Drug Medi-Cal State Plan Billing Manual

Version 1.5

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CHAPTER ONE: – INTRODUCTION

1.0 Introduction

The Short Doyle/Medi-Cal (SD/MC) claims processing system allows California counties to submit electronic claims for reimbursement of covered Drug Medi-Cal Program (DMC - State Plan) services provided by Drug Medi-Cal enrolled and certified providers to Medi-Cal-eligible beneficiaries. The Department of Health Care Services (DHCS) Local Governmental Financing Division (LGFD) oversees the SD/MC claims processing system. This manual provides guidance on how to ensure that a claim and the service lines in that claim are approved by the SD/MC claims processing system. CalAIM Behavioral Health Payment Reform Frequently Asked Questions contain clarifications and corrections related to claiming policy. To stay current on corrections to the billing manual, please check this site periodically.

This manual does not include clinical guidance on when specific procedure codes or modifiers are appropriate or on the documentation that must accompany the procedure codes submitted on a claim.

This chapter includes:

1. About This Billing Manual
2. Program Background
3. Authority
4. Medi-Cal Claims Customer Service (MEDCCC)

1.1 About This Billing Manual

This DMC - State Plan Billing Manual is a publication of DHCS. DHCS administers the DMC- State Plan program. This Billing Manual provides stakeholders with a reference document that describes the processes and rules relative to SD/MC claims for DMC - State Plan services. Stakeholders include Counties and DMC – State Plan providers, Billing Vendors, and others.

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 information related to:
    - State and Federal laws and regulations
    - Letters and Information Notices
    - Reference documents such as:
        i. SD/MC User Manual
        ii. Companion Guides
        iii. Companion Guide Appendix

This manual is not intended to duplicate the contents of the Companion Guides or the Companion Guide Appendix. However, key concepts from those documents have been included to help explain the SD/MC claiming process.

1.2 Program Background

Title XIX of the Social Security Act, enacted in 1965, authorized Federal grants to States for medical assistance to low-income persons who are 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women and children. The Affordable Care Act (ACA) expanded Medicaid eligibility to all persons in households with income below 138 percent of the federal poverty level in states that chose to expand Medicaid. California chose to expand Medicaid. The Medicaid program is jointly financed by the Federal and State governments and administered by the 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 single State agency.

DHCS holds administrative responsibility for DMC - State Plan services including but not limited to:

1. Determination of Aid Codes[1]
2. Maintenance of eligibility information technology systems (e.g., Medi-Cal Eligibility Determination System [MEDS])
3. Adjudication of DMC - State Plan claims
4. Processing of claims for Federal Financial Participation (FFP) payments
5. Submission of expenditure to the Centers for Medicare & Medicaid Services (CMS) to obtain FFP

For DMC - State Plan services provided to a beneficiary by a certified provider, the cost of these services is paid by a combination of State, County, and Federal funds. The 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, local county funds and other sources such as grants.

1.3 Authority

Authority for the Drug Medi-Cal program is derived from 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 USC § 1396-1396v, Subchapter XIX, Chapter 7 (1965), provides the basis for the development of each State's Medicaid plan.

1.3.2 Social Security Act Title XXI

The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid Expansion and separate CHIP programs. CHIP is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. Under sections 1905(b) and 2105(b) of the Social Security Act, Title XXI Medicaid expenditures will be matched at an enhanced Federal Medical Assistance Percentage (FMAP).

1.3.3 Health Insurance Portability and Accountability Act of 1996

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.

1.3.4 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. Title 45 CFR Part 160 and Subparts A and E of Part 164 provide regulatory guidance for the HIPAA Privacy Rule.

[1] The most current SD/MC Aid Codes Master Chart is in the MEDCCC Library

1.3.5 Welfare and Institutions Code (W&I Code)

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

1.3.6 California Code of Regulations (CCR)

State regulations applicable to Drug – Medi-Cal services are found in the California Code of Regulations, CCR, Title 22, Division 3, Subdivision 1, Chapter 3. Narcotic Treatment Program regulations are found in CCR, Title 9, Division 4, Chapter 4.

1.3.7 DHCS Information Notices

In accordance with Welfare and Institutions Code 14184.102(d), DHCS may implement the California Advancing and Innovating Medi-Cal (CalAIM) by means of all-county letters, plan letters, provider bulletins, information notices or similar instructions. As information notices that pertain to payment reform are issued or changes to the billing system are made, this manual, which is an attachment to an information notice, will be updated.

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

The Companion Guide is used to clarify, supplement, and further define specific data content requirements to be used in conjunction with, but not in place of, the X12 Implementation Guides for all transactions mandated by HIPAA. The Companion Guide contains DHCS specific data requirements that may not be specifically defined in the Implementation Guide. If you have access to the portal as described in section 2.1, access the Companion Guide in a subfolder called "Companion Guides" in the "System Documentation" folder.

Please contact MEDCCC@dhcs.ca.gov for assistance accessing the DHCS Application Portal.

1.3.9 Companion Guide for the 835 Healthcare Claim Payment/Advice

The Companion Guide is used to clarify, supplement, and further define specific data content requirements to be used in conjunction with, but not in place of, the X12 Implementation Guides for all transactions mandated by HIPAA. The Companion Guide contains DHCS specific data requirements that may not be specifically defined in the Implementation Guide.

1.3.10 Short-Doyle/Medi-Cal (SD/MC) Companion Guide Appendix ("Companion Guide Appendix")

1.3.11 ASC X12N/005010X223 Health Care Claim: Institutional (837I) Implementation Guide

This is the technical report document for the ANSI ASC X12N 837 Health Care Claims (837) transaction for institutional claims and/or encounters. This document provides a definitive statement of what trading partners must be able to support in this version of the 837. For more information about the 837I Implementation Guide, please refer to the X12 website.

1.3.12 ASC X12N/005010X222 Health Care Claim: Professional (837P) Implementation Guide

This is the technical report document for the ANSI ASC X12N 837 Health Care Claims (837) transaction for professional claims and/or encounters. This document provides a definitive statement of what trading partners must be able to support in this version of the 837. For more information about the 837P Implementation Guide, please refer to the X12 website.

1.3.13 ASC X12N/005010X221 Health Care Claim Payment/Advice (835) Implementation Guide

The purpose of this implementation guide is to provide standardized data requirements and content for all users of ANSI ASC X12.835, Health Care Claim Payment/ Advice (835). This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. For more information about the 835 Healthcare Claim Payment/Advice, please refer to the X12 website.

1.3.14 Claim Adjustment Reason Codes-Remittance Advice Remarks (CARC-RARC)

This is more detailed information about the meaning of the denial codes received.

1.4 Medi-Cal Claims Customer Service Office (MEDCCC)

MEDCCC was created to provide counties a single point of contact to assist them with SD/MC claiming process questions and issues. MEDCCC provides counties 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 counties when a potential issue with a claim process or business rule has been identified. MEDCCC assists counties with streamlining the claim process, resulting in improved processes, and understanding of requirements at both the county and State levels.

What counties can expect when contacting MEDCCC:

- An email response acknowledging receipt of the counties issue or concern within 48 business hours.
- The most current information on Drug Medi-Cal claims
- Assistance with troubleshooting claim and/or payment issues
- Helpful answers to claiming policy and procedure questions.
- MEDCCC will generally respond to inquiries within five business days. However, some responses may take more time.

To ensure the accuracy of the inquiry and responses, MEDCCC requests that counties email inquiries to MEDCCC@dhcs.ca.gov.

CHAPTER TWO: GETTING STARTED

2.0 Introduction

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

- Enrolling in the DHCS Application Portal
- Provider Numbers and National Provider Identifiers
- Provider Enrollment and Medi-Cal Certification
- Companion Guide and Appendix

2.1 DHCS Application Portal

The DHCS Application Portal (Portal) is a collection of web applications that allow DMC - State Plan trading partners (e.g., counties, Contracted Providers, and authorized Vendors) to access information securely over the Internet. DHCS will continue to allow trading partners to have two Approvers per system. Each county's behavioral health director appoints Approvers.

All system Approver certification forms are available on the DHCS Drug Medi-Cal Application Information website. If the Approver's organizational domain name is already associated with a Microsoft or Office 365 AAD account, the Approver will be able to select that account when logging in at the Portal. Otherwise, the Approvers will be prompted to create an account.

After DHCS has added an Approver as a new member, they will receive an invitation to join SD/MC-SD/MC-ADP (Substance Use Disorder). The Designated Approvers will also be able to send their own staff invites to the Portal as users.

By adding users to a trading partner group, an Approver grants that member access to the Approver's personal health information data in that system. For that reason, security group owners receive quarterly e-mail notifications instructing them to perform an access review. Those reviews must be completed in a timely manner. If they are not, group members could temporarily lose access to the Portal.

2.2 Provider Numbers and NPIs

All providers wishing to bill Medi-Cal for providing Drug Medi-Cal services must have:

- A State-assigned provider number
- A National Provider Identifier (NPI)

Federal regulations require that individual healthcare providers and organizations obtain NPIs. DHCS maintains a Drug medi-Cal Providers website designed to assist providers and share the resources available to understand provider processes including information about obtaining an NPI. DHCS also makes available Drug Medi-Cal Provider Enrollment information related to provider obligations. Providers must identify, by NPI, the rendering provider and the billing and service facility locations in healthcare claim transactions. To request a provider number, use the Provider Application and Validation for Enrollment page.

2.3 Provider Enrollment and Medi-Cal Certification

The Provider Enrollment Division (PED) within DHCS is responsible for the receipt, review, and approval of all DMC certification applications. To provide DMC - State Plan services, providers must first be DMC

certified by DHCS PED. Certification is unique to a particular facility location and specifies the DMC services that can be provided at that location. Certification also distinguishes between services that can be provided within the regular (non-perinatal) DMC program, and those that may be provided within the perinatal DMC program for substance use disorder services for pregnant and postpartum women. For more specific certification information, contact PED by email, DHCRecert@dhcs.ca.gov , or visit the DHCS Provider Enrollment Division website. Additionally, DHCS requires that DMC providers complete a recertification process every five years to maintain their DMC certification. In order to bill and receive reimbursement for DMC services, most DMC certified providers must have a contract either with the county in which the provider site is located, or directly with DHCS. If a DMC certified provider serves an EPSDT beneficiary from a DMC State Plan County, unless the service rendered is NTP dosing and counseling, the provider must have an association with any county within the state to be able to render services to EPSDT beneficiaries. DMC certified providers that are Indian Health Care Providers may serve a beneficiary from any county.

2.4 Companion Guide and Appendix

DHCS publishes a Companion Guide and a Companion Guide Appendix for each Health Insurance Portability and Accountability Act (HIPAA) compliant transaction type used by SD/MC (e.g., 835, 837). The Companion Guide details how to format HIPAA-compliant 837 files and what information the county can expect to receive on an 835 file. The Companion Guide Appendix provides technical details about claim submission procedures, appropriate code usage, error codes, conversion tables, and such.

CHAPTER THREE: CLIENT ELIGIBILITY

3.0 Introduction

This chapter contains information about Medi-Cal eligibility including:

- Client Eligibility
- Aid Codes

3.1 Client Eligibility

Drug Medi-Cal beneficiaries must be Medi-Cal eligible for the county to be reimbursed through the SD/MC Claim Processing System. The sections in this chapter describe Medi-Cal Eligibility Determination and Medi-Cal Eligibility Review.

3.1.1 Medi-Cal Eligibility Determination

DHCS is responsible for instituting procedures for establishing Medi-Cal eligibility criteria. 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 Medi-Cal Eligibility Division.

The following information regarding Medi-Cal eligibility is integral to the management of Drug Medi-Cal claiming:

- Medi-Cal eligibility is established on a monthly basis.
- External auditors can review verification of beneficiary Medi-Cal eligibility after the claimed month of service.
- Medi-Cal eligibility may require that a beneficiary's Share of Cost (SOC) be met before Medi-Cal will pay for any services.
- Clients who are eligible for Supplemental Security Income (SSI) are Medi-Cal eligible. Medi-Cal eligibility may be established retroactively through legislation, court hearings, and/or decisions.
- HIPAA 270/271 transactions are available from DHCS to verify beneficiary Medi-Cal eligibility.
- Counties and/or providers should verify beneficiary Medi-Cal eligibility prior to submitting claims for reimbursement.

3.1.2 Eligibility Review

Once Medi-Cal eligibility is established, authorized county staff may review beneficiary eligibility information. With few exceptions, the source of this eligibility verification information will be the DHCS Point of Service System.

3.1.3 Monthly MEDS Extract File (MMEF)

The Monthly MEDS Extract File (MMEF) contains, among other data, all Aid Codes for which beneficiaries who are the county's responsibility are eligible at the date/time the file was 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 Medi-Cal Eligibility Data System (MEDS) for eligibility data at the time the claim is being adjudicated.

For additional information about the kind of data elements available in MMEF, refer to Appendix 4.

3.1.4 MEDS and MEDSLITE

MEDS and MEDSLITE provide eligibility status code(s) for a beneficiary. For a particular month and year of service, if the eligibility is valid, then the approved Aid Code will be the highest-paying eligible SD/MC Aid Code.

If a beneficiary is found in MEDS or MEDSLITE, but none of the Aid Codes assigned to the beneficiary are applicable to SD/MC, the claim will be denied.

MEDSLITE is an Internet-based program that allows MHPs to verify eligibility information but does not allow MHPs to view the Social Security Administration data that is contained within MEDS. For additional information about MEDSLITE such as how to gain access, contact the MEDSLITE Coordinators at BHMEDSLITE@dhcs.ca.gov.

For additional information about the kind data elements available in MEDSLITE, refer to Appendix 4.

3.2 Aid Codes

During the Medi-Cal application and enrollment process, Aid Codes are assigned to Medi-Cal eligible clients to indicate the program(s) under which the client qualifies for services. The DHCS Short Doyle Medi-Cal Aid Codes Master Chart (which includes both Mental Health and Drug Medi-Cal) can be found on the MEDCCC Library. The Aid Codes Master Chart provides useful information about the following:

- FFP
- Aid Codes
- Types of benefits
- Share of cost
- Code description
- Indication of reimbursement through the DHCS Fiscal Intermediary, Drug Medi-Cal Program (DMC), Mental Health Programs, and/or EPSDT programs.

CHAPTER FOUR: COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered DMC - State Plan services and it includes:

- DMC - State Plan Covered Services
- DMC - State Plan Levels of Care

4.1 DMC - State Plan Covered Services

Substance use disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. SUD treatment services are based on medical necessity.

The following services, per State Plan Amendment 20-0006, are reimbursable under the DMC – State Plan Program. Claims for reimbursement of DMC-SPA services may be submitted to the SD/MC claiming system via the Portal.

4.1.1 Assessment: State Plan Amendment (SPA 20-0006-A)

Assessment consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, regulations, and standards.

Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current Diagnostic, Statistical Manual (DSM), and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

4.1.2 Group Counseling: SPA 20-0006-A

"Group Counseling" means a contact with multiple beneficiaries at the same time. Group counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes at least two and no more than 12 participants.

4.1.3 Individual Counseling: SPA 20-0006-A

"Individual Counseling" means a contact with a beneficiary. Individual counseling also includes a contact between a beneficiary, substance use disorder treatment professional, and one or more collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Individual counseling also includes preparing the beneficiary to live in the community and providing linkages to treatment and services available in the community.

4.1.4 Medical Psychotherapy: SPA 20-0006-A

"Medical Psychotherapy" means a type of counseling service to treat SUDs other than Opioid Use Disorders (OUD) conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

4.1.5 Medication Services: SPA 20-0006-A

"Medication Services" means the prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT to treat Opioid Use Disorders as defined below.

4.1.6 Medication for Addiction Treatment (also known as Medication Assisted Treatment (MAT)) for Opioid Use Disorders (OUD): SPA 20-0006-A

Medications for Addiction Treatment for OUD includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders as authorized by the Social Security Act, Section 1905(a)(29) and described in Supplement 3 to Attachment 3.1-A.

HCPCS code H0033 should be used to designate the administration of medication outside of the NTP and cannot be reported by the NTP.

4.1.7 Mobile Crisis Services: State Plan Amendment: SPA 22-0043

Mobile crisis services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis. Locations may include, but are not limited to, the individual's home, school, or workplace, on the street, or where the individual socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours a day, seven days a week, and 365 days per year.

4.1.8 Patient Education: SPA 21-0058

"Patient Education" means education for the beneficiary on addiction, treatment, recovery, and associated health risks.

4.1.9 Peer Support Services: SPA 20-0006-A

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goal . Peer support services are based on an approved plan of care and can be delivered as a standalone service. Peer support services are an optional benefit that DMC State Plan counties may choose to offer.

Peer support services include the following service components:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness, and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Peer Support Services can only be claimed as a standalone service and must be claimed separately. DMC State Plan providers delivering Peer Support Services must use the Peer Support Services procedure codes to claim for Peer Support Services. Peer Support Services is not covered as a service component of DMC levels of care. Peer Support Services are covered under the DMC State Plan program even if the beneficiary is not receiving treatment at a DMC level of care (e.g., the "Engagement" service component is designed to support outreach and engagement efforts prior to initiation and treatment).

However, DMC State Plan providers may deliver Peer Support Services to beneficiaries receiving treatment at all DMC levels of care. Beneficiaries may concurrently receive Peer Support Services while receiving other DMC State Plan services. Peer Support Services must be claimed separately.

4.1.10 SUD Crisis Intervention Services: SPA 20-0006-A

SUD Crisis Intervention Services consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of

relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

4.2 DMC – State Plan Levels of Care

4.2.1 Intensive Outpatient Treatment (IOT): SPA 22-0024

Intensive Outpatient Services are provided to beneficiaries when medically necessary in a structured programming environment. Intensive Outpatient Treatment includes the following service components:

- Assessment
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services
- MAT for OUD
- SUD Crisis Intervention Services

4.2.2 Narcotic Treatment Program (NTP): SPA 22-0024

Narcotic Treatment Program is an outpatient program that provides FDA-approved drugs to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications including methadone, buprenorphine, naloxone, and disulfiram. NTPs shall offer adequate counseling services to each beneficiary as clinically necessary. The components of the Narcotic Treatment Program are:

- Assessment
- Individual Counseling
- Group Counseling
- Patient Education
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- SUD Crisis Intervention Services

NTP counseling is limited to 200 minutes per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP providers may bill and be reimbursed for additional counseling. Medical justification for the additional counseling must be clearly documented in the patient record and completed within 14 days of treatment.

4.2.3 Outpatient Treatment Services (also known as Outpatient Drug Free (ODF)): SPA 20-0006-A

Outpatient Treatment Services are provided to beneficiaries as medically necessary.

Outpatient Services include the following components:

- Assessment
- Individual Counseling
- Group Counseling
- Patient Education
- Medication Services

- MAT for OUD
- Crisis Intervention Services

4.2.4 Perinatal Residential Substance Use Disorder Treatment: SPA 20-0006-A

Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnosis. Each beneficiary shall live on the premises and shall be supported in their effort to restore and apply interpersonal and independent living skills and access community support systems. Perinatal Residential Substance Use Disorder Treatment programs shall provide a range of activities and services for pregnant and postpartum beneficiaries. Supervision shall be available day and night, seven days a week. Medically rehabilitative services are provided in accordance with individualized beneficiary needs. The cost of room and board is not reimbursable. Facilities shall store and safeguard all residents' medications, and facility staff members may assist with resident's self-administration of medication.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Assessment
- Individual Counseling
- Group Counseling
- MAT for OUD
- Patient Education
- SUD Crisis Intervention Services

4.2.5 Services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit

Federal EPSDT statutes and regulations require states to furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct or ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. SUD services are outlined in California's Medicaid State Plan and are available to children and youth as medically necessary. Specifically, beneficiaries under 21 who are residents of DMC State Plan counties are entitled to receive all SUD services that are appropriate and necessary to correct or ameliorate the substance use disorder or condition.

As a result, counties may bill for residential services for EPSDT beneficiaries. The HD modifier should not be included for EPSDT non-perinatal residential claims. EPSDT residential services are reimbursable only when provided in a facility with treatment capacity of sixteen beds or less. In addition, EPSDT beneficiaries in DMC-State Plan counties may receive DMC-ODS services, as described in the "Expanded Substance Use Disorder Treatment Services" section of the California Medicaid State Plan. DMC State Plan Counties should consult the DMC-ODS billing manual for guidance on how to bill for expanded substance use disorder treatment services provided to EPSDT beneficiaries.

CHAPTER FIVE: CLAIMS PROCESSING

5.0 Introduction

This chapter provides an explanation of how the SD/MC claiming system processes claims. The chapter is divided into the following broad sections:

- Accepting and Rejecting Claims
- Approving and Denying Original Claims
- Replacing Approved and Denied Claims
- Voiding Approved Claims
- Requesting Delay Reason Codes

5.1.0 Accepting and Rejecting Claims

When a claim file is submitted, the SD/MC claiming system will either accept or reject claims within the claim file. If any portion of a claim does not meet the Workgroup for Electronic Data Interchange Strategic National Implementation Process HIPAA Transaction and Code Sets Final Rules ("SNIP edits"), SD/MC will reject the entire claim. If the claim meets the SNIP edits, SD/MC will accept the claim.

SD/MC posts three reports to the county's folder in the DHCS Portal after completing the SNIP edits. The first is the 999 Functional Acknowledgment, which tells the county whether the claim file or individual claim within the claim file was accepted or rejected. The second report is the TA1 Interchange Acknowledgement Report, which tells the county if the rejection was due to structural issues with the claim file or syntax errors in the claim. The third report is the SR Acknowledgement Report, which tells the county how many claims within the claim file were accepted, how many were rejected, and provides more granular information about the reason for rejection.

5.2.0 Approving and Denying Claims

The SD/MC claiming system adjudicates all claims that pass the SNIP edits and are accepted. Adjudication involves application of all business requirements described in this chapter of the billing manual. Claims or service lines that meet all the business requirements are approved and claims or services lines that do not meet a business requirement are denied.

5.2.1 Zero Dollar Claims

A service line must be submitted for an amount greater than $0. SD/MC will deny all service lines submitted for $0.

5.2.2 Beneficiary Share of Cost

Beneficiaries with a share of cost must meet that share of cost before Medi-Cal will reimburse providers for services rendered to the beneficiary. Counties should not submit claims to SD/MC for services provided to beneficiaries who have not met their share of cost, including $0 claims. SD/MC will deny claims submitted for services provided to beneficiaries who have not met their share of cost.

5.2.3 Beneficiary Eligibility

Beneficiaries must be enrolled in Medi-Cal during the month in which the service was rendered. The Client Identification Number (CIN) uniquely identifies each beneficiary. SD/MC verifies that the beneficiary was enrolled in Medi-Cal by matching the CIN reported on the claim with the CIN recorded in MEDS. If the CIN reported on the claim does not match a CIN in MEDS, SD/MC will deny the claim.

SD/MC verifies that the beneficiary was enrolled in Medi-Cal during the month in which the service was rendered by matching the month of service as reported on the claim with the beneficiary's months of eligibility. If the beneficiary was not enrolled in Medi-Cal during the month in which the service was rendered, the claim will be denied.

5.2.4 County of Residency/County of Responsibility

Except for NTP dosing and counseling, a DMC – State Plan County must only submit claims for beneficiaries who are its responsibility and/or for beneficiaries who reside in that county. A claim will be denied if the submitting county for the claim is not the beneficiary's county of responsibility or the beneficiary's county of residence as recorded in MEDS. This rule does not apply for the following services: NTP dosing, individual and group counseling, services (H0004 (individual counseling), H0005 (group counseling), H0020 (methadone administration and service provision), S5000 (NTP dosing), and S5001 (NTP dosing)) if those service codes are claimed with modifiers UA (ASAM OTP/NTP) and HG (Opioid treatment program).

5.2.5 Beneficiary Date of Birth

The beneficiary's date of birth (month and year), as reported on the claim, must match the date of birth (month and year) as recorded in MEDS. If the date of birth does not match, the claim will be denied.

5.2.6 Beneficiary Gender

The beneficiary's gender needs to be reported on the claim but will not be verified by SD/MC as of 7/1/2023.

5.2.7 Beneficiary Date of Death

A provider may not provide a service to a beneficiary after the beneficiary has died. SD/MC will deny all service lines with a date of service that occurred after the beneficiary's date of death as recorded in MEDS. Services provided on the date of death will be adjudicated.

5.2.8 Dates of Services Within a Claim

For any single claim, all dates of service must be within the same calendar month. SD/MC will deny service lines submitted with dates of service that do not conform to this guidance.

5.2.9 Claims for Residential Stays that Cross One or More Months

A county must submit multiple claims for residential stays that crossover one or more months. For example, if a residential stay is submitted for January 31st, a separate claim would have to be submitted for a residential stay on February 1st or claim will be denied.

5.2.10 Service Lines and Date Ranges

All service lines, except for NTP dosing services, must have a single date of service. Service lines for NTP dosing services may include a date range (i.e., from date and to date). Service lines for all other services that have a date range will be denied. For example, if a service line is submitted for counseling services with a start date of November 3, 2023, and an end date of November 5, 2023, the service line will be denied.

5.2.11 Date of Service and Date of Submission

The date of service cannot be later than the date of submission. For example, if submission date is November 3, 2021, and service date is November 5, 2021, the service will be denied.

5.2.12 Duplicate Services

24-Hour Services

24-hour service procedure codes are listed in service table 1 and duplicates are not allowed. 24-hour services are considered duplicate if all of the following data elements associated with two service lines are the same:

- The beneficiary's Client Index Number (CIN)
- Date of service

Outpatient Services

Outpatient services are listed in the service table. Except for peer support, group (H0025), sign language or oral interpretive services (T1013), interactive complexity (90785), mobile crisis (H2011, POS 15), and health behavior interventions for the family without the patient present (96170 and 96171), a procedure code is considered a duplicate if all of the following data elements are the same:

- The beneficiary's CIN
- Rendering provider NPI
- Procedure code(s)
- Date of service

Duplicate services are not allowed.

If a provider renders the same service to the same beneficiary on the same day more than once, the provider should submit the claim as one service rather than two services. For example, a provider may render 60 minutes of counseling in the morning and an additional 30 minutes of counseling in the evening to the same beneficiary, in this particular scenario, the county would submit one claim for 90 minutes of counseling.

5.2.13 Claiming for Interpretation, Health Behavior Intervention, and Interactive Complexity

Sign language or oral interpretation (T1013), Interactive Complexity (90785), and health behavior intervention (codes 96170 and 96171) occur along with another service, such as counseling. These codes must be submitted on the same claim as the primary service. DMC eligible providers can also submit claims for interpretation (T1013) when they use an oral interpreter to provide counseling to a patient who needs sign language or interpretive services.

A claim for interpretation should be submitted when the provider and the patient cannot communicate in the same language, and the provider uses an on-site interpreter and/or individual trained in medical interpretation to provide medical interpretation. Interpretation time may not exceed the time spent providing a primary service. For example, if a counseling session lasted 45 minutes, a maximum of three units of T1013 may be claimed.

Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the per diem rate. Interpretation also cannot be claimed for automated/digital translation or

relay services. Counties may not claim for interpretation when claiming for mobile crisis services as the rate for mobile crisis incorporates interpretation.

A claim for interpretation should include the taxonomy code and NPI of the individual who provided the primary service. The standard rate per unit of oral or sign language interpretation is based on the Bureau of Labor Statistics data.

Only one unit of interactive complexity (90785) is allowed with any service. Either 90785 or T1013 can be billed in any given encounter; 90785 and T1013 cannot be billed together. A claim for interpretation should be submitted if the service is delivered by a provider other than the provider of the primary service.

5.2.14 Claim Timeliness – Original Claims

The timeline for initial submission of DMC-State Plan claims is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section WIC 14021.6(g)). An original claim submitted after 12 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied. Please see section 5.5 for more information about requesting a DRC.

5.2.15 Service Facility Location

The Service Facility Location NPI combined with zip code +4 will be verified to process claims when the submitting provider is a sole proprietor. Service will be denied if the Service Facility NPI does not match zipcode+4 as recorded in the provider file.

5.2.16 Service Facility Validation

SD/MC verifies that the service facility identified on the claim was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided. As discussed in Section 2.3, DHCS records in the Provider Application and Validation for Enrollment each organizational provider's NPI number and the substance use disorder treatment services the provider is certified to render. SD/MC will deny a service line if the provider, as determined by the service facility NPI number on the claim, is not certified to provide the service billed.

5.2.17 Rendering Provider Taxonomy Code

Outpatient services are listed in the Service Table. SD/MC will deny service lines for outpatient services that do not contain the rendering provider's taxonomy code unless the service is mobile crisis (H2011 Place of Service 15), transportation mileage (A0140) or transportation staff time (T2007). If the claim is for H2011 and POS 15, A0140, or T2007, SD/MC will ignore the rendering provider taxonomy code.

In all other instances, SD/MC uses the rendering provider's taxonomy code to verify that the rendering provider is eligible to provide the service rendered or use the procedure code reported on the service line. The Service Table identifies SD/MC Allowable Disciplines for each procedure code. Appendix 1 lists each discipline that is eligible to provide one or more substance disorder treatment services and the first four characters of the taxonomy codes that identify each discipline.

SD/MC will deny all service lines for outpatient services where the first four characters of the rendering provider's taxonomy code does not identify a SD/MC Allowable Discipline for the procedure code on the service line. SD/MC does not verify the taxonomy code against the rendering provider's NPI. The AOD

Counselor provider type is designated using the five-character taxonomy code 101Y**A**. Four-character taxonomy code 101Y refers to Licensed Professional Clinical Counselors.

As specified in the Service Table, certified Medi-Cal peer support specialists may only submit claims to Short Doyle Medi-Cal (SD/MC) for Medi-Cal peer support services (H0038 and H0025) under the peer taxonomy code. If the Medi-Cal Peer Support Specialist meets the qualifications for another practitioner type, the Medi-Cal Peer Support Specialist may submit a separate claim under a different taxonomy code for any non-Medi-Cal Peer Support Services. For additional information, refer to the Medi-Cal Support Services Specialist Program-Frequently Asked Questions.

5.2.18 Place of Service Codes

SD/MC will deny all claims for outpatient services that do not include a place of service code. The Service Table lists all the outpatient procedure codes and the place of service codes that may be billed with each procedure code. SD/MC will deny service lines that contain place of service code that may not be billed with the procedure code on the service line. If the service was provided via telehealth or telephone, the place of service must be 02 or 10.

Note that CMS added Place of Service Code 27, effective October 1, 2023, to capture services that are provided in a non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Medicaid does not reimburse services provided to residents of a public institution, which includes jails and prisons. SD/MC will deny all service lines for outpatient services with place of service code 09 (Correction Facility).

5.2.19 Level of Care Modifiers

Except for residential service codes H0018 and H0019, all services are required to be submitted with a level of care modifier. The following levels of care modifiers are used by DMC – State Plan Counties:

- U1 (ASAM 3.1, Residential),
- U2 (ASAM 3.3, Residential),
- U3 (ASAM 3.5, Residential),
- U7 (Outpatient Services (ODF)),
- U8 (Intensive Outpatient Services (IOS)), and
- UA and HG (Opioid treatment program (OTP)).

Services will be denied if a procedure modifier defining level of care has not been submitted or if the submitted outpatient procedure code is not allowable with the submitted modifier(s). Refer to the Service Table for a list of the valid procedure/modifier combinations. Claims for NTP services must be submitted with both HG and UA modifiers.

5.2.20 Multiple Levels of Care on Same Day

Services for one level of care will not be allowed in combination with other services in another level of care for the same beneficiary and same date of service except for NTP services.

5.2.21 Perinatal and Non-Perinatal Services

All service lines on a claim must be either perinatal or non-perinatal. SD/MC will deny a claim if it has both perinatal and non-perinatal service lines.

To indicate that a service is perinatal, the service line must include modifier HD. Claims submitted with service lines that contain the HD modifier must also set the pregnancy indicator to yes or the claim will be denied.

5.2.22 Dependent Codes

The service table lists all outpatient procedure codes. The procedure codes listed in Column C labeled "Code" are considered primary procedure codes. The procedure codes listed in Column O labeled "Dependent on Codes" identifies procedure codes that must be billed before the primary procedure can be billed. SD/MC will deny a service line with the primary procedure code if a Dependent on Code was not billed on the same claim or approved on the same day for the same beneficiary in history.

Some service encounters may need to be claimed with two procedure codes, the primary code, and a dependent code referred to as an add-on code to correctly indicate the time spent providing the service. Some services have a specific primary procedure code and a specific add-on code. All evaluation and management codes and CPT codes that do not have a dedicated add-on code use G2212 as the add-on code. If a practitioner provides a service that exceeds the maximum time allowed for the series of evaluation and management codes, use G2212 to claim reimbursement for the additional time. The primary procedure code and add on code must be submitted on the same claim. SD/MC will deny a service line billed with an add-on procedure code if the primary procedure code is not present in the same claim.

5.2.23 Units of Service – Outpatient Services

All claims for outpatient services must be billed in units. SD/MC will deny a service line that is not billed in units of service for all outpatient codes must be billed in whole numbers. For example, if service code 90791 (Psychiatric diagnostic evaluation) is billed for 1.5 units, the service will be denied.

5.2.24 Maximum Units – Outpatient Services

All claims for outpatient services must use units of service. Column R, labeled "Maximum Units that Can be Billed per Beneficiary Per Day" in the Service Table identifies the maximum units of service that may be included on a service line for each outpatient procedure. SD/MC will deny a service line that is not billed in units or reports units that exceed the unit maximum as displayed in the "Maximum Units that Can Be Billed per Beneficiary per Day" Column. Only the time it takes to provide direct services associated with that code can be counted toward a unit of service.

5.2.25 How to Select Codes Based on Time

Column D of the Service Table, "Minimum Time Needed to Claim 1 Unit" states the minimum time of direct patient care associated with one unit of the code in column C and Column E "Time When Add-On Code or next Code in Series Can be Claimed" states at what point an add-on code should be claimed. The calculations displayed in the two columns reflect the rules outlined below.

<u>Most Codes</u>

Most codes (with exceptions noted below) should be selected based on the midpoint rule meaning that a unit associated with a code is attained when the mid-point is passed. For example, if one unit of a code is 15 minutes, one unit of that code is attained when 8 minutes of direct patient care have been provided. A disruption in the service does not create a new, initial service. For example, if a patient receives 15 minutes of telephone assessment in the morning and 15 minutes of assessment in the

afternoon, the provider will claim one unit of 90791 (psychiatric diagnostic evaluation) and one unit of G2212 (prolonged service code) to indicate 30 minutes of assessment. They would not claim two units of 90791.

Codes with Defined Time Ranges

Some codes, such as Evaluation and Management (E&M) codes, have defined time ranges and are not subject to the midpoint rule. When claiming these codes, when a provider delivered the lower bound of the service indicated in the range, they can claim one unit of that code. For example, when selecting a unit of an E&M code (e.g., CPT codes 99202-99499), the time defined for the service is used for selecting the appropriate code. This means that the code can be claimed once the lower bound of the time indicated on the code has been reached. For example, if billing for 99202 (office or other outpatient visit, 15-29 minutes) a provider can bill for one unit of that code when they saw the patient for 15 minutes.

5.2.26 Other Health Coverage – Medicare

Medi-Cal is the payer of last resort. This means that providers must submit claims to Medicare for Medi-Cal eligible services performed by Medicare-recognized providers before submitting a claim to Medi-Cal. The claim submitted to Medi-Cal must include Other Health Coverage (OHC) information. Medi-Cal will reimburse the county the difference between the amount it would normally pay and the amount that Medicare already paid.

Medicare Eligible Services

The Medi-Cal state plan covers some DMC services that Medicare does not cover. Column Q in the Service Table, labeled "Medicare COB Required?" identifies the specific services that may be billed directly to Medi-Cal, and which must be submitted to Medicare first. -If the Medicare COB Required column displays 'Yes' for a particular CPT or HCPCS code, the service is covered by Medicare. If the Medicare COB Required column displays 'No' for a particular CPT or HCPCS code, the service is not covered by Medicare. Medicare must be billed first when the Medicare covered services is rendered by a Medicare recognized provider. Subsequently, the claim submitted to Medi-Cal must contain information about the Medicare claim. When billing a CPT code and G2212 submit those service lines on one claim and report Medicare COB at the claim level.

Please note that although SD/MC and Medicare codes overlap, there are differences between the two systems. When billing Medicare, counties must follow Medicare claiming rules as spelled out in the Medicare manual. If the counties are unsure about the specific Medicare rules in a particular circumstance, they may wish to contact California's Medicare Fiscal Intermediary.

If Medicare does not respond within 90 days, the provider may submit a claim to Medi-Cal on the 91st day.

Subsequently, the claim submitted to Medi-Cal must contain OHC information about the Medicare claim even if the OHC is $0.

NTP services and Medicare Part B beneficiaries:

Medicare Part B reimburses Opioid Treatment Programs (OTPs) a weekly rate for a bundle of services that includes dosing, individual counseling, and group counseling. When billing NTP services for a beneficiary that has Medicare Part B, all dates of service on the claim must fall within a 7-day calendar

window associated with the Medicare Part B payment. Services submitted outside of the 7-calendar day window will be denied. For example, if a claim submitted for NTP services rendered to a Medicare Part B beneficiary, indicates services were rendered on dates of service between November 3 and November 12 (10 calendar days), services with dates of service from November 10 and after, which fall outside the 7-calendar day window, will be denied. Please see BHIN 21-065 for additional guidance on billing for NTP services for dual eligible beneficiaries.

Procedure codes H0004 (Individual Counseling), H0005 (Group Counseling), H0020 (Methadone administration), S5000 (Prescription drug: generic), and S5001 (Prescription drug: brand name) are not exempt from Medicare COB when related to Narcotic Treatment Program (NTP)/ Medication Assistance Treatment (MAT) dosing. These services must first be billed to Medicare when related to NTP/MAT dosing unless the medication is drug type 3 (Disulfiram), 6 (Acamprosate), 7 (Buprenorphine combination), or 10 (Naltrexone: Long-Acting Injection). As stated above, please refer to BHIN 21-065 for additional guidance on billing for NTP services for dual eligible beneficiaries.

Medicare does not cover drug types 3, 6, 7, and 10.

Medicare Recognized Providers

The Medi-Cal state plan identifies some provider types that are eligible to render Drug Medi-Cal services, which are not eligible to render Medicare services. If the rendering provider is not eligible to render Medicare services, the county may bill Medi-Cal directly. Medicare must be billed first when one of the following licensed provider types provides Medicare eligible service to a Medicare beneficiary:

1. Physicians
2. Physician assistants
3. Nurse practitioners
4. Licensed clinical social workers
5. Clinical psychologists
6. Licensed Marriage and Family Therapists
7. Licensed professional Clinical Counselors

5.2.27 Other Health Care Coverage – Non-Medicare

Medi-Cal should always be the payer of last resort. This means that providers must submit a claim to a beneficiary's other health coverage for eligible services before submitting a claim to Medi-Cal. With the exception of NTP claims, the claim submitted to Medi-Cal must include Other Health Coverage (OHC) information. Medi-Cal will reimburse the county the difference between the amount it would normally pay and the amount that the OHC already paid.

Services that can be billed directly to Medi-Cal

The beneficiary's OHC must be billed first when it covers the service. However, the Medi-Cal state plan covers some Drug Medi-Cal services that a beneficiary's Other Health Coverage does not cover. The following services may be billed directly to Medi-Cal:

1. Claims for Treatment Planning (H2014, H2015, H2021)
2. Claims for Mobile Crisis, Transportation Staff Time, and Transportation Mileage services (H2011 with POS 15, A0140, T2007)
3. Claims for Peer Support services (H0025 and H0038)

In addition, services to beneficiaries who are enrolled in minor consent aid codes do not have to have OHC information.

5.2.28 Institutions for Mental Disease (IMDs)

Services provided to beneficiaries in an Institution for Mental Disease (IMD) are not eligible for federal Medicaid reimbursement. An IMD is 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 (42 CFR 435.1010). The exceptions to this rule are if the beneficiary is 65 years or older or under 22 years old receiving services in an inpatient psychiatric facility. DHCS posts a list of facilities that are classified as an IMD on the Institution for Mental Diseases List.

5.2.29 Lockout Rules

Outpatient Lockouts:

SD/MC enforces two types of lockout rules. The California Code of Regulations prohibits some specialty mental health services from being provided to a beneficiary on the same day. SD/MC will deny a service line when the California Code of Regulations prohibits that service from being provided to a beneficiary on the same day as a service approved in history. The Centers for Medicare and Medicaid Services (CMS) also requires states to implement the National Correct Coding Initiative (NCCI). NCCI identifies procedure codes that should not be billed on the same day for the same beneficiary unless certain conditions are met. SD/MC will also deny a claim for a service when NCCI prohibits that service from being provided to a beneficiary on the same day as a service approved in history unless certain conditions are met.

The Service Table identifies the combinations of procedure codes that cannot be billed for the same beneficiary on the same day. Excel column C, labeled "Code", lists each outpatient procedure code. Column J, labeled "Outpatient Lockout Codes," lists all procedure codes that are locked out for the procedure code in Column C when provided to the same beneficiary on the same day. Column K, labeled "Outpatient Overridable Lockouts with Appropriate Modifiers" identifies those codes that can be billed with the code listed in Column C under extraordinary circumstances.

Target codes are listed in Column L. The combination of the Code in Column C and each lockout code in Columns K or L represents a lockout situation when both are provided to the same beneficiary by the same provider on the same day. SD/MC will deny a claim for a service if it produces a lockout situation, when combined with a service approved in history, unless one of the codes is a target code with an over-riding modifier.

Target codes in Column L are identified by one or two asterisks (*). Target codes with one asterisk are not locked out when combined with the procedure code in Column 2 if the target code is billed with one of the following over-riding modifiers: 59, XE, XP or XU. Target codes with two asterisks are not locked out when combined with the procedure code in Column 1 if the target code is billed with one of the following over-riding modifiers 27, 59, XE, XP, or XU.

Medication Services Lockouts:

Procedure codes used to claim reimbursement for Medication Services are listed in the Service Table. Certain medication services have lockouts and are not allowed to be billed on the same day**.** Below is a list of these lockouts.

- Disulfiram cannot be billed the same day with Vivitrol or Acamprosate.

- Naloxone, Disulfiram, Acamprosate, methadone, and vivitrol cannot be billed more than once on the same day.
- Vivitrol cannot be billed on the same day with Acamprosate.
- Buprenorphine is not allowed on the same day as Vivitrol.

5.2.30 Pregnancy Indicator

The pregnancy indicator should be set to yes if the beneficiary is pregnant. SD/MC will deny a claim submitted for a beneficiary enrolled in an aid code restricted to pregnancy services if the pregnancy indicator is not set to yes.

5.2.31 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a Medicaid benefit that requires states to provide beneficiaries under 21 years of age who are eligible for full scope benefits any Medicaid covered service that is necessary to correct or ameliorate a substance use disorder health condition whether or not the service is identified in the state plan. EPSDT beneficiaries in DMC - State Plan counties are eligible for all DMC – ODS services. The county of residence or county of responsibility must submit claims for expanded DMC – ODS services provided to EPSDT beneficiaries in DMC – State Plan counties.

DMC certified providers must have an association with any county within the state to be able to render services to EPSDT beneficiaries.

5.2.32 Covered Diagnosis

Residential claims must have at least one DMC **covered** substance use disorder ICD-10 diagnosis code as indicated in Appendix 5-Covered Residential Diagnoses. A covered diagnosis codes are a subset of valid ICD-10 codes. Counties are required to use the appropriate ICD-10 codes to submit residential claims for reimbursement. If the diagnosis code is not a covered ICD-10 code, the service will be denied.

Outpatient claims must have a **valid** substance use disorder ICD-10 diagnosis code. Valid substance use disorder ICD-10 diagnostic codes are published by CMS. Please see BHIN 22-013 for additional information.

5.3.0 Replacing Approved and Denied Claims

Replacement claims for **previously approved claims** must be submitted within 6 months from the date of initial payment issued. If the replacement claim is submitted after this 6-month period, the replacement claim will be denied.

Replacement claims for **previously denied claims** must be submitted within 6 months from the date that 835 file was sent. If a replacement claim is submitted after this 6-month period, the replacement claim will be denied.

Please note that once the SDMC system is updated in July, counties will be able to replace an approved or denied claim no later than 15 months after the month of service.

A replacement claim can be submitted if an 835 has been issued and if the claim being replaced has not been voided. Replacement claims for outpatient services, day services, or 24-hour services must have the Billing Employer Identification Number. The replacement claim must match two of the following four

data elements in the original claim: Procedure code or revenue code (as appropriate), date of service, place of service, and service facility NPI.

5.4.0 Voiding Approved Claims

Counties may void previously approved claims. A void reverses the previously approved claim. SD/MC does not require voids to be submitted within a certain time frame after the service was rendered.

5.5.0 Requesting Delay Reason Codes

Counties may request a Delay Reason Code (DRC) to submit an original claim more than 15 months from the month of service or a replacement claim more than 15 months from the date of initial payment issued/date the 835 was sent if the delay in submitting the original or replacement claim is because proof of eligibility was unknown or unavailable, litigation, there was a delay in certifying the provider, there was a third party processing delay, there was a delay in eligibility determination, special circumstances that cause a billing delay such as a court decision or fair hearing, determination by DHCS that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control by contacting MEDCCC at MEDCCC@dhcs.ca.gov. Submission of replacement claims must not exceed 15 months from initial payment or 15 months from the date that the 835 was sent (whether or not the DRC is present) or claim will be denied.

CHAPTER SIX: FUNDING

6.0 Introduction

Drug Medi-Cal services are financed with a combination of federal, state, and county funds. The proportion of the approved claim paid with federal, state, and county funds depends upon the service rendered and the beneficiary served. This chapter provides an explanation of how the SD/MC claiming system determines the federal, state, and county share for each service submitted and approved for reimbursement.

1. Federal Share – FMAP Percentage and Aid Codes
2. State Share and Proposition 30
3. One Hundred Percent County Funded

6.1 Federal Share: FMAP Percentage and Aid Codes

After a claim passes all the adjudication edits, SD/MC determines the total amount eligible for reimbursement, which is called the total approved amount. SD/MC multiplies the total approved amount by an FMAP percentage to determine the amount of federal funds to reimburse the county. The FMAP percentage depends upon a combination of the service provided and the beneficiary's aid code. If a beneficiary is assigned more than one aid code, SD/MC will select the aid code eligible for the service billed with the highest FMAP.

The federal share for all services provided to a beneficiary enrolled in Medi-Cal, including State Only Medi-Cal, who is pregnant is 65 percent of the total approved amount. The service line must set the pregnancy indicator to yes to indicate the beneficiary is pregnant.

The federal share for services funded by the American Rescue Plan Act (ARPA) is 85 percent of the total approved. Mobile crisis services are currently the only ARPA-funded services.

The federal share for non-pregnancy services provided to a beneficiary enrolled in the State Only Medi-Cal program is 0 percent. The federal government does not reimburse states for the cost of non-pregnancy services provided to beneficiaries with unsatisfactory immigration status.

6.2 State Share and Proposition 30

The State realigned financial responsibility for Drug Medi-Cal Services to the counties in 2011 as part of 2011 Public Safety Realignment. The voters approved Proposition 30 in the November 2012 election, which added Section 36 to the California State Constitution. Proposition 30 requires the state to reimburse counties a portion of the non-federal share of increased costs incurred to implement new requirements in the Drug Medi-Cal Program after the 2011 realignment. More specifically, the state must reimburse counties one hundred percent of the non-federal share for new requirements imposed by the State and fifty percent of the non-federal share for new requirements imposed by the federal government. This section of the billing manual discusses those Drug Medi-Cal services that counties must provide as a result of a state-imposed requirement and a federally imposed requirement; and how counties must submit claims for those services so that the State reimburses the county the appropriate portion of the non-federal share with State General Funds.

6.2.1. State Required Proposition 30 Services

The state will reimburse counties 100 percent of the non-federal share for DMC services provided as a result of a new state requirement implemented after 2011 realignment. Either the beneficiary aid code or service modifier identifies whether the service was provided as a result of a new state requirement. This subsection discusses each of the new state requirements implemented after 2011 realignment and

whether SD/MC uses a modifier or the beneficiary's aid code to identify the service as a state requirement.

If a beneficiary is eligible for services as a result of the Affordable Care Act (ACA), the state will be responsible for 100 percent of the non-federal share. If the beneficiary is eligible for services as a result of Family First Prevention Services Act (FFPSA), the state will be responsible for 50 percent of the non-federal share. If the beneficiary is eligible as a result of Senate Bill (SB) 75, young adult expansion, older adult expansion, or is receiving continuum of care services, the state will be responsible for one hundred percent of the non-federal share.

6.2.1.1. Medi-Cal Optional Expansion Full Scope Beneficiaries

For Full Scope beneficiaries enrolled through the Medi-Cal Optional Expansion Program (ACA), the state will reimburse State Plan counties one hundred percent of the non-federal share for all services (pregnancy and non-pregnancy).

This means that DHCS will reimburse State Plan counties one hundred percent of the approved amount for services provided to a beneficiary with unsatisfactory immigration status enrolled through the ACA.

6.2.1.2. State Only Medi-Cal Beneficiaries Added After September 30, 2012

The state will reimburse counties 100 percent of the approved amount for Drug Medi-Cal services provided to State Only Medi-Cal beneficiaries added after September 30, 2012. This subsection discusses each group of State Only Medi-Cal beneficiaries added after September 30, 2012.

Senate Bill (SB) 75 – Medi-Cal for All Children

Children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements (SB 75, Chapter 8, Statutes of 2015). As a result, children under 19 years of age who do not have satisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which beneficiaries are eligible for the State-Only Medi-Cal Program as a result of SB 75 by the beneficiaries' aid code and data from MEDS. The state will reimburse counties 100 percent of the non-federal share for all services provided to beneficiaries enrolled in the State Only Medi-Cal Program pursuant to SB 75.

Young Adult Expansion

As of January 1, 2020, young adults under the age of 26 are eligible for full-scope Medi-Cal regardless of immigration status, as long as they meet all other eligibility requirements (Welfare and Institutions Code section 14007.8). As a result, young adults from 20 through 25 years of age who do not have satisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which beneficiaries are eligible for Medi-Cal as a result of the young adult expansion by the beneficiaries' aid code. The state will reimburse counties 100 percent of the non-federal share for allservices provided to beneficiaries enrolled through the Young Adult Expansion

Older Adult Expansion

Older adults over 50 years of age are eligible for full-scope Medi-Cal regardless of immigration status, as long as they meet all other eligibility requirements. As a result, older adults over 50 years of age who have unsatisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which beneficiaries are eligible for the State Only Medi-Cal Program as a result of older adult expansion by the beneficiaries' aid code. The state will reimburse counties 100 percent of the non-federal share for all services provided to beneficiaries enrolled through the Older Adult Expansion.

6.2.2 Community-Based Mobile Crisis Intervention Services

SPA 22-0043 added community-based mobile crisis services benefit. This benefit, as described in section 4.1.7, provides rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health and/or SUD (behavioral health) crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services are a state requirement. Therefore, when a county claims for providing those services for non-UIS Medi-Cal beneficiaries, the state will reimburse counties 100 percent of the non-federal share. The county should use modifier HW to indicate that this service is provided as a result of a state mandate.

6.2.3. Federally Required Proposition 30 Services

DHCS will reimburse state plan counties 50 percent of the non-federal share for Drug-Medical services that were mandated by the federal government. Currently, Medication Addiction Treatment (MAT) falls under this requirement. Counties must include modifier HV when submitting MAT services claims.

Methadone provided in NTP settings does not fall under this funding requirement.

6.2.4. One Hundred Percent County Funded

The county is responsible to finance 100% of the cost to provide services to beneficiaries in the following eligibility groups described below.

Qualified Non-Citizens

California provides full scope Medi-Cal benefits to Qualified Non-Citizens who are not federally eligible because they have not been in the United States for at least five years. Federal reimbursement is not available for non-pregnancy services provided to Qualified Non-Citizens enrolled through the State Only Medi-Cal Optional Expansion Program. State reimbursement is not available for DMC services provided to Qualified Non-Citizens unless the service was provided as a result of a State Requirement as described in Section 6.2.1 or unless the beneficiary is pregnant. Counties are responsible for 100 percent of the cost of all other services provided to Qualified Non-Citizens.

Permanently Residing Under Color of Law (PRUCOL)

California provides full scope Medi-Cal benefits to individuals Permanently Residing in the United States Under Color of Law (PRUCOL) who are otherwise eligible for Medi-Cal. Some of PRUCOL beneficiaries are not eligible for federal benefits and are enrolled in the State Only Medi-Cal Program. Federal reimbursement is not available for non-pregnancy services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program. State reimbursement is not available for DMC-ODS` Services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program unless the service was provided as a result of a State Requirement as described in Section 6.2.1 or the beneficiary is pregnant. Counties are responsible for 100 percent of the cost of all other services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program.

Minor Consent Beneficiaries

California provides limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, family planning, outpatient mental health services, pregnancy and postpartum services to minors who are at least 12 years of age and under the age of 21. Federal reimbursement is not available for services provided to minor consent beneficiaries. Counties must cover 100 percent of the cost for services provided to minor consent beneficiaries. Minor consent beneficiaries are enrolled in specific aid codes that are listed in the Aid Code Master Chart.

CHAPTER SEVEN: 2023 CPT UPDATES

The American Medical Association's (AMA) CPT 2023 Professional Edition Codebook with Rules and Guidelines included significant changes to the CPT code set that will be utilized in the SD/MC billing system beginning July 1, 2023. The changes include:

- Deleted codes
- Renamed and redefined codes
- Codes whose descriptions changed how they should be billed

The SD/MC business rules will remain the same and will be based on the AMA's 2022 rules until the SD/MC is updated to reflect the 2023 and 2024 code set and rules.

One code (99217: Observation care discharge day management) has been deleted. The substitution codes are 99238 (Hospital inpatient or observation discharge day management, 30 minutes or less on the date of the encounter) and 99239 (Hospital Inpatient or observation day management, more than 30 minutes on the date of the encounter). If a county claimns a code theat has been deleted in 2023, SD/MC will reject that claim. As a result, counties are advised to use AMA-recommended substitution codes instead of the code that has been deleted.

CHAPTER EIGHT: ANCILLARY TABLES

Tables 1-3 describe discipline and place of service that must accompany each claim and modifiers that will be present on most claims.

Table 1 Disciplines

Rendering providers/practitioners may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description. The following table describes the abbreviations that are used in the Service Table. The column labeled Abbreviations gives the abbreviation used in the Service Table and the column labeled Discipline states what the discipline is. A taxonomy code describing the provider delivering the service must be listed on all professional claims (837P claims) or the claim will be denied. The SD/MC claiming system will verify whether the service was provided appropriately based, in part, on whether the provider's taxonomy code is associated with the service provided. Providers allowed to perform each procedure are specified in the Service Table. Taxonomy codes associated with the providers below can be found in Appendix 1-Taxonomy Codes.

DMC State Plan Counties	
Abbreviations	**Discipline**
MD	Medical Doctor
DO	Doctor of Osteopathy
PA	Physician Assistant
Pharm	Registered Pharmacist
Psy	Psychologist (Licensed, Registered or Waivered)
LCSW	Licensed Clinical Social Worker
MFT	Licensed Marriage Family Therapist
LPCC	Licensed Professional Clinical Counselor
RN	Registered Nurse
NP	Nurse Practitioner
AOD	Certified/Registered AOD Counselor
Peer	Certified Peer Support Specialist

Table 2 Place of Service Codes for Professional Claim

Many codes have specified place of service codes describing where they can be performed. As a result, allowable places of service must accompany appropriate CPT and HCPCS codes for SD/MC to process the claim. Below are the allowable places of service that are associated with codes listed in the Service Table. The Service Table column titled Allowable Place of Service lists the place of service code associated with the name of that place of service. The column below titled Place of Service Description describes the place of service. Place of service codes must be used on 837 professional claims to specify where the service(s) were rendered, or the claim will be denied. Allowable places of service for each code are listed in the Service Table. As the Centers for Medicare and Medicaid Services (CMS) develops and maintains place of service codes and descriptions, DHCS will not be changing or in any way altering them until they are modified by CMS. Please note that if a service is provided via telehealth (audio only or audio/video) place of service code 02 or 10 **must** be used unless the service is mobile crisis.

Place of Service Code	Place of Service Name	Place of Service Description
01	Pharmacy	A facility where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home'	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters)
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic

Place of Service Code	Place of Service Name	Place of Service Description
		(surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other Place of Service code.
17	Walk-in Retail Health Clinic	A walk-in retail clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other Place of Service code, owned and operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.

Place of Service Code	Place of Service Name	Place of Service Description
19	Off Campus—Outpatient Hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On-Campus Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

Place of Service Code	Place of Service Name	Place of Service Description
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility—Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility, which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

Place of Service Code	Place of Service Name	Place of Service Description
57	Non-residential Substance Abuse Treatment Facility	A location, which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia or influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically underserved area, that provides ambulatory primary medical care under the direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Table 3 Modifiers

Modifiers provide a way to report or indicate that a service or procedure that has been performed has been modified by some specific circumstance but not changed in its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. For example, a service code with an HL/GC modifier (service provided by a pre-licensed professional or resident) should be billed directly to SD/MC. If a modifier is used to override a lockout (for example modifier XP can be used to indicate that two CPT codes that could not otherwise be billed together can be billed together in this case) the modifier must be used with the "target" code or the code that would otherwise not be able to be billed with the primary service. Please note that HCPCS (alpha) modifiers can be used with CPT and HCPCS codes, but CPT (numeric) modifiers can only be used with CPT codes.

The column labeled Modifier provides the modifier number or alphanumeric character. The column labeled Definition provides the definition of the modifier from the CPT Codebook or HCPCS list, as appropriate. The column labeled "When to Use" explains the only times when that modifier should be used. Modifiers not listed in this table are not used in the SD/MC claiming system.

For a transaction to be HIPAA-compliant, a procedure code cannot use more than four modifiers. DHCS recommends that, in the rare situations that counties exceed four modifiers per procedure code in a given transaction, they not use telehealth modifiers. If not using telehealth modifiers is not enough to keep transaction under four modifiers, DHCS recommends counties not to include modifiers HL (Intern) and GC (Resident).

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
27	**Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date**: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level of outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden are listed in Column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have ** next to them in the Service Table. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		codes cannot be billed together, whichever code is processed second will be denied.	
59	**Distinct Procedural Service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden are listed in Column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" in the Service Table. The codes that can be overridden have * or ** next to them. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will be used with CPT codes that are part of an over-ridable lockout combination.
93	**Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunication System:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telephone. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service and via telephone.

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunication System:** Synchronous telemedicine is defined as a **real-time** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telehealth. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service.
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use this modifier when the service was performed by a physician resident. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising physician's NPI would be reported with modifier GC after the service to indicate that the service was performed by a resident. If the service was performed by a pre-licensed professional who is not a resident, use modifier HL.	
GT	Via interactive audio and video telecommunication systems	Use this modifier when part of the mobile crisis, transportation mileage, or transportation staff time service delivery system was provided via telehealth.	This modifier only applies to HCPCS codes H2011, POS 15, A0140, and T2007
HA	Child/adolescent program	Use this modifier with 24-hour services when the beneficiary is less than 21 years old on the service date.	
HD	Pregnant/ Parenting women's program	All claims must have an HD modifier when service is provided to a woman who is pregnant/postpartum.	
HG	Opioid treatment program (OTP).	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		for those with severe opioid use disorder. All claims must have HG (and UA) modifier when the service is provided in NTP Setting	
HL	Intern	Use this modifier when the service was performed by registrants and interns who are working in clinical settings under supervision to obtain licensure. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising clinician's NPI would be reported with modifier HL after the service to indicate that the service was performed by a pre-licensed professional. If the service was performed by a resident, use modifier GC.	Services provided by individuals who are currently registered with the applicable Board.
HQ	Group setting	Use this modifier to indicate that a service was provided in a group setting. If the code means a group service (ie, is H0005 or H0025) **do not** use this modifier.	This modifier should be used with codes indicated in the service tables when the service was provided in a group setting. If the code means a group service do not use this modifier
HV	Funded by state addictions agency. The State covers 50% of the nonfederal share, as the service was determined to be covered under Proposition 30.	State Plan counties should use this modifier to identify services that the county provided as a result of a **federal** mandate that are subject to Proposition 30. Currently, Medication Addiction Treatment (MAT) falls under this requirement. Counties must include modifier HV when submitting MAT services claims. Methadone provided in NTP settings does not fall under this funding requirement.	H0033 with an NDC code
HW	The State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30	Use this modifier to identify services that the county provided as a result of a **state** mandate that are subject to Proposition 30.	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
SC	Valid for codes when the service was provided via telephone or audio-only systems.	Modifier SC is only used with HCPCS codes and to indicate that the service was provided via telephone or audio-only. If using the SC modifier, the place of service must be 02 or 10, unless the service is mobile crisis. With HCPCS codes, if the service is in POS 02 or 10 but does not have the SC modifier, the telehealth service is video/audio.	This modifier only applies only to HCPCS codes when telephone services are being provided.
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will be used with CPT codes that are part of an over-ridable lockout combination.
XP	Separate practitioner, a service that is distinct because it was performed by a separate practitioner.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history.	This modifier will be used with CPT codes that are part of an over-ridable lockout combination.

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		If two service codes cannot be billed together, whichever code is processed second will be denied.	
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden are listed in column K, "Outpatient Overridable Lockouts with Appropriate Modifiers" and have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will be used with CPT codes that are part of an over-ridable lockout combination.
U1	ASAM 3.1 Residential (RES)	Clinically Managed Low - Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	
U2	ASAM 3.3 Residential (RES)	Clinically Managed Population - Specific High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	
U3	ASAM 3.5 Residential (RES)	Clinically Managed High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
U7	Outpatient Services (ODF)	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	
U8	Intensive Outpatient Services (IOT)	Nine or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	
UA	ASAM OTP/NTP	All claims must include an UA (and an HG) modifier when service is provided in NTP setting.	

CHAPTER NINE: ADDENDUM TO SERVICE TABLES

The Service Table describes the procedure codes associated with each service type: Assessment, Discharge, Group Counseling, Individual Counseling, Medication Services, Mobile Crisis Services, Peer Support Services, SUD Crisis Intervention, and Treatment Planning. There is also a group of codes called Supplemental. Supplemental codes are codes that must be used with another code. As stated above, outpatient codes are not allowable when billed on the same date of service as the following 24-hour services except on the dates of admission or discharge:
DMC - State Plan Counties:

a. H0018|HD: Behavioral Health: Short-term residential (non-hospital residential treatment program), without room and board.
b. H0019|HD: Behavioral Health; Long Term Residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days) without room and board.

The Service Table contains the following columns:

1. Code: This lists the procedure code.

2. Code Type: This column describes the service type that a particular code was placed in. A code may be groupled in the following service types:
    a. Assessment: Assessment consists of activities to evaluate and monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessment shall be conducted in accordance with applicable State and Federal laws, regulations, and standards. Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:
        i. Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
        ii. Diagnosis of substance use disorders utilizing the current DSM assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under "Other laboratory and X-ray services" benefit of the California State Medicaid Plan).
        iii. Treatment planning, a service that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.
    b. Crisis Intervention: Crisis intervention services consist of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD crisis intervention services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation and be provided in the least intensive level of care that is medically necessary to treat the condition.

c. Discharge Services: Discharge services include coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
d. Group Counseling: Group counseling consists of contacts with multiple beneficiaries at the same time. Group counseling focuses on the needs of the participants and is provided to a group that includes 2-12 individuals.
e. Individual Counseling: Individual counseling consists of contacts with a beneficiary. Individual counseling can include contacts with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.
f. Medication Services: Medication services include prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and Other non-Opioid Substance Use Disorders.
g. Mobile Crisis: Community-based mobile crisis services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health and/or SUD (behavioral health) crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.
h. Peer Support Services: Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources and to educate beneficiaries and their families about their conditions and the process of recovery.
i. Treatment Planning: Treatment Planning is a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.
j. Supplemental Services: Supplemental service codes are codes that describe additional and simultaneous services that were provided to the beneficiary during the visit or codes that describe the additional severity of the patient's condition. For example, T1013 indicates that interpretation was provided during the visit while 90785 indicates that certain factors increase the complexity of a patient's treatment. Supplemental codes cannot be billed separately. They have to be billed with another (primary) procedure.

3. Service (Brief Definition) based on 2022 Rules: This column provides a **brief** description of the procedure. Most descriptions are self-explanatory but there are a few items that should be noted.
    a. New vs. established patients: Some evaluation and management (E/M) codes are described as being services for a new or established patient, and should be billed accordingly. For these codes:

i. A new patient means an individual who has not received any professional services from the physician/qualified healthcare professional; or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
ii. An established patient is an individual who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
iii. Refer to the CPT Codebook, E/M Services Guidelines for additional information on new and established patients.

b. Qualified healthcare professional: In the context of E/M codes, "qualified healthcare professional" usually means a physician, physician assistant or advanced practice nurse. In general, E/M services can be rendered by a physician, physician assistant, or nurse practitioner. Please also note that the service descriptions provided in the Service Table are brief descriptions. For a full descriptions of the services, please consult the CPT Codebook. CPT Codebooks are copyrighted to the American Medical Association (AMA) and are commercially available for purchase. AMA publishes CPT errata and technical corrections throughout the year on the AMA website dedicated to this purpose.
c. Time: Each code is associated with a length of time or time range as part of the service description. DHCS policy will only consider the time it takes to provide direct services associated with that code as part of time.

4. Minimum Time Needed to Claim 1 Unit: This column specifies the minimum number of minutes of direct patient care needed before a provider can claim one unit of the code in column "Code".

5. Minimum Time When Add-On Code or Next Code in Series Can Be Claimed: This column specifies at what minute the next code in a series or add-on code (as applicable) can be claimed.

6. Can This Code Be Extended With G2212?: This column specifies whether the code in column "Code" can be extended with prolonged service code G2212. A "Yes" in this column means that this code can be extended with prolonged service code G2212 and a "No" in this column means that it cannot be extended with prolonged service code G2212.

7. Example Calculation: This column provides examples of how to calculate units of primary and add-on codes. It also specifies when no calculation is necessary and when the county should, instead, claim the next code in the series.

8. SD/MC Allowable Disciplines: This column lists the disciplines that are allowed to perform each procedure. A professional claim must have a taxonomy code that is associated with the discipline rendering the service or the claim will be denied. A list of the first four alpha-numeric characters of the relevant taxonomies is located in Appendix 1-Taxonomy Codes. The county is responsible for ensuring that providers deliver services within their scope of practice. If a service is performed by an individual registered with the appropriate board

or resident, the service code should have mofieir HL or GC after it. A service code with an HL or GC modifier should not be submitted to Medicare first; it should be submitted to SD/MC directly.

9. Allowable Place of Service: CPT codes must be reported in allowable places of service. This column lists the number of the place(s) of service where the different procedure codes are allowed. Refer to Table 2-Place of Service Codes for Professional Claim for a description of the Place of Service codes. If a claim does not list a place of service, it will be denied. If a service is provided via telehealth, the place of service **must be** either 02 or 10 unless the service is mobile crisis. No service code may be claimed for place of service 09.

10. Outpatient Non-Overridable Lockout Codes: Some outpatient codes cannot be billed together under any circumstances. This column lists those outpatient codes that cannot, in any circumstances, be claimed with the code in column "Code".

11. Outpatient Overridable Lockouts with Appropriate Modifiers: Some codes can only be billed together in extraordinary circumstances. The codes that can be billed with the code listed in column "Code" under extraordinary circumstances are listed in this column. If a code a single * after it, then it can be used with the code listed in column "Code" if the code listed in column "Outpatient Overridable Lockouts with Appropriate Modifiers" is followed by modifier 59, XE, XP, or XU. If a code has two ** after it, then it can be claimed with the code in column "Code" if the code in column "Outpatient Overridable Lockouts with Appropriate Modifiers" is followed by modifier 27, 59, XE, XP, or XU. Please note that it would be inappropriate to use a code describing one service to "prolong" a code that describes a different service. If a service needs to be prolonged, use add-on codes or prolonged service code G2212 if the code does not have a dedicated add-on code or is an evaluation and management code.

12. Locked Out Against Residential?: This column indicates whether the outpatient code in column "Code" can be billed with a residential service. A "No" in this column means that the outpatient code can be billed with a residential service and a "Yes" in this column means that it cannot be billed with a residential service.

13. Dependent on Codes: Some codes can only be billed after certain other codes are billed. If there are codes listed in the "Dependent on Codes" column, those codes must be billed **before** the procedure in question. The dependent codes must be billed on the same claim as the primary code(s). If the column states "None," then the codes in column "Code" can be billed alone. Only one code can be submitted per line so dependent codes would need to be on the same claim but on a different line than the code they are dependent on.

14. Units of T1013 Associated with 1 Unit of Code: This column specifies how many units of sign language or oral interpretive services can be claimed with one unit of the code in column "Code". Sign language or oral interpretation must be submitted on the same claim as the code in column "Code". Claims for interpretation may not exceed the time associated with claims for the code in column "Code". One unit of sign language or interpretation is equal to 15 minutes.

15. Units of 96170 Associated with 1 Unit of Code: This column specifies how many units of initial health behavior intervention, family (without the patient present) can be claimed with the code in column "Code". Initial health behavior intervention must be submitted on the same claim as the code in column "Code". Claims for initial health behavior intervention may not exceed the time associated with the claim for the code in column "Code". One unit of initial health behavior intervention is equal to 30 minutes.

16. Units of 96171 Associated with 1 Unit of Code: This column specifies how many units of additional health behavior intervention, family (without the patient present) can be claimed with the code in column "Code". Additional health behavior intervention must be submitted on the same claim as the code. Claims for additional health behavior intervention may not exceed the time associated with the claim for the code. One unit of additional health behavior intervention is equal to 15 minutes.

17. Medicare COB Required?: This column specifies whether a claim for a procedure, if rendered to a Medi-Medi beneficiary, must be submitted to Medicare before being submitted to SD/MC if it is rendered by a Medicare-recognized provider and the service does not carry an HL or GC modifier. Medicare-recognized providers are: Physicians, Physician Assistants, Nurse Practitioners, Clinical Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors, and Clinical Psychologists. A "Yes" in the column indicates that the procedure **must** be submitted to Medicare first. A "No" in the column indicates that it **does not** need to be submitted to Medicare first and can be billed directly to SD/MC. If the procedure was not provided by a Medicare-recognized professional listed above to a Medi-Medi beneficiary, the service should not be submitted to Medicare.

18. Maximum Units that Can be Billed per Beneficiary per Day: This column lists the maximum number of units that the procedure listed in column "Code" **may** be billed in a 24-hour period by the rendering provider. Codes must be billed in whole units. Fractional units will be denied. When selecting a CPT code, providers should follow the CPT Codebook for instructions on how to bill each code using time. DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in that are either already included in the service rate for the code or are claimed separately by the county.

19. Allowable Modifiers: This column lists the modifiers that are allowed with the procedure code listed in column "Code". Modifiers provide a way to report or indicate that a service or procedure performed was altered by some specific circumstance but not changed in its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for that service. There are some instances (such as lack of over-riding modifier) when lack of a modifier will cause a service to be denied.

Service Table 1- Existing 24-Hour and Day Services

Residential Treatment (ASAM Levels 3.1, 3.3, and 3.5)
This treatment is a non-institutional, 24-hour non-medical, short-term program that provides rehabilitation services which includes intake, individual and group counseling, patient education, family therapy, safeguarding medications, crisis intervention, treatment planning, and discharge services. Residential services may be provided to perinatal beneficiaries in facilities with no bed capacity limit. Service code H0018 and H0019 in table below represent this benefit.

Narcotic Treatment Program (NTP) Services:
Narcotic treatment program services include intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone. Service code H0020 in table below represents these services and it is considered a day service. Other medications, under the Opioid NTP program, which includes Buprenorphine, Naloxone and Disulfiram are billed using codes S5000 and S5001 using a National Drug Code (NDC). Please use modifiers HG and HV for procedures S5000 and S5001 to indicate when a Medication Assistance Treatment service was provided. One unit per day is allowed for dosing.

If a service (other than the actual dosing of medications) was provided via telehealth, use Modifier GT: (Valid for codes when the service was provided via synchronous, interactive audio and telecommunication systems).

Please note that the NTP dosing bundled rates include costs for physical exam; drug screening; intake assessment; medical director supervision; TB, syphilis, HIV and Hepatitis C tests; drug screening; dosing; and ingredient costs.

For the services below, the HA (Child/adolescent program) modifier must be included if the beneficiary was less than 21 years old on the date of service.

DMC – State Plan			
Category	**Procedure Code & Modifier**	**Description**	**Exempt from Medicare COB?**
Existing 24-Hour Service	H0018	Behavioral Health: Short-term residential	Yes
Existing 24-Hour Service	H0019	Behavioral Health; Long Term Residential	Yes
Existing Day Service	H0020: UA: HG	Alcohol and/or drug services; Methadone	No
Existing Day Service	S5000: UA: HG	Prescription Drug: Generic (Naltrexone)	Yes

Existing Day Service	S5001: UA: HG	Prescription Drug: Brand Name (Naltrexone)	Yes
Existing Day Service	S5000: UA: HG: HV	Prescription Drug: Generic (MAT Services)	No
Existing Day Service	S5001: UA: HG: HV	Prescription Drug: Brand Name (MAT Services)	No

CHAPTER TEN: APPENDICES

Appendix 1 Taxonomy Codes

Taxonomy codes are unique 10-character codes that are used by healthcare providers to self-identify their specialty. The code set is structured into three distinct levels: Provider Grouping, Classification, and Area of Specialization. The codes are maintained by the National Uniform Claim Committee (NUCC) and are updated twice per year on July 1 and January 1. Each code has a set of the first four characters of appropriate taxonomies associated with it. A claim will be denied if the rendering provider's taxonomy does not match the first four alphanumeric characters of a taxonomy code allowed for that service code. See the service table for the rules governing outpatient service codes. Even though SD/MC only verifies the first four alphanumeric characters, the provider is obligated to provide the entire taxonomy code on the 837P claim. For beneficiaries who are also eligible for DMC, please see the Mental Health Billing Manual to reference taxonomy codes under the Mental Health Services program.

The column labeled Discipline denotes the discipline and the column labeled First Four Alpha-Numeric Characters of Taxonomy Code denotes the various first four alphanumeric codes that can be used to describe that discipline. Please note that in the case of AOD Counselors, the first **five** alpha numeric characters are displayed.

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Alcohol and Other Drug Counselors (AOD Counselors)	101YA
	146D
	146L
	146M
	146N
	171M
	374K
	2258
	2260
	4053
Marriage and Family Therapist (MFT) or Licensed Professional Clinical Counselor (LPCC)	1012
	101Y
	102X
	103K
	106H
	1714
	222Q
	225C

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	2256
Nurse Practitioner (NP)	363L
Pharmacist (Pharma)	1835
Physician Assistant (PA)	363A
Licensed Physician (LP)	202C
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081
	2082
	2083
	2084
	2085
	2086

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	2088
	208C
	208D
	208G
	208M
	202D
	208U
	208V
	2098
Peer Support Specialist	175T
Psychologist (Psy)	102L
	103G
	103T
Registered Nurse (RN)	3675
	376G
	163W
Licensed Clinical Social Worker (LCSW)	1041
	106E

Appendix 2: Definitions

Claim: A request for payment that a provider submits to the county or the county submits to DHCS detailing the services provided to one individual. The claim information includes the following information for an encounter between a patient and a provider: 1) patient description, 2) the condition for which the patient was treated, 3) services provided, 4) how much the treatment cost. A claim can include multiple service lines.

Claim File: A file in Electronic Data Interchange (EDI) format that contains multiple claims and an overall request for payment. Counties submit claim files.

Community-based wrap-around service: This service is designated by HCPCS code H2021 and refers to coordination of care between providers in the Drug Medi-Cal System and providers who are outside the Drug Medi-Cal system. H2021 can only be used to show that a delivery-system coordination of care has occurred. For other kinds of coordination, other service codes must be used.

Dependent Procedure: These are procedure codes that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes). Dependent procedures cannot be billed unless the provider first bills primary procedure to the same beneficiary by the same rendering provider on the same date on the same claim.

Direct Patient Care: If the service code billed is a patient care code, direct patient care means time spent with the patient for the purpose of providing healthcare. If the service code billed is a medical consultation/care coordination code, then direct patient care means time spent with the consultant/members of the beneficiary's care team. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

Electronic Healthcare Transactions: A transaction typically encompassing multiple claims for one or more individuals.

Group Practice: The entity that owns and is responsible for the beneficiary's medical record describing services provided by a licensed or intern/resident professional. If county-operated and/or county-employed health care professionals provide professional services to the beneficiary, the county is considered the "group practice" because the county owns and is responsible for the beneficiary's medical record. If the beneficiary receives their DMC services from a county-contracted provider (a community-based organization or other provider), then the clinic or the clinic's owner in that location owns and is responsible for the beneficiary's medical record. If a physician, advanced practice nurse and physician assistant all work for a practice at a discrete location, then that practice owns the medical record and is considered the group practice. If the physician owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the physician, then the physician-owner is considered the group practice as he/she owns and is responsible for the beneficiary's medical record.

Intern: A registered, pre-licensed professional who is registered with the appropriate licensing board and working in a clinical setting under supervision. An intern should use the taxonomy code most appropriate for the practitioner and should bill using the HL modifier after the service code to indicate that the services were provided by a registered, pre-licensed mental health professional working in a clinical setting under supervision.

Lockouts: Lockouts are codes that cannot be billed together. Sometimes lockouts can be overridden with an appropriate modifier. Lockouts that can be overridden are indicated with either one or two asterisks in the lockout column in the service table.

Resident: According to the Medical Board of California, a resident is an individual who is issued a Postgraduate Training License [and] is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited postgraduate training program in California. The resident may engage in the practice of medicine only in connection with their duties as a resident in the approved training program, including its affiliate sites, or under those conditions as are approved by the director of their program. A Postgraduate Training License is issued to an individual who has graduated from an approved medical school, passed all required examinations, has not completed 36 months of ACGME postgraduate training, and is enrolled in an approved California residency program.

Service Line: A line on the claim describing one service and containing one procedure code. A service line can contain multiple units of one procedure code, but it cannot contain more than one procedure code.

Services Provided by Interns/Residents: To indicate that an intern use modifier HL provided the service after the service code. Indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. To indicate that the service was provided by a resident use modifier GC after the service code. On the claim, indicate that the supervising professional is the billing provider. Services that have modifiers HL or GC after them, even if they are otherwise eligible for Medicare COB, should be sent directly to Medi-Cal.

Student: Individuals who are not registered with the appropriate licensing board. These individuals should use a taxonomy code that is most appropriate for the professional. For students who are pre-licensed and not yet registered with their professional licensing boards, counties should use a taxonomy code within the AOD Counselor or Certified Peer Specialist categories as appropriate based on the student's education, training and experience.

Target Code: In an over-ridable combination, this is the code that must use the over-riding modifier.

Waivered Professional: A professional from another state whose license is recognized by California. Waivered professionals can bill under their own license and do not need to use an HL or a GC modifier.

Appendix 3- Monthly Medi-Cal Eligibility File (MMEF) Data Elements

The below data elements are contained in the MMEF. Please note this is not the data dictionary but the list of the kind of data elements one would see in the MMEF:

1. Med-Cal Eligibility Data System (MEDS) identification number
2. Health Insurance Claim (HIC) number
3. Social Security
4. Date of Birth
5. Gender
6. Ethnicity
7. Primary Language
8. Social Security Number Verification Code
9. Case Name
10. Beneficiary's Last Name
11. Beneficiary's First Name
12. Beneficiary's Suffix
13. Beneficiary's Address
14. Eligibility Worker Code
15. Client Index Number
16. Government Responsibility
17. County Case ID
18. The aid code under which the beneficiary is eligible
19. Beneficiary's Serial Number
20. Recipient's Family Budget Unit
21. Beneficiary Person Number
22. Special Status-Federal Financial Participation Indicator
23. Special Status: Indicates if the beneficiary has ever been known to either California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP) or both.
24. Beneficiary's current eligibility year
25. Beneficiary's current eligibility month
26. Aid code under which beneficiary is eligible
27. County of responsibility
28. County of residency

29. Beneficiary's eligibility status
30. Share of cost amount the beneficiary is obligated to meet
31. Beneficiary's Medicare status: do they Medicare Part A, Part B, or Part D
32. Beneficiary's carrier code for Medicare Part D
33. Federal contact number
34. Medicare Part D Benefit package
35. Type of prescription drug plan
36. Status of beneficiary's enrollment in an associated health plan
37. The Medi-Cal managed care plan in which the beneficiary has been enrolled or dis-enrolled
38. Beneficiary's health care coverage by an insurance company
39. Identifies if the beneficiary has been placed on or removed from restricted status
40. Identifies the aid code under which the beneficiary is eligible for the specific Special Program.
41. Identifies the county of responsibility for the specific Special Program aid code
42. Beneficiary's Special Program normal/exceptional eligibility
43. Indicates what percentage of the obligation the recipient is responsible for
44. Indicates the Stop/Start of Healthy Families if the beneficiary is not enrolled for the entire month.

Appendix 4- MEDSLITE Data Elements

The below data elements are contained in the MEDSLITE. Please note this is not the data dictionary but the list of the kind of data elements one would see in MEDSLITE:

1. Med-Cal Eligibility Data System (MEDS) identification number
2. Client Index Number
3. Beneficiary's gender
4. Beneficiary's primary ethnicity code
5. Beneficiary's spoken language code
6. Beneficiary's written language code
7. Government Responsibility indicator
8. Beneficiary's first and last name
9. Beneficiary's date of birth
10. Eligibility termination date
11. Beneficiary's current primary eligibility aid code and county identification
12. County of responsibility
13. County of residency
14. MEDS current renewal date
15. Reason for termination
16. Current eligibility status
17. County ID
18. Eligibility worker code
19. Case name
20. District code
21. Annual re-determination due month
22. Latest re-determination completed date
23. Beneficiary's address
24. Beneficiary's primary and alternate phone numbers
25. Beneficiary's primary aid code history by month
26. Beneficiary's eligibility status and history by month
27. County of responsibility and history by month
28. Share of cost amount, current and by previous months
29. Share of cost certification day, current and in previous months

30. Health insurance claim number
31. Health care plan status reason code (current and by previous months)
32. Health care plan enrollment status (current and by previous months)
33. Health care plan code (current and by previous months)
34. Other coverage (current and by previous months)
35. First, last name and middle initial of the authorized representative
36. Authorized representative's address
37. Date of Death
38. Source of the date of death information
39. Country of origin
40. Current Special Program 1 County identification
41. Special Program 1 worker code
42. Special program 1 district
43. Special program 1 case name
44. Special program 1 annual redetermination due month
45. Special program 1 latest re-determination completed date
46. Special program 1 eligibility status (current and by previous months)
47. Special program 1 county code by month
48. Special program 1 aid code by month
49. Current Special Program2 County identification
50. Current Special Worker 2 Code
51. Special Program 2 District
52. Special Program 2 Case Name
53. Special program 2, annual redetermination due month
54. Special program 2 latest redertimnation completed date
55. Special program 2 eligibility status (current and by previous month)
56. Special program 2 county code by month
57. Special program 2 aid code by month
58. Mail delivery address data
59. Last line of mailing address
60. Current Special Program 3 County Identification
61. Current Special Worker 3 Worker code
62. Special program 3 eligibility status (current and by previous month)
63. Special program 3 county code (current and by previous month)

64. Special program 3 aid code (current and by previous month)
65. Special program termination reason
66. Medicare Part A change date
67. Source of the information about Medicare Part A change
68. Source of the information about Medicare Part A change
69. Medicare Part B change date
70. Source of information about Medicare Part B change
71. Medicare Part D change date
72. Source of information about Medicare Part D change
73. Medicare Parts A/B status (current and by previous months)
74. Medicare Part D status (current and by previous months)
75. Medicare Part A entitlement start date
76. Medicare Part B entitlement start date
77. Restricted special program services code (current and by previous month)
78. Current food stamp identification number
79. County case name/current food stamp information
80. Food stamp eligibility status (current and by previous month)
81. Food stamp county identification by month
82. Special Program 1 termination reason
83. Special program 1 termination date
84. Special program 2 termination reason
85. Special program 2 termination date
86. Medicare beneficiary identifier
87. Date Medi-Cal application filed
88. Medi-Cal application flag
89. Date Medi-Cal application denied
90. Reason Medi-Cal application denied
91. Family size in Medi-Cal application
92. Medi-Cal application status
93. Medi-Cal application status date
94. Relationship to applicant
95. Special program 3 district
96. Special program 3 case name
97. Special program 3 annual redetermination due month

98. Special program 3 latest redetermination completed date
99. Special program 3 termination reason
100. Special program 3 termination date
101. Medicare Part D entitlement start date
102. Medicare Part D, Notice of Adverse Action date
103. Notice of Adverse Action, Medicare Part D mail date
104. Medicare Part D, Notice of Action Type
105. Medi-Cal appeal date
106. Medi-Cal appeal decision

Appendix 5- Covered Residential Diagnoses

ICD-10 Code	Code Description
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.130	Alcohol abuse with withdrawal, uncomplicated
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisiting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid use, uncomplicated

ICD-10 Code	Code Description
F11.11	Opioid use, in remission
F11.120	Opioid use with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.13	Opioid abuse with withdrawal
F11.14	Opioid abuse with opioid-induced mood disorder
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.11	Cannabis abuse, in remission
F12.120	Cannabis abuse with intoxication, uncomplicated
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.13	Cannabis abuse with withdrawal
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated

ICD-10 Code	Code Description
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.23	Cannabis dependence with withdrawal
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced mood disorder
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic, or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.11	Cocaine abuse, in remission
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium

ICD-10 Code	Code Description
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.13	Cocaine abuse, unspecified with withdrawal
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.11	Other stimulant abuse, in remission
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.13	Other stimulant abuse with withdrawal
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder

ICD-10 Code	Code Description
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.11	Hallucinogen abuse, in remission
F16.120	Hallucinogen abuse with intoxication, uncomplicated
F16.121	Hallucinogen abuse with intoxication with delirium
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.11	Inhalant abuse, in remission
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder

ICD-10 Code	Code Description
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.11	Other psychoactive substance abuse, in remission
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19.131	Other opsychoactive substance abuse with withdrawal delirium
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance
F19.14	Other psychoactive substance abuse with psychoactive substance-induced disorder
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance abuse-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated

ICD-10 Code	Code Description
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder