-Cal services provided by students, volunteers, and paid consumers. Please be aware, however, that these units of services must be counted when determining unit costs and that only the actual amounts paid to the students, volunteers, and paid consumers may be included in the cost report (e.g., zero dollars for a volunteer). Generally,

1. A "student" is someone who is taking courses in social work, counseling, or related subject matter at the undergraduate or graduate school level.
2. A "volunteer" is someone who is not employed by the provider. For example, a person accumulating qualifying hours to become licensed, and works without pay is a volunteer.
3. A "paid consumer" is a beneficiary who is employed by the provider. Typically consumers provide peer support and interact with the provider's clients.

GLOSSARY

MHSD MEDI-CAL BILLING MANUAL

Glossary

835	Health Care Claim Payment/Advice sent to MHP from DHCS-ITWS
837I	Institutional Services Claim/HIPAA Transaction submitted to DHCS-ITWS by MHP
837P	Professional Services Claim/HIPAA Transaction submitted to DHCS-ITWS by MHP
AB	Assembly Bill
ADP	Alcohol and Drug Programs, a Division within CA Dept of Health Care Services
BIC	Beneficiary Identification Card
Beneficiary	A person who is receiving financial benefit from Medi-Cal
CCR	California Code of Regulations
CFR	Code of Federal Regulations; County of Financial Responsibility; Cost and Financial Reporting
CFRS	Cost and Financial Reporting System
CIMH	California Institute for Mental Health
CIN	Client Index Number
CIR	County Interim Rate
CMHDA	California Mental Health Directors Association
CMS	Centers for Medicare and Medicaid Services, a branch within the US Department of Health and Human Services
CPE	Certified Public Expenditure
CSI	Client Services Information System
Client	Anyone who is receiving specialty mental health services (even a one-time initial assessment) See Also: Beneficiary
Crosswalk	Cross-reference table
DCS	Disallow Claim System
DHCS	CA Department of Health Care Services
DHCS-MHSD	DHCS- Mental Health Services Division
DHS	Department of Health Services; Now DHCS
DMC	Drug Medi-Cal
DMH	Department of Mental Health, prior to 7/1/2012 (now DHCS-MHSD)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EVC	Eligibility Verification Confirmation
FAQ	Frequently Asked Questions

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FFP	Federal Financial Participation
FFS	Fee-for-Service
FMAP	Federal Medical Assistance Percentages
HF	Healthy Families (A part of SCHIP)
HIPAA	Health Insurance Portability and Accountability Act
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IP	Inpatient
IPC	Inpatient Consolidation
ITWS	Information Technology Web Services
LE	Legal Entity
MAA	Medi-Cal Administrative Activities
M/C	Medi-Cal
MCHIP	Medicare Children's Health Insurance Program
MedCCC	Medi-Cal Claims Customer Service Office
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan
MHSD	Mental Health Services Division
Medi-Cal	California's Medicaid program
NICHY	National Dissemination Center for Children with Disabilities
NPI	National Provider Identifier
NTE	Not to Exceed
OBRA '89	Omnibus Budget Reconciliation Act of 1989
OP	Outpatient
OPS	Online Provider System
PCCN	Payer Claim Control Number
PHF	Psychiatric Health Facility
PIN	Provider Identification Number
POS	a) Place of Service b) Point of Service device used to verify MEDS Eligibility
PRV	Provider System
Provider	A supplier of specialty mental health services delivered to M/C beneficiaries of an MHP
Provider File	Located on ITWS, lists all providers of SMHS used by MHPs

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SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SDMC	Short-Doyle Medi-Cal
SDMC Phase 1	Implementation of HIPAA translator into claim system: Jan '04
SDMC Phase 2	HIPAA-compliant claim system: Jan '10
SED	Seriously Emotionally Disturbed
SEP	Special Education Pupils
SGF	State General Fund
SMA	Statewide Maximum Allowance
SMHS	Specialty Mental Health Services
SNF	Skilled Nursing Facility
SPMP	Skilled Professional Medical Personnel
SSA	Social Security Administration
SSI	Supplemental Security Income
TAR	Treatment Authorization Request
TBS	Therapeutic Behavioral Services
Title 9	The section of California Code of Regulations explaining Community Mental Health Services
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
USC	U.S. Government Code
W&I Code	Welfare and Institutions Code

REFERENCE GUIDE TO HYPERLINKS IN THIS MANUAL

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Reference Guide to Hyperlinks in this Manual

CFR Title 42, Volume 4 http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl

CMS EPSDT Information <http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrnl/>

CMS HCPCS Code Set <http://www.cms.hhs.gov/MedHCPCSGenInfo>

CMS HIPAA Information <http://www.cms.hhs.gov/HIPAAGenInfo/>

CMS Medicaid Information <http://www.cms.hhs.gov/home/medicaid.asp>

DHCS Aid Codes Master Chart http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/SDMC_Aid_Code_Master_Chart_01-29-13_FINAL.pdf

DHCS Bulletins & Manuals <http://www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx>

DHCS Companion Guides [http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-ShortDoyleII\(SDII\).aspx](http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-ShortDoyleII(SDII).aspx)

DHCS Cost and Financial System Reporting Manual
https://itws.dhcs.ca.gov/systems/cfrs/docs/private/cfrs_manual.asp

DHCS County of Fiscal Responsibility Files (CFR) Subsystem Excel File
<https://itws.dhcs.ca.gov/itws/transfer.asp?SysID=1>

DHCS County Multi-Year Mental Health Medi-Cal Excel Pivot Tables
https://itws.dhcs.ca.gov/systems/sdmc/docs/private/anomaly_reports.asp

DHCS EPSDT Therapeutic Behavioral Services <http://www.dhcs.ca.gov/services/Pages/EPSDT.aspx>

DHCS Inpatient/Outpatient Medi-Cal Manual http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

DHCS MHSD Information Notices & Letters <http://www.dhcs.ca.gov/services/MH/Pages/MH-Letters-Notices.aspx>

DHCS Medi-Cal Certification and Transmittal Form (MH2180)
<https://itws.dhcs.ca.gov/systems/provider/docs/private/information.asp>

DHCS Medi-Cal Eligibility Branch <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-Cal%20Eligibility%20Division.aspx>

DHCS Medi-Cal Mental Health Policy: Consolidation and Managed Care
<http://www.dhcs.ca.gov/services/mh/Pages/MCMHP-Consolidation.aspx>

DHCS Stop Medi-Cal Fraud website <http://www.dhcs.ca.gov/individuals/pages/stopmedi-calfraud.aspx>

DMH Information Notices <http://www.dhcs.ca.gov/formsandpubs/Pages/MentalHealth-InfoNotices.aspx>

DMH Letters <http://www.dhcs.ca.gov/formsandpubs/Pages/MH-Letters.aspx>

FMAP <http://aspe.hhs.gov/health/fmap.htm>

Federal Register Volume 71, Number 230
<http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-20264.pdf>

Healthy Families <http://www.healthyfamilies.ca.gov/hf/hfhome.jsp>

ICD-9 Medical Codes <http://www.icd9data.com/>

ICD-10 Medical Codes <http://www.icd10data.com/>

ITWS <https://itws.dhcs.ca.gov/default.asp>

ITWS Contact Page <https://itws.dhcs.ca.gov/docs/public/contact.asp>

ITWS Enrollment Guide <https://itws.dhcs.ca.gov/docs/public/enrollmentGuides.asp>

ITWS Error Correction Report Handbook
<https://itws.dhcs.ca.gov/systems/sdmc/docs/public/referenceinfo.asp>

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Reference Guide to Hyperlinks in this Manual

ITWS Mental Health Medi-Cal Claim Submission Schedule

<https://itws.dhcs.ca.gov/systems/sdmc/docs/public/referenceinfo.asp>

ITWS Mental Health Medi-Cal Reference Information

https://itws.dhcs.ca.gov/systems/sdmc/docs/public/short_doyle_-_medi-cal_phase_ii.asp

ITWS OPS Online Provider System <https://itws.dhcs.ca.gov/itws/Provider/>

ITWS Provider File Update Form (3829) and Legal Entity Update Form (3840)

<https://itws.dhcs.ca.gov/systems/provider/docs/private/information.asp>

ITWS Provider System Documentation Manual

<https://itws.dhcs.ca.gov/systems/provider/docs/private/systemdocs.asp>

ITWS Virtual Tour https://itws.dhcs.ca.gov/docs/public/virtual_tour.asp

MHSD Information Notices <http://www.dhcs.ca.gov/formsandpubs/Pages/MentalHealth-InfoNotices.aspx>

MHSD Letters <http://www.dhcs.ca.gov/formsandpubs/Pages/MH-Letters.aspx>

MedCCC <http://www.dhcs.ca.gov/services/MH/Pages/MedCCC.aspx>

Medi-Cal Inpatient/Outpatient Manual http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

Medi-Cal National Provider Identifier (NPI) <http://files.medi-cal.ca.gov/pubsdoco/npi/npi.asp>

Medi-Cal POS System www.medi-cal.ca.gov

Medi-Cal Publications <http://www.medi-cal.ca.gov/publications.asp>

Medi-Cal Share of Cost http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

Medi-Cal Treatment Authorization Request (TAR) <http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx>

NICHY National Dissemination Center for Children with Disabilities <http://nichcy.org/>

Social Security Administration Supplemental Security Income Website

<http://www.ssa.gov/pubs/11000.html>

X-12 Companion Guide and Appendix <http://www.x12.org>