Specialty Mental Health Services
Medi-Cal 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's County Mental Health Plans (MHP) to submit electronic claims for reimbursement of covered Specialty Mental Health Services (SMHS) provided to Medi-Cal-eligible beneficiaries. The Department of Health Care Services Local Governmental Financing Division (DHCS 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 not denied 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 services/procedure codes or modifiers are appropriate or on the documentation that must accompany the service codes claimed. This chapter includes:

- About This Billing Manual
- Program Background
- Authority
- Medi-Cal Claims Customer Services (MEDCCC)

1.1. About This Manual

This Mental Health Medi-Cal Billing Manual is a publication of DHCS. DHCS administers the Specialty Mental Health Services Medi-Cal program (administered by the former Department of Mental Health through 6/30/2012). This Billing Manual provides trading partners with a reference document that describes the processes and rules relative to SD/MC claims for SMHS. Trading partners include Mental Health Plans (MHP), Billing Vendors of MHPs 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 links and/or information related to:
    - State and Federal laws and regulations
    - Letters and Information Notices
    - Reference documents such as:
        - SD/MC User Manual
        - Companion Guides
        - Companion Guide Appendix

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

1.1.2. Internet Addresses and Links

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

1.2. Program Background

Title XIX of the Social Security Act, enacted in 1965, 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 Medi-Cal specialty mental health services including but not limited to:

- Determination of Aid Code[1]
- Maintenance of eligibility information technology systems (e.g., Medi-Cal Eligibility Determination System [MEDS])
- Adjudication of SD/MC Mental Health claims
- Processing of claims for Federal Financial Participation (FFP) payments
- Submission of expenditure claims to the Centers for Medicare & Medicaid Services (CMS) to obtain FFP

For Medi-Cal specialty mental health services provided to a beneficiary by a certified provider, the cost of these services is paid by a combination of State, 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 Percentage (FMAP).

County expenditures represent a combination of State realignment funds, Mental Health Services Act (MHSA) funds, local county funds and other sources such as grants. Counties submit claims to the State which pays the full claim.

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

1.3. Authority

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

1.3.1. Social Security Act, Title XIX

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. Code of 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.

1.3.5. Welfare and Institutions Code

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

1.3.6. Additional Resources:

- California Code of Regulations & DHCS Information Notices
  Most applicable California regulations are in Title 9, Chapter 11. 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.

- Companion Guide for the 837 Professional and Institutional Health 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.

- 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.

- **ASC X12N/005010X222 - Health Care Claim - Professional (837)**
  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.

- **ASC X12N/005010X223 - Health Care Claim - Institutional (837)**
  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.

- **ASC X12N/005010X221 - Health Care Claim - Payment/Advice (835)**
  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.

- Mental Health Claim Adjustment Reason Codes-Remittance Advice Remark Codes (CARC-RARC)

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

1.4. Medi-Cal Claims Customer Service (MEDCCC) Office

MEDCCC was created to provide MHPs a single point of contact to assist them with SD/MC claiming process questions and issues. MEDCCC provides MHPs direct access to the State when they have questions regarding claim payment, need technical assistance with claim processing, have a question about policy, need assistance with accurate and timely submission and processing of claims or have other billing and/or claim-related issues. MEDCCC also uses a proactive approach of delivering information to MHPs when a potential issue with a claim process or business rule has been identified. MEDCCC assists MHPs with streamlining the claim

process, resulting in improved processes and understanding of requirements at both the MHP and State levels.

What MHPs Can Expect When Contacting MEDCCC:
An email response acknowledging receipt of the MHP's issue or concern within 48 hours of receipt.

- An email response acknowledging receipt of the MHP's issue or concern within 48 business hours
- The most current information on MHP's 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 MHPs 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
- Legal Entity, Provider Numbers and National Provider Identifiers (NPI)
- Provider Enrollment and Medi-Cal Certification
- Online Provider System
- Companion Guide and Appendix

2.1. DHCS Application Portal

The DHCS Application Portal (Portal) is a collection of web applications that allow Mental Health Services trading partners (e.g., MHPs, 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. Approvers are appointed by each MHP director.

All system approver certification forms are available on the DHCS 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 login website. Otherwise, the Approver 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-DMH or SD/MC-ADP as appropriate. The 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 Enrollment and Medi-Cal Certification

For a provider to be able to submit claims for providing SMHS to beneficiaries of an MHP, they must be Medi-Cal certified by the State and enrolled in Medi-Cal through the Provider Information Management System (PIMS). MHPs shall have completed, and submitted to DHCS, one Medi-Cal Certification and Transmittal form (Transmittal) for each provider utilized by the MHP. The Transmittal form can be found on either: 1) DHCS website or 2) by e-mailing DMHCertification@dhcs.ca.gov. The purpose of the Transmittal is to "transmit" provider information, necessary to adjudicate claims submitted to the Portal.

2.3. Companion Guide and Appendix

DHCS publishes a Companion Guide and a Companion Guide Appendix for each HIPAA-compliant transaction type used by SD/MC (e.g., 835, 837). The Companion Guide details how

to format HIPAA-compliant 837 forms and what information the MHP can expect to receive on an 835 form. The Companion 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

Specialty mental health clients must be enrolled in Medi-Cal in order for the MHP to be reimbursed through the SD/MC claiming 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 enrolling individuals in the Medi-Cal program. The determination of beneficiary eligibility and the collection of beneficiary eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding beneficiary eligibility criteria may be obtained through the DHCS Medi-Cal Eligibility Division website.

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

- Medi-Cal eligibility is established on a monthly basis.
- Medi-Cal eligibility may require that a beneficiary's Share of Cost be met before Medi-Cal will pay for any services.
- 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.
- MHPs should verify beneficiary Medi-Cal eligibility for the month of service prior to submitting claims for reimbursement.

3.1.2. Medi-Cal Eligibility Review

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

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 3.

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 Chart (which includes both Mental Health and Drug Medi-Cal) is posted on the MEDCCC Library. The Aid Codes Chart provides useful information about the following:

- FFP
- Aid codes
- Type of benefits
- Share of cost
- Aid code descriptions

- Indication of reimbursement through the DHCS Fiscal Intermediary, Drug Medi-Cal Program (DMC), Mental Health Plans, and/or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) [2] programs.

[2] The County Interim Rate Table is located in the MedCCC Library

CHAPTER FOUR: COVERED SERVICES

4.0. Introduction

This chapter provides explanations of covered Specialty Mental Health Services and provider certification.

- Covered services
- Provider Certification

4.1. Covered Services

The specialty mental health services listed below are Medi-Cal covered services. Claims for reimbursement of specialty mental health services may be submitted to the SD/MC claiming system via the Portal.

4.1.1. Mental Health Services: State Plan Amendment (SPA) 22-0023.

Mental Health Services are individual, group or family-based interventions that are designed to provide reduction of the beneficiary's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental health services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Mental health services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. This service includes one or more of the following service components:

- **Assessment**: A service activity designed to collect information and evaluate the current status of a beneficiary's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that beneficiary. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards.

- **Treatment Planning**: A service activity to develop or update a beneficiary's course of treatment, documentation of the recommended course of treatment, and monitoring of a beneficiary's progress.

- **Therapy:** Service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles

of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a beneficiary or a group of beneficiaries and may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.

- **Psychosocial Rehabilitation**: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Psychosocial rehabilitation includes assisting beneficiaries to develop coaching skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources and/or medication education. Psychosocial rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Refer to the Service Table for the rules governing the procedure codes associated with these services.

4.1.2. Specialty Mental Health Services for Children and Youth: Mental Health Contract Template

Specialty Mental Health Services for Children and Youth include the following:

- **Intensive Care Coordination (ICC)**: ICC is a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria to access SMHS. ICC service components include: assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. The CFT is comprised of-as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends and clergy and all ancillary

individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
- Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;
- Supports the parent/caregiver in meeting their child's needs;
- Helps establish the CFT and provides ongoing support; and
- Organizes and matches care across providers and child serving systems to allow the child to be served in the community[3]

- **Intensive Home Based Services (IHBS)**: IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community, and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities include, but are not limited to assessment, treatment plan, therapy and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.
- **Therapeutic Behavioral Services (TBS):** Intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.
- **Therapeutic Foster Care (TFC) Services:** This model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services (SMHS) activities. In accordance with Attachment 4.19-B of the State Plan, the services provided in a treatment foster home include plan development, rehabilitation, and crisis intervention. TFC services are available to children up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. TFC is intended for children who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

4.1.3. Hospital Inpatient: CCR Title 9, § 1820.205

[3] See Exhibit E – Attachment 2, Section J of the Mental Health Contract Template.

Hospital inpatient services are provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital licensed by the California Department of Public Health to provide psychiatric services. Hospital inpatient services must be medically necessary for diagnosis or treatment of a mental health disorder requiring an inpatient level of care. With the exception of Short-Doyle Medi-Cal (SD/MC) hospitals[4], inpatient services are not billed through the SD/MC system but are billed through the Fiscal Intermediary. As of July 1, 2023, SD/MC and Fee-for-Service Medi-Cal (FFS/MC) hospitals are reimbursed a bundled rate for routine and ancillary services. MHPs reimburse professional services provided in both SD/MC and FFS/MC hospitals and submit claims for federal reimbursement to the SD/MC claiming system using the 837P.

The claim must include "FFS" in the Claim Note Segment and the first three digits in the rendering provider's taxonomy code must be 101, 103, 104, 106, 163, 193, 207, 208, 363, or 364. The SD/MC claiming system does not validate that individual and group providers are enrolled in Medi-Cal when adjudicating a claim.

4.1.4. Psychiatric Inpatient Hospital Professional Services: CCR Title 9, §1810.237.1

Psychiatric Inpatient Hospital Professional Services means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services. Claims for professional services should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.5. Hospital Inpatient Administrative Day Services: CCR Title 9, § 1810.202

During a hospital stay, the MHP shall authorize payment for administrative day services if the following criteria are met: (1) beneficiary no longer needs inpatient care, but has previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services, (2) there is no appropriate, non-acute treatment facility within a reasonable geographic area and (3) the hospital demonstrates attempts to transfer to a lower level of care by documenting contacts with a minimum of five appropriate, non-acute treatment facilities per week.

[4] Hospitals that are Short Doyle/Medi-Cal hospitals are listed on Attachment 4.19-A, page 40.5 of State Plan Amendment 09-004. State Plan 09-004 also outlines the different methodologies for the rates paid to SD/MC and FFS/MC hospitals.

4.1.6. Psychiatric Health Facility Services: SPA 22-0023

Psychiatric Health Facility services are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by the Department of Health Care Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychological Rehabilitation
- Crisis intervention

4.1.7. Children's Crisis Residential Programs: Health and Safety Code § 1502(a)(21)

Children's Crisis Residential Programs (CCRP) provide children with Medi-Cal services, primarily crisis residential treatment services. CCRPs serve children experiencing mental health crises as an alternative to psychiatric hospitalization. CCRPs are a type of community care facility, and are, by definition, non-medical facilities.

4.1.8. Crisis Residential Treatment Services: SPA 22-0023

Crisis Residential Treatment Services (CRTS) are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a treatment staff person of the facility on the day of service.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- Crisis Intervention

4.1.9. Adult Residential Treatment Services: Social Security Act § 1905(i) and 42 CFR §435.010
Adult residential treatment services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential program.

The service is available 24 hours a day, seven days a week and structured day and structured day and evening services are available all seven days.

Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

Services will not be claimable unless the beneficiary has been admitted to the program and there is face-to-face contact between the beneficiary and a staff person of the facility on the day of service.

The service includes one or more of the following service components:
- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.10. Crisis Stabilization: SPA 22-0023
Crisis stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the beneficiary or others , or substantially increase the risk of the beneficiary becoming gravely disabled.

Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization may include contact with

significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Medical backup services must be available either on site or by written contract or agreement with general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

All beneficiaries receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's needs will be made, to the extent resources are available.

This service includes one or more of the following service components:

- Assessment
- Therapy
- Crisis Intervention
- Medication Support Services
- Referral and Linkages

4.1.11. Day Treatment Intensive: SPA 22-0023

Day Treatment Intensive is a structured, multi-disciplinary program which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Services are available for at least three hours each day. Day treatment intensive is a program that lasts less than 24 hours each day. Day treatment intensive may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.12. Day Rehabilitation: SPA 22-0023

Day Rehabilitation is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and

functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the beneficiary.

Day rehabilitation services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.13. Targeted Case Management (TCM): CCR Title 9, § 1810.249

Targeted case management is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services. The service activities may include but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the beneficiary's progress; placement services and plan management. TCM services may be face-to-face or by telephone/telehealth with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

4.1.14. Mental Health Services: Professional Inpatient (IP) Visit

Mental Health Services: Professional IP visit services are the same as mental health services, except they are provided in a Fee-for-Service inpatient setting by professional staff. Claims for Mental Health Services: Professional Inpatient (IP) Visit should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.15. Medication Support Services: SPA 22-0023

Medication support services include prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Medication support services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

This service includes one or more of the following service components:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Treatment Planning

Refer to the Service Table for the rules governing the codes associated with this service.

4.1.16. Medication Support: Professional IP Visit

Medication Support: Professional IP Visit services are the same as Medication Support, except they are provided in a Fee-for-Service IP setting by professional staff. Refer to the Service Table for the rules governing the codes associated with this service. Claims for Medication Support: Professional IP Visit should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.17. Crisis Intervention: State Plan Amendment 22-0023

Crisis intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

Crisis intervention may be provided face-to-face, by telephone or by telehealth and may be provided in a clinic setting or anywhere in the community.

This service includes one or more of the following service components:

- Assessment
- Therapy
- Referral and Linkages

4.1.18. Crisis Intervention: Professional IP Visit

Crisis intervention: Professional IP visit services are the same services as crisis intervention except that the services are provided in a Fee-For-Service or SD/MC IP setting by professional staff. Refer to the Service Table or the rules governing the codes associated with this service. Claims for Crisis Intervention: Professional IP Visit should be submitted in the same manner as

fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.19 Peer Support Services: State Plan Amendment 22-0023

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 goals.

Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of 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 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.

4.1.20 Referral and Linkages: State Plan Amendment: 22-0023

Referral and Linkages are services and supports to connect a beneficiary with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources,

making appointments, and assisting a beneficiary with a warm handoff to obtain ongoing support.

4.1.21 Community-Based Mobile Crisis Intervention Services: State Plan Amendment 22-0043
Community-based mobile crisis intervention 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 that 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. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary a behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where a beneficiary 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 per day, seven days per week, 365 days per year.

To claim for Mobile Crisis services, use Healthcare Common Procedure Coding System (HCPCS) code H2011 **with** Place of Service (POS) 15. Please note that *only* HCPCS H2011 with POS 15 means mobile crisis services as defined here.

For information on how to claim for mobile crisis, refer to the Service Table.

4.2. Provider Certification

To receive payment for SMHS, the submitted service facility NPI must be certified to render the billed services on the date of service. Provider certification is performed by Medi-Cal's Provider Enrollment Division. Please refer to Provider System Documentation and Specialty Mental Health Services (SMHS) Provider Enrollment Frequently Asked Questions.

Certification of SMHS services is validated using Mode of Service and Service Function Codes. Any site certified to perform any Mode 15 service can provide any of the services listed in the Service Table. Table 1 provides a crosswalk of the service function codes associated with Modes 5 and 10 and the codes that can be claimed within Modes 5 and 10. Facility certification can be verified via Provider Information Management System (PIMS).

24-Hour services are identified by Mode of Service '05,' along with the following Service Functions codes:

- 10-18: Acute Psychiatric Inpatient Hospital Services
- 19: Administrative Day Services
- 20-29: Psychiatric Health Facility
- 40-49: Crisis Residential Treatment (Children and Adults)
- 65-69: Adult Residential
- 95: Therapeutic Foster Care

Day services are identified by Mode of Service '10,' along with the following Service Function codes:

- 20-24: Crisis Stabilization – Emergency Room
- 25-29: Crisis Stabilization – Urgent Care
- 81-89: Day Treatment Intensive
- 91-99: Day Rehabilitation

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 Claims
- Requesting Delay Reason Codes

5.1. 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 file. 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. Approving and Denying Claims

The SD/MC claiming system adjudicates all claim files 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 service lines that do not meet a business requirement are denied.

5.2.1. Zero Dollar Claims

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

5.3.0 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 as recorded in months. If the beneficiary was not enrolled in Medi-Cal during the month in which the service was rendered, the claim will be denied.

5.3.1. 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.

5.3.2. 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.

5.3.3. 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.

5.4.0 Dates of Services Within a Claim

For any single claim, all dates of service must be within the same calendar month, except for claims for psychiatric inpatient hospital services. The discharge date on the claim for psychiatric inpatient hospital services may occur on the first day of the following month. For example, a claim for an individual who was admitted to the hospital on October 28 and discharged on November 1 would be admissible. SD/MC will deny service lines submitted with dates of service that do not conform to this guidance.

5.4.1 Claims for Inpatient Stays that Cross One or More Months

A county must submit multiple claims for psychiatric inpatient hospital stays that cross-over one or more months, unless the date of discharge is on the first day of the month following the month in which the beneficiary was admitted to the hospital. For example, a claim for a psychiatric inpatient hospital stay that began on October 15th and ended on November 15th would need two claims. The first claim would be for the date of admission (October 15th) through October 31st. The first claim would not include a date of discharge. Since the claim

does not include a discharge date, it needs to be identified as an interim claim. A service line for psychiatric inpatient hospital service that does not have a discharge date or is not identified as an interim claim will be denied. The second claim would be for November 1st through November 15th. The second claim would have a discharge date of November 15th and would not be identified as interim claim.

5.5.0 Duplicate Services

Inpatient, 24-Hour, and Day Services

Inpatient, 24-Hour, and day services are listed in service table 10. A claim for an inpatient, 24-Hour, or day service is considered a duplicate if all the following data elements are the same for another already approved service:

- The beneficiary's client Index Number (CIN)
- The County submitting the claim
- The facility location's NPI
- Date of services
- Procedure Code
- Units of service
- The billed amount

Except for Crisis Stabilization, billed with S9484:HE:TG, all duplicate inpatient, 24-hour, and day services will be denied. Crisis Stabilization billed with S9484:HE:TG may duplicate a previously approved claim for Crisis Stabilization once without additional modifiers and Crisis Stabilization may be duplicated more than once with an appropriate over-riding modifier (i.e., 59, 76, or 77). Refer to Table 3 – Modifiers for a description of these modifiers.

Outpatient Services

Outpatient services are listed in the Service Table. Except for Sign Language or Oral Interpretive Services (T1013) Interactive Complexity (90785), Peer Support Services, group services (H0025), Group Psychosocial Rehabilitation (H2017:HQ), and Group medication training and support (H0034:HQ), a claim for an outpatient service is considered a duplicate if all the following data elements are the same as another service approved in history:

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

If Mobile Crisis (H2011, place of service 15) is claimed, place of service is also a factor in determining whether the claim is a duplicate. Counties can submit a claim for more than one mobile crisis encounter on the same day for the same beneficiary.

If a provider renders two services to the same beneficiary on the same day in two or more separate encounters, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services. For example, if a provider renders psychotherapy for crisis to a beneficiary for 30 minutes in the morning and provides psychotherapy for crisis to the same beneficiary for 30 minutes in the afternoon, the claim would be submitted for 60 minutes for psychotherapy for crisis (90839).

5.6.0 Co-Practitioners

If multiple practitioners render services to the same beneficiary at the same time, each provider must submit a separate claim for the distinct service each practitioner rendered. Please see MHSUDS Information Notice 18-002 and BHIN 20-060R for more information about submitting claims to SD/MC for services rendered by multiple practitioners rendered to the same beneficiary at the same time.

5.7.0 Claiming for Interpretation and Interactive Complexity

Sign language or oral interpretation and Interactive Complexity occurs along with another service, such as therapy. Sign language or oral interpretation and interactive complexity must be submitted on the same claim as the primary service. For example, if a clinician used an oral interpreter to provide therapy, the claim will include a service line for the therapy and a service line for the oral interpretation. Only one unit of interactive complexity is allowed with any service it can modify. Refer to the Service Table for additional details. 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 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. Interactive complexity (90785) and interpretation (T1013) should not be claimed together.

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

Claims for interpretation may not exceed the claims for the primary service. One unit of sign language or oral interpretation is equal to 15 minutes. If a county submits more units of T1013 than are allowed by the sum of all the primary services provided, the interpretation services service line will be cut back to the time of the primary service. For example, if the MHP submits a claim that includes psychotherapy for 60 minutes and 5 units of sign language or oral interpretation, SD/MC will approve 4 units of sign language or oral interpretation services and deny one unit.

A claim for interpretation, should include the taxonomy code and NPI of the individual who provided the primary service or the rendering provider.

5.8.0 Claim Timeliness – Original Claims

The timeline for initial submission of a Specialty Mental Health Medi-Cal claim is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section 14705 and 42 CFR Section 447.45(d)). 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 5.31.0 for more information about requesting a DRC.

5.9.0 Service Facility Location Address

The submitted service facility address must be a physical address. If a service facility address is submitted as a P.O. Box, Lock Box or Lock Bin, the associated service will be denied. This limitation only applies to the service facility address.

5.10.0 Professional Claims/Fee-for-Service Medi-Cal (FFS/MC) Individual and Group Providers

Counties may contract with individual and group providers who are licensed and enrolled to provide mental health services under the Fee-for-Service Medi-Cal program. Counties may also submit claims for professional services provided in a hospital. Psychiatric inpatient hospital professional services are defined in Title 9, California Code of Regulations (CCR), Section 1810.237.1. When a service is rendered by a FFS/MC individual or group provider, the claim must include "FFS" in the Claim Note Segment and the first three digits of the rendering provider's taxonomy code must be 101, 103, 104, 106, 163, 193, 207, 208, 363, or 364. SD/MC will deny the service line if the Claim Note Segment contains "FFS" and the first three digits of the rendering provider's taxonomy code does not start with 101, 103, 104, 106, 163, 193, 207, 208, 363, or 364. The SD/MC claiming system does not conduct the Service Facility Validation described in Section 5.11.0 on claims formatted as described above when adjudicating a claim.

5.11.0 Service Facility Validation

Except for claims submitted for FFS/MC individual and group providers as described in section 5.10.0 SD/MC verifies that the service facility (i.e., organizational provider) was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided. As discussed in Section 4.2, DHCS records in the Provider Information Management System (PIMS) each organizational provider's NPI number and the specialty mental health services the organizational provider is certified to render. SD/MC will deny a service line if the organizational provider, as determined by the service facility NPI number on the claim, is not certified to provide the service billed, as determined by the procedure code on the service line.

5.12.0 Psychiatric Inpatient Hospital Services – Revenue Codes

All claims for psychiatric inpatient hospital services (acute psychiatric inpatient hospital and administrative day services) must include a valid revenue code. SD/MC will deny all service lines for psychiatric inpatient hospital services that do not have a valid revenue code.

5.13.0 Date of Admission and Date of Discharge

All claims for psychiatric inpatient hospital services and 24-hour services must include the beneficiary's date of admission. As discussed in section 5.4.1, claims for 24-hour services do

not require a discharge date. SD/MC will deny all service lines for psychiatric inpatient hospital services and 24-hour services that do not include an admission date.

5.14.0 Administrative Day Services – Date of Admission
Administrative day services cannot be claimed on the day of admission to the hospital. SD/MC will deny all service lines for administrative day services that occurred on the beneficiary's date of admission to the hospital.

5.15.0 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, 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 specialty mental health 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 do not identify a SD/MC Allowable Discipline for the procedure code on the service line. Consistent with Implementation Guide Sections 1.10.1 and 1.10.4, the provider's NPI and taxonomy codes do not have to match.

5.16.0 Telehealth Modifiers and Place of Service Codes
If a telehealth modifier is used, the place of service code must be 02 or 10 unless the service is mobile crisis. Appropriate telehealth modifiers and how to use them are described in Ancillary Table 3-Modifiers.

5.17.0 Day Treatment Intensive and Day Rehabilitation Services – Minimum Hours
Day treatment intensive and day rehabilitation must be provided for at least three hours before it is eligible for reimbursement. One unit of service is equal to 1 hour of service. SD/MC will deny service lines for day treatment intensive and day rehabilitation services with less than 3 units of service.

5.18.0 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.

Therapeutic Foster Care includes a bundle of services provided to a beneficiary placed in a therapeutic foster home. Claims for therapeutic foster care must include a place of service code and the place of service code must be one of the following: 03 (School), 11 (Office), 12 (Home), or 16 (Temporary Lodging). SD/MC will deny a service line for Therapeutic Foster Care if the place of service is code is not one of the four listed above.

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).

5.19.0 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.

5.20.0 100 Percent County Funded Services

Counties are responsible to pay for 100 percent of the cost to provide some services provided to Qualified Non-Citizens and individuals Permanently Residing in the United States Under Color of Law (PRUCOL) who are enrolled in the State Only Medi-Cal Program. SD/MC will deny a service line when the county is responsible for 100 percent of the cost to provide the service. Please see Section 6.3 for more information about services for which the county is responsible to pay 100 percent of the cost.

5.21.0 Units of Service – 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. All units of service must be whole numbers or the service line will be denied.

Some service encounters may need to be claimed with two procedure codes, the primary code, and an add-on code, to comply with this rule. Some services have a specific primary procedure code and a specific add-on code. For example, if psychological testing evaluation takes two hours, the claim would need to include 1 unit of procedure code 96130 for the first hour and 1

unit of procedure code 96131 for the second hour. 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. For example, CPT codes 99202-99205 are used to claim reimbursement for an office visit for a new patient. The maximum time that can be claimed with this series of codes is 74 minutes using CPT code 99205. If the provider sees a beneficiary for 89 minutes, the provider would bill 1 unit of 99205 and one unit of G2212. Similarly, 90832, 90834, and 90837 are used to claim psychotherapy. The last code in that series, 90837, does not have a dedicated add-on code. The maximum that can be claimed using code 90837 is 60 minutes of psychotherapy. If the provider sees a beneficiary for 75 minutes, the provider would bill 1 unit of 90837 and 1 unit of G2212. 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.

5.22.0 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 one hour, one unit of that code is attained when 31 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 30 minutes of therapy in the morning and 20 minutes of therapy in the afternoon, the provider will claim one unit of 90834 (Psychotherapy, 45 minutes with patient) because 38-52 minutes of psychotherapy had been provided. There are however, exceptions to the midpoint rule.

<u>Codes with Defined Time Ranges</u>
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 (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.

Drug Administration CPT (**not HCPCS**) Codes

One unit of a drug administration CPT code can be reported when the minimum number of minutes for that code has been attained. For example, 96365 (intravenous infusion 1-60 minutes) can be reported when 1 minute of service has been attained. If the infusion takes more than 90 minutes and less than 120 minutes, report 96366. There is no CPT code that can be reported for an infusion that takes 70 minutes.

5.23.0 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 Providers

The Medi-Cal state plan identifies some provider types that are eligible to render specialty mental health 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 the Medicare eligible service is provided by one of the following licensed provider types:

1. Physician
2. Physician assistant
3. Nurse practitioner
4. Clinical nurse specialist
5. Licensed clinical social worker
6. Clinical psychologist
7. Licensed Marriage and Family Therapists
8. Licensed Professional Clinical Counselors

Medicare Eligible Services

The Medi-Cal state plan covers some specialty mental health 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 are rendered by a Medicare eligible 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 SDMC 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.

5.24.0 Other Health Coverage – Non-Medicare

Medi-Cal is the payer of last resort. This means that providers must submit claims to a beneficiary's other health coverage for eligible services 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 the OHC already paid.

Eligible Services

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

- Targeted case management (T1017)
- Therapeutic behavioral services (H2019)
- Therapeutic foster care (S5145)
- Peer Support Services (H0025 or H0038)
- Mobile Crisis (H2011 with Place of Service 15)
- Transportation Mileage (A0140)
- Transportation Staff Time (T2007)

The claim submitted to Medi-Cal must contain information about the claim submitted to the beneficiary's OHC. If the beneficiary's OHC does not respond within 90 days, the provider may submit a claim to Medi-Cal on the 91st day.

5.25.0 Institutions for Mental Disease

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 PIMS posts a list of facilities that are classified as an IMD to the following webpage.

SD/MC will deny service lines for services provided by facilities on this list when the following conditions are met: When the facility is a hospital, psychiatric health facility, mental health rehabilitation center, or nursing facility and the beneficiary is from 22 years of age through 65 years of age. When the facility is a Short-Term Residential Therapeutic Program, SD/MC will deny the service line without regard to the beneficiary's age.

5.26.0 Combined Aggregate Limits

California Code of Regulations establishes limits on the amount of time certain services may be provided to a beneficiary in a 24-hour period. Medication Support Services are limited to 4 hours (9 CCR 1840.372), Crisis intervention Services are limited to 8 hours (9 CCR 1840.366), and Crisis Stabilization Services are limited to 20 hours (9 CCR 1840.368) in a 24-hour period

The Service Table lists the procedures codes that may be used to claim reimbursement for crisis intervention services. When adjudicating a service line with a Crisis Intervention Service procedure code, SD/MC determines whether the service billed exceeds the combined aggregate limit. The combined aggregate is equal to the sum of time associated with all approved Crisis Intervention Services in history provided to the same beneficiary on the same day. The following table lists all the procedure codes and the time associated with each procedure code that SD/MC uses to calculate the combined aggregate for Crisis Intervention Services. SD/MC will deny a Crisis Intervention Service if the time associated with that service results in the combined aggregate exceeding 8 hours for that date of service. For the purposes of calculating the combined aggregate, SD/MC uses the minimum time for which a service can be billed. For example, one unit of psychotherapy for crisis (90839) can be 30 to 74 minutes but for the purposes of calculating a combined aggregate, SD/MC calculates one unit of psychotherapy for crisis (90839) as 30 minutes.

CRISIS INTERVENTION COMBINED AGGREGATES	
PROCEDURE CODE	**TIME**
90839	30 minutes
90840	30 minutes
H2011	15 minutes

The Service Table lists all procedure codes that may be used to claim reimbursement for Medication Support Services. When adjudicating a service line with a Crisis Intervention Service procedure code, SD/MC determines whether the service billed exceeds the combined aggregate limit. The combined aggregate limit is equal to the sum of time associated with all approved Medication Support Services in history provided to the same beneficiary on the same day. The following table lists all the procedure codes and the time associated with each procedure code that SD/MC uses to calculate the combined aggregate for Medication Support services. SD/MC will deny a Medication Support Services if the time associated with that service results in the combined aggregate exceeding 4 hours for that date of service. For the purposes of calculating the combined aggregate, SD/MC uses the minimum time for which a service can be billed. For example, one unit of intravenous infusion (96365) can be claimed for 1-60 minutes but for purposes of the combined aggregate calculation, one unit of intravenous infusion is assumed to be 1 minute. By contrast, since H0033 (Medication Administration-any type of administration) is a 15-minute code, for the purposes of the combined aggregate calculation, one unit of medication administration (any kind of administration), H0033 is assumed to be 15 minutes.

Effective in 2023, the American Medical Association (AMA) deleted the ten (10) codes shown in strike-out. If the County submits claims using those codes to SD/MC, the claims will be rejected. If any claim in a claim file is rejected, the entire claim file will be rejected. Please refer to Chapter 8 for codes AMA recommends be claimed in their place.

MEDICATION SUPPORT SERVICES COMBINED AGGREGATES	
PROCEDURE CODE	**TIME**
90865	15 minutes
96365	1 minute
96366	31 minutes
96367	60 minutes
96368	15 minutes
96369	16 minutes
96370	30 minutes
96371	15 minutes
96372	1 minutes
96373	1 minutes
96374	15 minutes
96375	15 minutes
96376	8 minutes
96377	1 minutes
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes
99212	10 minutes
99213	20 minutes
99214	30 minutes
99215	40 minutes
~~99324~~	~~15 minutes~~
~~99325~~	~~26 minutes~~
~~99326~~	~~36 minutes~~
~~99327~~	~~51 minutes~~
~~99328~~	~~66 minutes~~
~~99334~~	~~10 minutes~~
~~99335~~	~~21 minutes~~
~~99336~~	~~36 minutes~~
~~99337~~	~~51 minutes~~
99341	15 minutes
99342	26 minutes
~~99343~~	~~36 minutes~~
99344	51 minutes

99345	66 minutes
99347	10 minutes
99348	21 minutes
99349	36 minutes
99350	51 minutes
99605	15 minutes
99606	15 minutes
99607	15 minutes
G2212	15 minutes
H0033	15 minutes
H0034	15 minutes

The Service Table lists the procedure codes for Crisis Stabilization. Crisis Stabilization is billed with HCPCS code S9484 in 1-hour increments. The combined aggregate limit for Crisis Stabilization is equal to the sum of time associated with all approved Crisis Stabilization services in history provided to the same beneficiary on the same day. SD/MC will deny a Crisis Stabilization service if the time associated with that service results in the combined aggregate exceeding 23 hours for that date of service.

5.27.0 Lockout Rules

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.[5] 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.

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

[5] For an explanation of why certain codes that usually cannot be billed together can be billed together in certain circumstances, refer to the 2021 NCCI Policy Manual for Medicare Services, chapter 1 pages I-4, I-5, and I-8 through I-10.

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 are listed in Column L.

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.

5.28.0 Emergency and 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.

If the county includes an emergency indicator on the claim, the SD/MC system will ignore it. DHCS no longer considers any behavioral health service to be an emergency service for the purpose of federal reimbursement.

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

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396(r)(5) of the Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services needed to correct and ameliorate mental illness and conditions. Federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a mental health condition. All mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services as established in W&I Code section 14184.402(b) that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services and must be covered for beneficiaries who meet the criteria for access to the specialty mental health delivery system. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

DHCS currently provides the following specialty mental health services through the EPSDT benefit: Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), Child and Family Team (CFT), In-Home Behavioral Services (IHBS), and Therapeutic Foster Care (TFC). SD/MC will deny any service line for an EPSDT service if the beneficiary is not under 21 years of age, or the beneficiary is not enrolled in an aid code that is EPSDT eligible. Please consult the Aid Code Master Chart on the following DHCS webpage to determine whether or not a beneficiary's aid code is EPSDT eligible.

The following table displays the coding for each EPSDT service.

EPSDT Services	Procedure Code	Modifier
TBS	H2019	NA
ICC	T1017	HK
CFT	H2000	HK
TFC	S5145	NA
IHBS	Multiple[1]	HK

[1] Please see Service Table and Ancillary Table 3-Modifiers for more information about which procedure codes may be billed with the HK modifier.

5.30.0 Replacing Approved and Denied Claims

Replacement claims are claims that correct previously submitted claims. An MHP may submit a claim to replace an approved or denied claim no later than 15 months after the month of service. SD/MC will deny a replacement claim submitted more than 15 months after the month of service.

A replacement claim can be submitted if an 835 has been issued and the claim being replaced has not been voided. Replacement claims for outpatient services, day services, or 24-hour services must have the following data elements match the claim it is replacing: Billing Employer Identification Number, County Code, the same number of service lines, and client identification code (CIN). If a Delay Reason Code (DRC) was submitted with the original claim, it must have the same DRC as the original claim. The replacement claim must also have two of the following four data elements on each service line that match the corresponding service lines in the original claim: Procedure code or revenue code (as appropriate), date of service, place of service, and service facility NPI. If the replacement criteria are not met, the claim will be denied.

5.31.0 Voiding Approved Claims

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

5.32.0 Requesting Delay Reason Codes

MHPs may request a Delay Reason Code (DRC) to submit an original claim more than 12 months from the month of service or a replacement claim more than 15 months from the month of service if the delay in submitting the original or replacement claim is due to litigation, the original claim being rejected or denied for a reason unrelated to the billing limitation rules, or an administrative delay in the prior approval process. Contact MEDCCC at MedCCC@dhcs.ca.gov to request a DRC. Please refer to Information Notice 13-20 for more information about the DRC process.

CHAPTER SIX: FUNDING

6.0. Introduction

Specialty mental health 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. County Share

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 that 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 any non-pregnancy services, including emergency services, provided to beneficiaries with State-Only Medi-Cal. If there is an emergency indicator on the claim, SD/MC will ignore it.

6.2. State Share and Proposition 30

The State realigned financial responsibility for Medi-Cal Specialty Mental Health 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 for the Medi-Cal specialty mental health services program established after 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 Specialty Mental Health 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 Specialty

Mental Services so that the State reimburses the county the appropriate portion of the non-federal share with State General Funds. 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. State Required Specialty Mental Health Services

The state will reimburse counties 100 percent of the non-federal share for specialty mental health 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.

Affordable Care Act Optional Expansion Population

The Affordable Care Act (ACA) gave states the option to expand eligibility for beneficiaries to enroll in their Medicaid program. California chose to expand eligibility for Medi-Cal. Beneficiaries enrolled in Medi-Cal as a result of the ACA Optional Expansion are assigned specific aid codes (i.e., ACA Aid Codes). Counties are required to provide Specialty Mental Health Services to Medi-Cal beneficiaries enrolled in ACA Aid Codes. The state reimburses counties 100 percent of the non-federal share of the total approved amount for specialty mental health services provided to beneficiaries enrolled in ACA aid codes. [6] Services provided to beneficiaries enrolled in ACA aid codes do not need a modifier to be reimbursed 100 percent of the non-federal share.

Continuum of Care Reform

The State implemented Continuum of Care Reform in January of 2017. Continuum of Care Reform required mental health plans to assess children and youth before being placed in an STRTP and to participate in a child and family team when the child or youth needs mental health treatment. To indicate that a service was provided as part of continuum of care reform, the MHP should use modifier HW with that service. The Service Table indicates which procedure codes can be used with modifier HW in the "Allowable Modifiers" column.

Senate Bill 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

[6] Please see the aid code master chart for a list of ACA Aid Codes.

beneficiaries' aid code. The state will reimburse MHPs 100 percent of the non-federal share for Specialty Mental Health Services provided to beneficiaries enrolled in the State Only Medi-Cal Program pursuant to SB 75. The service does not need a modifier.

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 MHPs 100 percent of the non-federal share for Specialty Mental Health Services provided to beneficiaries enrolled through the Young Adult Expansion. The service does not need a modifier.

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 MHPs for 100 percent of the non-federal share of the cost of care for Older Adult Expansion beneficiaries. The service does not need a modifier.

Community-Based Mobile Crisis Intervention Services

DHCS added Community-Based Mobile Crisis Intervention Services to the State Plan to be effective on January 1, 2023. MHPs should use modifier HW to indicate that the mobile crisis, transportation mileage, and transportation staff time were provided as a result of a State mandate and is subject to Proposition 30.

6.2.2. Federally Required Specialty Mental Health Services

The state will reimburse counties 50 percent of the non-federal share for specialty mental health services provided as a result of a new federal 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 federal requirement. This subsection discusses each of the new federal 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.

Family First Prevention Services Act (FFPSA)

The Family First Prevention Services Act (FFPSA) requires a qualified individual to provide certain services to children and youth before they are placed and while they are placed in a Short-Term Residential Therapeutic Program (STRTP); and states to provide 6-months of aftercare services after a child or youth is discharged from an STRTP. For more information about FFPSA please refer to the joint DHCS and CDSS Information Notice 21-055. FFPSA can only be claimed for a child under 21.

To indicate that a service was provided as a result of FFPSA, the MHP must use modifier HV with that service. The Service Table indicates which procedure codes can be used with modifier HV in Column S titled "Allowable Modifiers." The State will reimburse the MHP 50 percent of the non-federal share if the service was provided to a child under 21 and has an HV modifier. If the child has unsatisfactory immigration status and is only eligible for these specific services as a result of FFPSA, SD/MC will deny the service line unless the HV modifier is present. If the HV modifier is present, the state will reimburse the MHP for 50 percent of the non-federal share of the cost of FFPSA services.

6.3. County Share

Counties are responsible for the share of all approved services that are not reimbursed with federal and/or state funds. Counties are not responsible for any portion of the amount approved for state required specialty mental health services as described in Section 6.2.1. Counties are responsible for half of the non-federal share of the amount approved for federally required specialty mental health services as described in Section 6.2.2. Counties are responsible for all the non-federal share of the amount approved for all other specialty mental health services. Some specialty mental health services provided to some beneficiaries are not eligible for federal and/or state reimbursement. The county is responsible for 100 percent of the cost to provide these services. The following discusses those services.

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 in the State Only Medi-Cal Program. State reimbursement is not available for specialty mental health 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 a Federal Requirement as described in Section 6.2.2. 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 Specialty Mental Health 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 a Federal Requirement as described in Section 6.2.2. 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.

CHAPTER SEVEN: OUT-OF-STATE CLAIMS

7.1.0 Out-of-State: Outpatient Services

Title 9, CCR, § 1810.355(b) states that out-of-state specialty mental health services cannot be billed to SD/MC except when it is customary practice to receive medical services in a border community outside the State. Border communities are listed in Title 9, CCR, § 1820.115(i).

7.2.0 Out-of-State: Inpatient Services

Title 22, CCR, § 51006 states that emergency services are available for emergency conditions. Emergency conditions include emergency psychiatric conditions. To be reimbursed for out-of-state inpatient emergency services, providers will need an approved Treatment Authorization Request (TAR). Please refer to Medi-Cal: Out-of-State Provider FAQs for additional details or call out-of-state provider support at (916) 636-1960.

CHAPTER EIGHT: 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 business rules will remain the same in SD/MC and will be based on AMA's 2022 rules until the SD/MC is updated to reflect the 2023 and 2024 CPT code set and rules. However, counties will be reimbursed based on the times provided in AMA's 2023 CPT Codebook but should select codes based on the times provided in this billing manual.

For example, in 2022, CPT code 99221 was defined as 'Initial hospital care per day for the evaluation and management of a patient.' The time range associated with 99221 was 20-39 minutes. In 2023, the AMA redefined 99221 to mean 'Initial hospital inpatient or observation care per day for the evaluation and management of a patient.' The time that is currently associated with CPT Code 99221 is 40-54 minutes. The county should *select* CPT code 99221 when the physician, PA, or advanced practice nurse provided at least 20 minutes of direct patient hospital care. However, the MHP will be *reimbursed* for one unit of CPT 99221 at the midpoint of 40 and 54 minutes or at 47 minutes. In this example, the MHP's reimbursement will be higher than the time that was associated with the code in 2022 because AMA's 2023 rules assign more time to this code.

If a county claims a code that has been deleted in 2023, SD/MC will reject that claim. If any claim in a claim file is rejected, the entire claim file will also be rejected. As a result, counties are advised to use AMA-recommended substitutions instead of the deleted codes. The table below lists the codes that have been deleted and their recommended substitutions.

Deleted Code	Deleted Code Category	Replacement Code	Replacement Code Category
99217	Therapy	99238/99239	Therapy
99218	Assessment	99221	Therapy
99219	Assessment	99222	Therapy
99220	Assessment	99223	Therapy
99241	Therapy	99242	Therapy
99251	Therapy	99252	Therapy
99324	Medication Support	99341	Medication Support
99325	Medication Support	99342	Medication Support
99326	Medication Support	99344	Medication Support
99327	Medication Support	99344	Medication Support
99328	Medication Support	99345	Medication Support
99334	Medication Support	99347	Medication Support
99335	Medication Support	99348	Medication Support
99336	Medication Support	99349	Medication Support
99337	Medication Support	99350	Medication Support
99343	Medication Support	99342	Medication Support

CHAPTER NINE: ANCILLARY TABLES

Tables 1-3 below 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 SDMC 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.

Abbreviations	Discipline
MD	Medical Doctor
DO	Doctor of Osteopathy
Pharm	General Pharmacist or Advanced Practice Pharmacist
CNS	Clinical Nurse Specialist
NP	Nurse Practitioner
RN	Registered Nurse
LCSW	Licensed Clinical Social Worker
LVN	Licensed Vocational Nurse
OT	Occupational Therapist
LPCC	Licensed Professional Clinical Counselor
LMFT	Licensed Marriage and Family Therapist
MHRS	Mental Health Rehabilitation Specialist
PhD	Doctor of Philosophy, Clinical Psychologist (licensed, waivered, or registered)
PsyD	Doctor of Psychology, Clinical Psychologist (licensed, waivered, or registered)
PA	Physician Assistant
Peer	Certified Peer Specialist
PT	Psychiatric Technician
Other	Other Qualified Provider

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 SDMC to process the claim. Below are the allowable places of service that are associated with codes listed in the Service Table. The column titled Allowable Place of Service lists the place of service code associated with the name of that place of service. The column 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 service 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.

Place of Service Code	Place of Service Name	Place of Service Description
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 (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, camp ground, 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.

Place of Service Code	Place of Service Name	Place of Service Description
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.
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.

Place of Service Code	Place of Service Name	Place of Service Description
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.
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.

Place of Service Code	Place of Service Name	Place of Service Description
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.
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 provides 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; a service billed with an HW modifier indicates that the county provided the service as a result of a state mandate and that the state will pay the non-federal share of that service pursuant to Proposition 30. 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 alpha-numeric character. The column labeled Definition provides the definition of the modifier from the CPT Manual 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 SDMC claiming system.

For a transaction to be HIPAA-compliant, a claim must use a current code and a procedure code cannot use more than four modifiers. DHCS recommends that, in the rare situations that MHPs exceed four modifiers per procedure code in a given transaction, they not use telehealth modifiers.

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)	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 SDMC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved*	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
	outpatient hospital setting(s) (e.g., hospital emergency department, clinic).	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.	
59	**Distinct Procedural Service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from services performed on the same day. Modifier 59 is used to identify procedures/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 codes that can be overridden have * or ** next to them. This modifier is also to be used by any appropriate professional to override a 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider. This does not mean that if a provider performs an outpatient service while a patient is in a crisis stabilization unit, they can submit a separate claim for that service. Doing so would cause the service to be denied. 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 SDMC 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 • S9484
76	**Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.	Use this modifier to override 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider.	This modifier will be used with: S9484

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
77	**Repeat Procedure by Another Physician or Other Qualified Health Care Professional:** It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. Note: This modifier should not be appended to an evaluation and management service.	Use this modifier to override 24-hour or day duplicate services lockout for S9484 (crisis stabilization). Do not use this code for crisis intervention or any other outpatient service. This modifier may be used by a licensed, pre-licensed or otherwise qualified healthcare professional employed by the county and/or contracted provider. This does not mean that if a provider performs an outpatient service while a patient is in a crisis stabilization unit, they can submit a separate claim for that service. Doing so would cause the service to be denied.	This modifier will be used with S9484
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 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.
95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video 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 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	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.

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
	the key components and/or requirements of the same service when rendered via a face-to-face interaction.		
SC	Valid for codes when the service was provided via telephone or audio-only systems.	Modifier SC is used only 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 to HCPCS codes when telephone services are being provided.
GT	Via telehealth in 24-hour or day facilities or as part of mobile crisis.	Use this modifier on day, 24-hour or mobile crisis, transportation mileage or transportation staff time claims when the service was provided via telehealth.	This modifier only applies to HCPCS codes H2011 -POS 15, A0140, and T2007
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.	
HA	Child/adolescent program	Use this modifier when billing for Children's Crisis Residential Program (CCRP) services or psychiatric inpatient: administrative day under 21.	
HB	Adult program, non-geriatric	Use this modifier when billing for crisis residential treatment services provided to adults from 18 through 64 years of age.	
HC	Adult program, geriatric	Use this modifier when billing for crisis residential treatment services provided to adults 65 years of age.	
HE	Mental health program	Use this modifier when billing for 24-hour and day services. For additional information about when this modifier is required refer to service table 1. Do not use this modifier when claiming for outpatient services.	

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
HK	Specialized mental health programs for high-risk populations	Use this modifier to indicate that a Katie A, IHBS, ICC, and/or CFT service was provided.	
HL	Intern	Use this modifier when the service was performed by a 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.	For specific codes that take this modifier, refer to the Service Table.
HV	This service is provided as a result of a federal mandate and the State covers 50 percent of the nonfederal share, as the service was determined to be covered under Proposition 30. Please note that this definition does not correspond to the national description reference; the definition reflects state policy.	Use this modifier to identify services that the county provided as a result of a **federal** mandate that are subject to Proposition 30. Currently, services provided by the Qualified Individual (QI) as a result of the federal requirements contained in the Family First Prevention Services Act (FFPSA), such as intensive care coordination services, should use the modifier HV. Likewise, aftercare services (for six months after discharge from an STRTP) are a new requirement of the FFPSA, and specialty mental health services provided as part of a High-Fidelity Wraparound program should also use the modifier HV.	
HW	This service is provided as a result of a State mandate and 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. Currently continuum of care services provided as a result of AB 403 and mobile crisis services should use the HW modifier.	
TG	Complex/high tech level of care	Use this modifier when billing for day treatment intensive and crisis stabilization. For additional information about when this	

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
		modifier is required refer to the Service Table. Do not use this modifier when claiming for outpatient services.	
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 SDMC 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 SDMC 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.
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	This modifier will be used with CPT codes that are part

Modifier	Definition	When to Use	Codes/Code Types This Modifier Applies To
		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 SDMC 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.	of an over-ridable lockout combination.

CHAPTER TEN: ADDENDUM TO THE SERVICE TABLE

The Service Table describes procedure codes associated with each outpatient service type in the State Plan: Assessment, Medication Support Services, Peer Support Services, Psychosocial Rehabilitation, Referral and Linkages, Therapy and Treatment Planning. There is also a table for a group of codes called Supplemental. Supplemental codes are codes that must be used with another code.

The Service Table contains the following columns:

1. Code Type: This column describes the service type that a particular code was placed in. A code may be grouped in the following service types:
    a. Assessment: A service activity designed to collect information and evaluate the current status of a beneficiary's mental, emotional or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that beneficiary.
    b. Medication Support Services: Include prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the beneficiary.

       Medication support services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization. This service includes one or more of the following components:
        - Evaluation of the need for medication
        - Evaluation of clinical effectiveness and side effects
        - Medication education including instruction in the use, risks and benefits of and alternatives for medication
        - Treatment Planning
    c. Mobile Crisis: Community-based mobile crisis intervention 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 that 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. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary a behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where a beneficiary 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 per day, seven days per week, 365 days per year.

d. Peer Support Services: Are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of 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: 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 and supporting beneficiaries in developing their own recovery goals and processes.
    - Therapeutic Activity: 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 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 other providing care or support to the beneficiary, family members, or significant support persons.

e. Psychosocial Rehabilitation: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Psychosocial rehabilitation includes assisting beneficiaries to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a beneficiary or a group of beneficiaries.
f. Referral and Linkages: Services and supports to connect a beneficiary with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a beneficiary with a warm handoff to obtain ongoing support.
g. Supplemental Services: Additional and/or 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 independently. They must be billed with a/another (primary) procedure.
h. Therapeutic Behavioral Service (TBS): An adjunctive program that supports other services patients are currently receiving. TBS is an intensive, individualized, one-to-one behavioral health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.
i. Therapy: Service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be

delivered to a beneficiary or a group of beneficiaries and may include family therapy directed at improving the beneficiary's and at which the beneficiary is present.

j. Treatment Planning: A service activity to develop or update a beneficiary's course of treatment, documentation of the recommended course of treatment, and monitoring a beneficiary's progress.

2. 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 an 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 Manual 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, however, E/M services can be rendered by a Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist. Please also note that the service descriptions provided are brief descriptions. For a full description of the services, please consult the CPT Manual. The CPT Manuals are copyrighted by 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 that 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.

3. Code: This lists the procedure code. Services codes that describe services provided in a hospital setting would be claimed by the MHP on behalf of fee-for-service hospitals, not on behalf of SD/MC hospitals.

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 an 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 MHP 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 modifier HL or GC after it. A resident and registered associate should claim using an HL or GC code, as appropriate after the service code. A service code that uses an HL or GC modifier should not be submitted to Medicare first; it should be submitted to SDMC 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 procedures are allowed. Refer to Table 2-Place of Service Codes for professional Claim or a description of the Place of Service codes. If a claim does not list a place of service, it will be denied. As stated in section 5.16.0 if a service is provided via telehealth, the place of service **must** be either 02 or 10 unless the services 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 has 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 dedicated add-on code or is an evaluation and management code.

12. Locked Out Against Inpatient?: This column indicates whether a code can be billed with Revenue Code 0100 or Revenue Code 0101. A "No" in this column means that the outpatient code can be billed with a Revenue Code and a "Yes" in this column means that it cannot be billed with a Revenue Code except on the days of admission or discharge.

13. Locked Out Against Residential?: This column indicates whether codes can be billed on the same date as a residential code. Most outpatient codes cannot be billed on the same date of service as residential codes except on the dates of admission or discharge. However, some can. A "No" in this column means that the code can be claimed with a residential service; a "Yes" in this column means that it cannot be claimed with a residential service except on the days of admission or discharge.

14. Locked Out Against Psychiatric Health Facility?: This column indicates whether codes can be billed on the same date as a psychiatric health facility service. Most outpatient codes cannot be billed on the same day as a psychiatric health facility service except on the dates of admission or discharge. However, some can be so billed. A "No" in this column indicates that the code can be claimed with a psychiatric health facility service; a "Yes" in this column means that it cannot be billed on the same day as a psychiatric health facility service except on the days of admission or discharge.

15. 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 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.

16. 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. Claims for interpretation may not exceed the claims for the code. For additional information, refer to Section 5.7.0.

17. Medicare COB Required: This column specifies whether a procedure, if rendered to a Medi-Medi beneficiary must first be submitted to Medicare before being submitted to SDMC 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 Nurse Specialists, Clinical Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors, Occupational Therapists, 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 a procedure was not provided by a Medicare-recognized professional listed above, the service should not be submitted to Medicare.

18. Maximum Units that Can be Billed per Rendering Provider 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. All codes must be billed in whole units; fractional units will be denied. When selecting a CPT code, providers should follow the CPT Manual for instructions on how to bill each code using time. DHCS policy states that only claimable service time should be counted toward selection of time. Claimable service time 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 rate for the service code or are claimed separately by the county.

19. Allowable Modifiers: This column lists the modifiers that are allowed with this procedure 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 the service. There are some instances (such as lack of an over-riding modifier) when lack of a modifier will cause a service code to be denied.

Service Table 1-Existing 24-Hour and Day Services

24-hour services are services that provide a therapeutic environment of care and treatment within a 24-hour setting. They include general psychiatric inpatient services, psychiatric hospital inpatient services, general psychiatric administrative day services, psychiatric health facility services, therapeutic foster care, adult crisis residential services, and adult residential services. Day services include crisis stabilization services, day treatment intensive services, and day rehabilitation services. Except for case management services, day, 24-hour, inpatient and outpatient services are locked out against each other except for the day of admission. Note that outpatient services are not locked out against therapeutic foster care (S5145).

In accordance with Title 9, CCR, § 1840.215, the following services are not reimbursable on days when psychiatric inpatient hospital services are reimbursed, except for the day of admission to psychiatric inpatient hospital services: 1) Adult Residential Treatment Services, 2) Crisis Residential Treatment Services, 3) Crisis Intervention, 4) Day Treatment Intensive, 5) Day Rehabilitation, 6) Psychiatric Nursing Facility Services[7], 7) Crisis Stabilization, and 8) Psychiatric Health Facility Services.

In accordance with Title 9, CCR, § 1840.360, Day Rehabilitation and Day Treatment Intensive are not reimbursable under the following circumstances: a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission to those services; b) Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive is provided; c) Two full-day or one full-day and one half-day or two half-day programs may not be provided to the same beneficiary on the same day.

In accordance with Title 9, CCR, § 1840.362, Adult Residential Treatment Services are not reimbursable under the following circumstances: a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission; b) When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.

[7] An exception shall be made for skilled nursing facility patients who exercise their bed hold. In accordance with Title 22, CCR, § 72520, if a patient of a skilled nursing facility is transferred to a general acute care hospital, the skilled nursing facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative.

In accordance with Title 9, CCR, § 1840.364, Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services: a) Mental Health Services, b) Day Treatment Intensive, c) Day Rehabilitation, d) Psychiatric Inpatient Hospital Services, e) Psychiatric Health Facility Services, f) Psychiatric Nursing Facility Services, g) Adult Residential Treatment Services, h) Crisis Intervention, and i) Crisis Stabilization.

In accordance with Title 9, CCR, § 1840.368, Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility services are reimbursed, except on the day of admission to those services.

In accordance with Title 9, CCR, § 1840.370, Psychiatric Health Facility Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Psychiatric Health Facility Services: a) Adult Residential Treatment Services, b) Crisis Residential Treatment Services, c) Crisis Intervention, d) Day Treatment Intensive, e) Day Rehabilitation, f) Psychiatric Inpatient Hospital Services, g) Medication Support Services, h) Mental Health Services, i) Crisis Stabilization, and j) Psychiatric Nursing Facility Services.

If a service was provided via telehealth, the following are applicable modifiers:

1. Modifier GT: Valid for codes when the service was provided via synchronous, interactive audio and telecommunication systems.
2. Modifier SC: Valid for codes when the service was provided via telephone or audio-only systems.

Title 9, CCR, § 1840.368 states that "the maximum number of hours claimable for Crisis Stabilization in a 24-hour period is 20 hours."

Category	Procedure Code & Modifier	Revenue Code	Description	Mode of Service	Service Function	Medicare COB Required?
Existing 24-Hour Service	H2015:HE	0100	General Psychiatric Inpatient	5	10-18	Yes
Existing 24-Hour Service	H2015:HE:HA	0100	Psychiatric Hospital Inpatient: Under Age 21	5	10-18	Yes
Existing 24-Hour Service	H2015:HE:HC	0100	Psychiatric Hospital Inpatient: over age 64	5	10-18	Yes
Existing 24-Hour Service	H0046:HE	0101	General hospital inpatient: Administrative Day	5	19	No
Existing 24-Hour Service	H0046:HE:HA	0101	Psychiatric Hospital Inpatient: Administrative Day Under 21	5	19	No

Category	Procedure Code & Modifier	Revenue Code	Description	Mode of Service	Service Function	Medicare COB Required?
Existing 24-Hour Service	H0046:HE:HC	0101	Psychiatric Hospital Inpatient: Administrative Day Over 64	5	19	No
Existing 24-Hour Service	H2013:HE	NA	Psychiatric Health Facility	5	20-29	No
Existing 24-Hour Service	S5145:HE	NA	Therapeutic Foster Care	5	95	No
Existing 24-Hour Service	H0018:HE:HC	NA	Adult Crisis Residential: Geriatric	5	40-49	No
Existing 24-Hour Service	H0018:HE:HB	NA	Adult Crisis Residential: Non-Geriatric	5	40-49	No
Existing 24-Hour Service	H0018:HE:HA	NA	Children's-Adult Crisis Residential	5	40-49	No
Existing 24-Hour Service	H0019:HE:HC	NA	Adult Residential: Geriatric	5	65-79	No
Existing 24-Hour Service	H0019:HE:HB	NA	Adult Residential: Non-Geriatric	5	65-79	No
Existing Day Service	S9484:HE:TG	NA	Crisis Stabilization: Emergency Room	10	20-24	No
Existing Day Service	S9484:HE:TG	NA	Crisis Stabilization: Urgent Care	10	25-29	No
Existing Day Service	H2012:HE:TG	NA	Day Treatment Intensive: Half Day	10	81-84	No
Existing Day Service	H2012:HE:TG	NA	Day Treatment Intensive: Full Day	10	85-89	No
Existing Day Service	H2012: HE	NA	Day Rehabilitation: Half Day	10	91-94	No
Existing Day Service	H2012:HE	NA	Day Rehabilitation: Full Day	10	95-99	No

CHAPTER 11: 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 alpha-numeric 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 alpha-numeric characters, the provider is obligated to provide the entire taxonomy code on the 837P claim.

To indicate that the service was provided by an intern use modifier HL after the service code. If the pre-licensed professional does not have their own NPI, indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. If the pre-licensed professional has their own NPI, they may use their own NPI as the rendering professional. 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 SD/MC.

The column labeled Discipline denotes the discipline and the column labeled First Four Alpha-Numeric Characters of Taxonomy Code denotes the various first four alpha-numeric codes that can be used to describe that discipline.

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Clinical Nurse Specialist	364S
Licensed Psychiatric Technician	106S
	167G
	3747
Licensed Vocational Nurse	164W
	164X
Marriage and Family Therapist or Licensed Professional Clinical Counselor	1012
	101Y
	102X
	103K
	106H

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	1714
	222Q
	225C
	2256
Mental Health Rehabilitation Specialist	146D
	146L
	146M
	146N
	171M
	174H
	1837
	2217
	224Y
	224Z
	2254
	2258
	225A
	2260
	2263
	246Y
	246Z
	2470
	374T
	376K
	3902
	4053
Nurse Practitioner	363L
Occupational Therapist	225X
Other Qualified Provider	171R
	172V
	3726

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	373H
	374U
	376J
Peer Specialist	175T
Pharmacist	1835
Physician Assistant	363A
Physician	202C
	202D
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081
	2082
	2083

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	2084
	2085
	2086
	2088
	208C
	208D
	208G
	208M
	208U
	208V
	2098
Psychologist	102L
	103G
	103T
Registered Nurse	163W
	3675
	376G
Licensed Clinical Social Worker	106E
	1041

Appendix 2- Definitions

Claim: A request for payment that a provider submits to the MHP or the MHP 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. Claim files are submitted by MHPs.

Community-based wrap-around service: This service is designated by HCPCS code H2021 and refers to coordination of care between providers in the Mental Health System and providers who are outside the Mental Health 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 procedures 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 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 Transaction: 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 the services provided by a licensed or pre-licensed professional. If professional services are provided to the beneficiary by county-operated and/or county-employed health care professionals, the MHP is considered to be the "group practice" because the MHP owns and is responsible for the beneficiary's medical record. If the beneficiary receives their specialty mental health 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 psychiatrist, 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 psychiatrist owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the psychiatrist, then the psychiatrist-owner is considered to be the group practice as he/she owns and is responsible for the beneficiary's medical record.

Intern: A registered, pre-licensed mental health 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 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 cannot contain more than one procedure code.

Services Provided by Interns/Residents: To indicate that the service was provided by an intern use modifier HL after the service code. If the pre-licensed professional does not have their own NPI, indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. If the pre-licensed professional has their own NPI, they may use their own NPI to indicate they were 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 Mental Health Rehabilitation Specialist, Other Qualified Professional, 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 current primary eligibility aid code and county identification
10. County of responsibility
11. County of residency
12. MEDS current renewal date
13. Reason for termination
14. Current eligibility status
15. Eligibility worker code
16. Case name
17. District code
18. Annual re-determination due month
19. Latest re-determination completed date
20. Beneficiary's address
21. Beneficiary's primary and alternate phone numbers
22. Beneficiary's primary aid code by month
23. Beneficiary's eligibility status by month
24. County of responsibility by month
25. Share of cost amount, current and by previous months
26. Share of cost certification day, current and in previous months

27. Health insurance claim number
28. Health care plan status reason code (current and by previous months)
29. Health care plan enrollment status (current and by previous months)
30. Health care plan code (current and by previous months)
31. Other coverage (current and by previous months)
32. First and last name of the authorized representative
33. Authorized representative's address
34. Date of Death
35. Source of the date of death information
36. Country of origin
37. Current Special Program County identification
38. Special Program worker code
39. Special program district
40. Special program case name
41. Special program annual redetermination due month
42. Special program latest re-determination completed date
43. Special program eligibility status (current and by previous months)
44. Special program county code by month
45. Special program aid code by month
46. Special program termination reason
47. Special program termination date
48. Medicare Part D start date
49. Medicare Part A change date
50. Source of the information about Medicare Part A change
51. Medicare Part B change date
52. Source of information about Medicare Part B change
53. Medicare Part D change date
54. Source of information about Medicare Part D change
55. Medicare Parts A/B status (current and by previous months)
56. Medicare Part D status (current and by previous months)
57. Benefits Identification Card (BIC) Number

58. BIC issue date
59. Incarceration and suspension information
60. Date of incarceration
61. Date of suspension
62. Date suspension ended
63. Release date
64. Date of specific aid code inquiry
65. County of responsibility's specific aid code inquiry
66. Date of eligibility inquiry
67. Date of inquiry of when eligibility started