DMC STATE PLAN BILLING MANUAL

July 2025

Version 3.0

SFY 2025-26

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CHAPTER ONE - INTRODUCTION

1.0 Introduction

The Short Doyle/Medi-Cal (SD/MC) claims processing system allows California counties to submit electronic claims for reimbursement of covered Drug Medi-Cal Program (DMC-State Plan) services provided by Drug Medi-Cal enrolled and certified providers to Medi-Cal-eligible members. The Department of Health Care Services (DHCS) 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 approved by the SD/MC claims processing system. CalAIM Behavioral Health Payment Reform Frequently Asked Questions contain clarifications and corrections related to claiming policy. To stay current on corrections to the billing manual, please check this site periodically. This manual does not include clinical guidance on when specific procedure codes or modifiers are appropriate or on the documentation that must accompany the procedure codes submitted on a claim.

This chapter includes:

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

1.1 About This Manual

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

1.1.1 Objectives

The primary objectives of this Billing Manual are to:

- Provide explanations, procedures, and requirements for claiming.
- Provide claiming system overviews and process descriptions.
- Provide 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.

1.2 Program Background

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

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

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

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

For DMC - State Plan services provided to a member by a certified provider, the cost of these services is paid by a combination of State, County, and Federal funds. The FFP sharing ratio (the percentage of costs reimbursed by the Federal government) is determined on an annual basis and is known as the Federal Medical Assistance Program

(FMAP) percentage. County expenditures represent a combination of State realignment funds, local county funds and other sources such as grants.

1.3 Authority

Authority for the 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 (W&I Code)

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

1.3.6 California Code of Regulations (CCR)

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

1.3.7 DHCS Information Notices

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

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

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

For assistance accessing the DHCS Application Portal, please submit an inquiry via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC. If you do not yet have access, please reach out to your designated county manager to request access.

1.3.9 Companion Guide for the 835 Healthcare Claim Payment/Advice

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

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

(*see "Companion Guide Appendix*")

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

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

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

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

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

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

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

This is posted on the MEDCCC Library and contains more detailed information about the meaning of the denial codes received.

1.4 Medi-Cal Claims Customer Service Office (MEDCCC)

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

What counties can expect when contacting MEDCCC:

- An email response acknowledging receipt of the counties issue or concern within 48 business hours
- The most current information on DMC – State Plan Medi-Cal claims

- Assistance with troubleshooting claim and/or payment issues
- Helpful answers to claiming policy and procedure questions
- MEDCCC will generally respond to inquiries within five business days. However, some responses may take more time.

To ensure the accuracy of the inquiry and responses, MEDCCC requests that counties submit their inquiries via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC . If you do not yet have access, please reach out to your designated county manager to request access.

CHAPTER TWO – GETTING STARTED

2.0 Introduction

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

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

2.1 DHCS Application Portal

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

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

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

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

2.2 Provider Numbers and NPIs

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

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

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

2.3 Provider Enrollment and Medi-Cal Certification

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

2.4 Companion Guide and Appendix

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

CHAPTER THREE – CLIENT ELIGIBILITY

3.0 Introduction

This chapter contains information about Medi-Cal eligibility including:

- Client Eligibility
- Aid Codes

3.1 Client Eligibility

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

3.1.1 Medi-Cal Eligibility Determination

DHCS is responsible for instituting procedures for establishing Medi-Cal eligibility criteria. The determination of member eligibility and the collection of member eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding member eligibility criteria may be obtained through the Medi-Cal Eligibility Division (MCED) website.

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

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

3.1.2 Eligibility Review

Once Medi-Cal eligibility is established, authorized county staff may review member eligibility information. With few exceptions, the source of this eligibility verification information will be the DHCS Point of Service System which can be reached at 1.800.456.2387.

3.1.3 Monthly MEDS Extract File (MMEF)

The Monthly MEDS Extract File (MMEF) contains, among other data, all Aid Codes for which members 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.

3.1.4 MEDS and MEDSLITE

MEDS and MEDSLITE provide eligibility status code(s) for a member. 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 member is found in MEDS or MEDSLITE, but none of the Aid Codes assigned to the member 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) can be found on the MEDCCC Library. The Aid Codes Chart provides useful information about the following:

- FFP

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

CHAPTER FOUR – COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered DMC-State Plan services.

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

4.1 DMC- State Plan Covered Services

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

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

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

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

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

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

interventions and to address and monitor a member's progress and restoration of a member to their best possible functional level.

4.1.2 Group Counseling: SPA 20-0006-A

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

4.1.3 Individual Counseling: SPA 20-0006-A

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

4.1.4 Medical Psychotherapy: SPA 20-0006-A

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

4.1.5 Medication Services: SPA 20-0006-A

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

4.1.6 Enhanced Community Health Worker (CHW) Services: SPA 24-0052

Enhanced CHW services are tailored preventive services for members with significant behavioral health needs, defined as members who meet the access criteria for specialty mental health and/or substance use disorder services. Enhanced CHW services may:

- Be provided in an individual or group setting.
- Address issues that include but are not limited to: control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and violence prevention.

- Enhanced CHW Services include:
    - Health education to promote the member's health or address barriers to health care, including providing information or instruction on health topics. The content of health education must be consistent with established or recognized health care standards. Health education may include coaching and goal setting to improve a member's health or ability to self-manage health conditions.
    - Health navigation to provide information, referrals, or support to assist members to:
        - Access health care, understand the health care system, or engage in their own care.
        - Connect to community resources necessary to promote a member's health, address health care barriers, or address health-related social needs.
    - Screening and assessment to identify the need for services.
    - Individual support or advocacy that assists a member in preventing a health condition, injury or violence.

4.1.7 Supported Employment: BHIN 25-009

The IPS model of Supported Employment is a community-based intervention that supports members living with significant behavioral needs to find and maintain competitive employment. Participation in IPS Supported Employment supports improved employment outcomes as well as improved self-esteem, independence, sense of belonging, and overall health and well-being.

4.1.8 Medication for Addiction Treatment (also known as medication assisted treatment (MAT) for Opioid Use Disorders (OUD): SPA 20-0006-A

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

HCPCS code H0033 with a National Drug Code (NDC) should be used to designate the administration of medication outside of the NTP and cannot be reported by the NTP.

4.1.9 Community-Based Mobile Crisis Intervention Services: State Plan Amendment 22-0043

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

Mobile crisis services include warm handoffs to appropriate settings and providers when the member 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 member is connected to ongoing care. Mobile crisis services are directed toward the member 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 member in addressing their behavioral health crisis and restore the member to the highest possible functional level.

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

Mobile crisis teams must be able to perform all mobile crisis service components. Service components include:

- **Crisis assessment** to evaluate the current status and environment of the member experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger, determining a short-term strategy for restoring stability and identifying appropriate follow-up care.
- **Mobile crisis response** consisting of an expedited on-site intervention with a member experiencing a behavioral health crisis with the goal of stabilizing the individual within a community setting and de-escalating the crisis.
- **Crisis planning** to develop a plan to avert future crises, including identifying conditions and factors that contribute to a crisis, reviewing alternative ways of

responding to such conditions and factors, and identifying steps that the member can take to avert or address a crisis.

- **Facilitation of a warm handoff** if the member requires urgent treatment in an alternative setting. The mobile crisis team must identify an appropriate facility or provider, and provide or arrange for transportation, as needed.
- **Referrals to ongoing supports** by identifying and connecting a member to ongoing behavioral health treatment, community-based supports, social services, and/or other supports that could mitigate the risk of future crises. This may include identifying appropriate services, making referrals or appointments, and otherwise assisting a member to secure ongoing support.
- **Follow up check-ins** to continue resolution of the crisis, provide further crisis planning, check up on the status of referrals, and provide further referrals to ongoing supports.

To claim 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 as defined here.

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

4.1.10 Patient Education: SPA 20-006-A

Patient Education is education for the member on addiction, treatment, recovery and associated health risks.

4.1.11 Peer Support Service: SPA 20-0006-A

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the process of recovery. Peer support services may be provided with the member 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 member by supporting the achievement of the member's treatment goal.

Peer support services are based on an approved plan of care and can be delivered as a standalone service. *Peer support services are an optional benefit that DMC State Plan counties may choose to offer*.

Peer support services include the following service components:

- Educational Skill Building Groups means providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members 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 members to participate in behavioral health treatment. Engagement may include supporting members in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by Peer Support Specialists 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 member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons.

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

However, DMC State Plan providers may deliver Peer Support Services to members receiving treatment at all DMC State Plan levels of care, including residential or inpatient levels of care. Members may concurrently receive Peer Support Services while receiving other DMC State Plan services. Peer Support Services must be claimed separately.

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

SUD Crisis Intervention Services consists of contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

4.2 DMC – State Plan Levels of Care

4.2.1 Intensive Outpatient Treatment (IOT): SPA 23-0026

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

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

4.2.2 Narcotic Treatment Program (NTP): SPA 23-0026

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

- Assessment
- Individual Counseling
- Group Counseling
- Patient Education
- Medical Psychotherapy

- Medication Services
- MAT for OUD
- SUD Crisis Intervention Services

Pursuant to Information Notice 15-028, NTP counseling is limited to 200 minutes per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP providers may bill and be reimbursed for additional counseling. Medical justification for the additional counseling must be clearly documented in the patient record and completed within 14 days of treatment.

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

Outpatient Treatment Services are provided to members as medically necessary.

Outpatient Services include the following components:

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

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

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

The components of Perinatal Residential Substance Use Disorder Treatment are:

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

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

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

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

4.2.6 CalAIM Justice-Involved Reentry Initiative: Behavioral Health Notice (BHIN) 23-059

As a result of the Justice-Involved Reentry Initiative, DMC counties may submit claims to SDMC for specified behavioral health care linkage services provided during the pre-release period. Codes that can be claimed to SDMC as part of the Justice-Involved Reentry Initiative are identified in the Service Table when column "JI Warm Linkage

Code?" contains a yes. All other pre-release services that could be delivered by county-based or county contracted providers, including clinical consultation, care management, and MAT should be billed by the behavioral health provider and not by the agency to CA-MMIS as either in-reach or embedded services. Please contact CA-MMIS at the contact email below for CA-MMIS claiming rules for services that are not warm linkage codes and that must be claimed to CA-MMIS.

For additional information please refer to BHIN 23-059. DHCS implemented the Justice-Involved Reentry Initiative on October 1, 2024. For questions pertaining to submitting justice involved claims to CAMMIS, please contact CalAIMJusticeAdvisoryGroup@dhcs.ca.gov.

CHAPTER FIVE – CLAIMS PROCESSING

5.0 Introduction

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

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

5.1.0 Accepting and Rejecting Claims

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

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

5.2.0 Approving and Denying Claims

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

5.2.1 Zero Dollar Claims

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

5.2.2 Member Share of Cost

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

5.2.3 Member Eligibility

Members must be enrolled in Medi-Cal during the month in which the service was rendered. The Client Identification Number (CIN) uniquely identifies each member. SD/MC verifies that the member 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 member 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 member's months of eligibility as recorded in MEDS. If the member was not enrolled in Medi-Cal during the month in which the service was rendered, the claim will be denied.

5.2.4 County of Residency/County of Responsibility

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

5.2.5 Member Date of Birth

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

5.2.6 Member Gender

The member's gender needs to be reported on the claim but will not be verified by SD/MC as of 7/1/2023. A claim that does not report the beneficiary's gender will be SNIP-rejected.

5.2.7 Member Date of Death

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

5.2.8 Dates of Services Within a Claim

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

5.2.9 Claims for Residential Stays that Cross One or More Months

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

5.2.10 Outpatient Service Lines and Date Ranges

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

5.2.11 Date of Service and Date of Submission

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

5.2.12 Duplicate Services

<u>24-Hour Services</u>

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

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

<u>Outpatient Services</u>

Outpatient services are listed in the service table. Except for peer support, group (H0025), sign language or oral interpretive services (T1013), interactive complexity

(90785), mobile crisis (H2011, place of service 15), and health behavior interventions for the family without the patient present (96170 and 96171), claims for group services/claims (ie, claims that have an HQ modifier or services that mean group), and T2024 (assessment substitute code), a procedure code is considered a duplicate if all of the following data elements are the same:

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

Duplicate services are not allowed.

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

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

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

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

Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the per diem rate. This only applies to the bundled inpatient and residential stay rates and does not include services that are not included in the bundled rate (e.g., care coordination). Interpretation also cannot be claimed for automated/digital translation or relay services. Interactive complexity (90785) and

interpretation (T1013) should not be claimed together. Counties may not claim for interpretation when claiming for mobile crisis services as the rate for mobile crisis incorporates interpretation.

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

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

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 a county submits a claim that includes psychiatric diagnostic evaluation 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.

5.2.14 Claim Timeliness – Original Claims

The timeline for initial submission of DMC-State Plan claims is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section WIC 14021.6(g)). An original claim submitted after 12 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied. Please see section 5.5 for more information about requesting a DRC. Please refer to Appendix 6 for a list of DRCs.

5.2.15 Service Facility Location

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

5.2.16 Service Facility Validation

Except for claims submitted for 1) BH-CONNECT providers and 2) Mobile crisis providers, SD/MC verifies that the service facility identified on the claim was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided and has a contractual agreement with the county submitting the claim. As discussed in

Section 2.3, DHCS records in the Provider Application and Validation for Enrollment each organizational provider's NPI number and the substance use disorder treatment services the provider is certified to render. SD/MC will deny a service line if the provider, as determined by the service facility NPI number on the claim, is not certified to provide the service billed.

5.2.17 Rendering Provider Taxonomy Code

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

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

SD/MC will deny all service lines for outpatient services where the first four characters of the rendering provider's taxonomy code does not identify a SD/MC Allowable Discipline for the procedure code on the service line. SD/MC does not verify the taxonomy code against the rendering provider's NPI. The AOD Counselor provider type is designated using the five-character taxonomy code 101Y**A**. Four-character taxonomy code 101Y refers to Licensed Professional Clinical Counselors.

The county is responsible for ensuring that each provider practices in accordance with applicable State of California licensure, certification, and/or Medi-Cal State Plan requirements.

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

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.
Rendering provider information should not be reported with day, residential, and mobile crisis services.

5.2.18 Clinical Trainees and Community Health Workers (CHW)

When claiming for clinical trainees, counties need to report a taxonomy code with the first four characters 1744 for medical students in clerkship or 3902 for all other Clinical Trainees, along with the appropriate procedure code modifier as indicated below to identify the type of Clinical Trainee. For example, to claim for a psychiatric diagnostic evaluation (CPT Code 90791), a Social Worker Clinical Trainee would use a taxonomy code with the first four characters 3902 and claim for the psychiatric diagnostic evaluation, using the procedure code: modifier combination 90791:AJ.

No.	Profession(s) Type	Taxonomy	Modifier
1.	Medical Student in Clerkship	1744	None
2.	LCSW, MFT or LPCC Clinical Trainee	3902	AJ
3.	Psychologist Clinical Trainee	3902	AH
4.	Registered Nurse Clinical Trainee	3902	TD
5.	Vocational Nurse Clinical Trainee	3902	TE
6.	Psychiatric Technician Clinical Trainee	3902	HM
7.	Occupational Therapist Clinical Trainee	3902	CO
8.	Nurse Practitioner/Clinical Nurse Specialist Clinical Trainee	3902	HP
9.	Pharmacist Clinical Trainee	3902	HO
10.	Physician Assistant Clinical Trainee	3902	None
11	Community Health Worker (CHW)	172V	None

When claiming for Clinical Trainees and CHWs, in addition to using the appropriate taxonomy and procedure code modifier, the supervisor's National Provider identifier (NPI) will be required on all claims for services rendered by Clinical Trainees and CHWs.

The supervisor's NPI must be reported at the claim level (loop 2310D) and/or at the service line level (loop 2420D). Specific details on how to report provider NPIs on 837P claims are documented in the ASCX12 5010 Implementation Guide available for purchase at https://wpc-edi.com/ . Claims for services provided by Clinical Trainees or CHWs that do not report a supervisor's NPI will be denied.

For clinical trainees, "supervisor" refers to the licensed clinician who co-signed the progress note and thereby assumed responsibility for the care the Clinical Trainee provided to the member. For CHWs, supervisor refers to the licensed or non-licensed

clinician who co-signed the progress note and thereby assumed responsibility for the care the CHW provided to the member. The supervisor's NPI needs to be on the claim. SDMC will validate the supervisor's NPI against data in the National Plan & Provider Enumeration System (NPPES). Claims for services rendered by Clinical Trainees or CHWs that do not contain a valid supervisor's NPI will be denied with adjustment group, reason code, and remarks code CO/208/N297.

The county must ensure that the licensed clinician supervising the Clinical Trainee or CHW meets the minimum qualifications described by the applicable licensing board. Please refer to the Service Table for the service codes each new provider type can claim.

5.2.19 Place of Service Codes

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

If a member received two outpatient services on the same day that were reported using the same procedure code and were rendered by the same rendering provider, county should report the place of service where the majority of the service occurred.

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.

5.2.20 Level of Care Modifiers

All services are required to be submitted with a level of care modifier. The following levels of care modifiers are used by DMC – State Plan Counties:

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

Services will be denied if a procedure modifier defining level of care has not been submitted or if the submitted outpatient procedure code is not allowable with the submitted modifier(s). Refer to the Service Table for a list of the valid procedure/modifier combinations. Claims for NTP services must be submitted with both HG and UA modifiers. Claims for standalone MAT should be submitted with the level of care for which these services were provided. MAT services can be provided from non-residential levels of care concurrent with a member's residential admission.

5.2.21 Perinatal and Non-Perinatal Services

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

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

5.2.22 Dependent Codes

The service table lists all outpatient procedure codes. The procedure codes listed in Column A 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 member in history.

5.2.23 Units of Service - Outpatient Services

All claims for outpatient services must bill using units. Column T, labeled "Maximum Units that Can be Billed per Rendering Provider 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 Member per Day" Column. Only the time it takes to provide direct services associated with that code can be counted toward a unit of service.

5.2.24 Maximum Units - Outpatient Services

All claims for outpatient services must use units of service. Column R, labeled "Maximum Units that Can be Billed per Member 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 Member 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. The primary procedure code and add on code must be submitted on the same claim. SD/MC will deny a service line billed with an add-on procedure code if the primary procedure code is not present in the same claim.

5.2.25 How To Select Codes Based on Time

Column D of the Service Table, "Minimum Time Needed to Claim 1 Unit" states the minimum time of direct patient care associated with one unit of the code in column A 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 when the time is continuous. Column F "Can This Code be Extended?" states when the code can be extended and if HCPCS Code T2024 should be used in its stead at a specified time. Please note that the Payment Reform Frequently Asked Questions document discusses the substitution rules at length.

A disruption in the service does not create a new, initial service. For example, if a clinician begins assessing a member and spends five minutes doing so but the assessment is interrupted and the provider assesses the member at a later time on the same day, the provider may "roll up" the units of assessment if they passed the midpoint or claim for the assessment after the interruption. However, the whole service is the same assessment. The calculations displayed in the two columns reflect the rules outlined below.

Most Codes

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 31 minutes of psychiatric diagnostic evaluation in the morning and 20 minutes of psychiatric diagnostic evaluation in the afternoon, the provider will claim one unit of 90791 (psychiatric diagnostic evaluation) because 31-60 minutes of psychiatric diagnostic evaluation had been provided. There are, however, exceptions to the midpoint rule detailed in the following sub-sections.

Codes with Defined Time Ranges

Some codes, such as Evaluation and Management (E&M) codes have defined time ranges and are not subject to the midpoint rule. When claiming these codes, when a provider delivered the lower bound of the service indicated in the range, they can claim one unit of that code. For example, when selecting a unit of an E&M code (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.

Codes To Which the American Medical Association (AMA) Does Not Assign a Time

The AMA did not assign a time to a unit of service for all the codes listed in the CPT Codebook. In situations where this occurs, the Medicare-assigned time will be used to describe one unit of service of those codes whenever possible. The codes to which this applies and how much service must be provided before a county can claim for one unit of service are listed in the table below.

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
90791	Psychiatric diagnostic evaluation	60 mins	At 31 minutes of service
90792	Psychiatric diagnostic evaluation with medical services	60 mins	At 31 minutes of service
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)	90 mins	At 46 minutes of service
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	60 mins	At 31 minutes of service

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	50 mins	At 26 minutes of service
96160[1]	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	15 mins	At 8 minutes of service

[1] Medicare does not assign a time to these codes. The 15-minute time per unit of service was therefore retained.

T-Codes and Medicare

Medi-Cal is the payor of last resort. Therefore, counties serving members who are dually covered by Medicare must claim reimbursement from Medicare using the appropriate CPT code(s) before submitting a claim with HCPCS code T2024 to Short Doyle. The county must claim reimbursement from Medicare pursuant to Medicare's rules.

For example, consider a provider that spends 100 minutes to complete a psychiatric diagnostic evaluation (90791). CPT code 90791 is a 60-minute code. Since 100 minutes exceeds the time basis for CPT code 90791, the county should report seven units of T2024 when submitting the claim to Short Doyle. CPT code 90791 should be reported to Medicare. DHCS would reimburse the county for the seven units of T2024 at the county-specific rate for the Medicare recognized rendering provider listed on the claim, less the Medicare COB amount.

5.2.26 Other Health Coverage – Medicare

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

difference between the amount it would normally pay and the amount that Medicare already paid.

Medicare Plans Exempt from Medicare COB

Cal MediConnect plans combine the benefits of Medicare and Medi-Cal in one plan. Therefore, if a beneficiary is enrolled in a Cal MediConnect plan, the county can submit a claim to SDMC directly.

Medicare Eligible Services

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

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

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

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

NTP services and Medicare Part B members:

Medicare Part B reimburses Opioid Treatment Programs (OTPs) a weekly rate for a bundle of services that includes dosing, individual counseling, and group counseling. When billing NTP services for a member that has Medicare Part B, all dates of service on the claim must fall within a 7-day calendar window associated with the Medicare Part B payment. Services submitted outside of the 7-calendar day window will be denied. For example, if a claim submitted for NTP services rendered to a Medicare Part B member, indicates services were rendered on dates of service between November 3 and November 12 (10 calendar days), services with dates of service from November 10 and

after, which fall outside the 7-calendar day window, will be denied. Please see BHIN 21-065 for additional guidance on billing for NTP services for dual eligible members.

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

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

Medicare Recognized Providers

The Medi-Cal state plan identifies some provider types that are eligible to render DMC 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. Licensed clinical social worker
5. Clinical psychologist
6. Licensed Marriage and Family Therapists
7. Licensed Professional Clinical Counselors

Effective January 1, 2024, Marriage and Family Therapists (MFTs) and Mental Health Counselors (LPCCs in California) can bill Medicare independently for their services for the diagnosis and treatment of mental illnesses. 5. Medicare has established requirements for MFTs that are more stringent than California. If an MFT does not meet the above requirements (e.g., if part of the MFT's 3,000 hours or two years of clinical supervised experience were accrued before the individual obtained the applicable doctor's or master's degree), they should claim SD/MC directly and use modifier HL. The system has been updated in March and the change is retroactive to the date of the federal final rule to ensure that counties will be able to claim for all services provided.

Section 4121, Division FF of the Consolidated Appropriations Act (CAA) of 2023 defines an MFT as an individual who:

1. Possesses a master's or doctorate degree which qualifies them for licensure or certification as a MFT under State law of the State in which such individual furnishes marriage and family therapy services, and
2. Is licensed or certified as an MFT by the State in which they furnish services,
3. Has performed at least two years of clinical supervised experience in marriage and family therapy or mental health counseling after obtaining the degree referenced above.

Section 4121 Division FF of the CAA, 2023, defines an LPCC as an individual who:

1. Possesses a master's or doctorate degree which qualifies for licensure or certification as a Mental Health Counselor (MHC), clinical professional counselor, or professional counselor under State law of the State in which such individual furnishes MHC services,
2. Is licensed or certified as an MHC, clinical professional counselor, by the State in which they furnish services, and
3. Has performed at least two years of clinical supervised experience in mental health therapy or mental health counseling after obtaining the degree referenced above.

5.2.27 Other Health Care Coverage – Non-Medicare

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

Services that can be billed directly to Medi-Cal

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

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

3. Claims for Peer Support services (H0025 and H0038)

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

5.2.28 Institutions for Mental Disease (IMDs)

Services provided to members 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 member is 65 years or older or under 22 years old receiving services in an inpatient psychiatric facility. DHCS posts a list of facilities that are classified as an IMD on the Institution for Mental Diseases List.

5.2.29 Lockout Rules

Outpatient Lockouts:

SD/MC enforces two types of lockout rules. The California Code of Regulations prohibits some specialty mental health services from being provided to a member 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 member 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 member unless certain conditions are met. SD/MC will also deny a claim for a service when NCCI prohibits that service from being provided to a member 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 member on the same day. Excel column A, 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 A when provided to the same member 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 A under extraordinary circumstances.

Target codes are listed in Column K. The combination of the Code in Column A and each lockout code in Columns J or K represents a lockout situation when both are provided to the same member by the same provider on the same day. SD/MC will deny a claim for a

service if it produces a lockout situation, when combined with a service approved in history, unless one of the codes is a target code with an over-riding modifier.

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

Appendix 7 explains the method used to look up outpatient lockouts.

Medication Services Lockouts:

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

5.2.30 Pregnancy Indicator

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

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

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

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

5.2.32 Covered Diagnosis

Residential claims must have at least one DMC **covered** substance use disorder ICD-10 diagnosis code as indicated in Appendix 5-Covered Residential Diagnoses. A covered diagnosis codes are a subset of valid ICD-10 codes. Counties are required to use the

appropriate ICD-10 codes to submit residential claims for reimbursement. If the diagnosis code is not a covered ICD-10 code, the service will be denied.

Outpatient claims must have a **valid** substance use disorder ICD-10 diagnosis code. Valid substance use disorder ICD-10 diagnostic codes are published by CMS.

5.3.0 Replacing Approved and Denied Claims

Replacement claims for **previously approved claims** must be submitted within 15 months from the date of initial payment issued. If the replacement claim is submitted after this 15-month period, the replacement claim will be denied.

A replacement claim can be submitted if an 835 has been issued and if the claim being replaced has not been voided. Replacement claims for outpatient services, day services, or 24-hour services must have the Billing Employer Identification Number. The replacement claim must match two of the following four data elements in the original claim or the replacement claim will be denied: Procedure code or revenue code (as appropriate), date of service, place of service, and service facility NPI.

5.4.0 Replacing Late Claims Due to CalAIM Claiming Challenges

Counties may use an expedited procedure to replace claims that are submitted more than 15 months from the original month of service for previously approved or denied DMC claims. To use this expedited procedure on late claims, counties should submit those claims with Delay Reason Code 9.

Delay Reason Code 9 is only allowed for use with true replacement claims where the original claim was previously submitted to SD/MC for adjudication and not denied for late submission.

Counties do not need to submit a Formal Reason for using the Delay Reason Code 9 to MedCCC if they are using it only due to CalAIM claiming challenges. However, the county needs to provide a document on county letterhead to MedCCC via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC that provides the following information:

- List reason for request: This is a request to utilize DRC 9 for replacement claims that are being submitted more than 15 months after the original month of service due to CalAIM clinical challenges.
- The months of service, number of claims for each month, and total dollar amount for those claims for each month.
  Example: July 2023-18 claims-$176,391.59

5.5.0 Voiding Approved Claims

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

5.6.0 Requesting Delay Reason Codes

Counties 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 claim is because proof of eligibility was unknown or unavailable, due to litigation, there was a delay in certifying the provider, there was a third party processing delay, there was a delay in eligibility determination, special circumstances that cause a billing delay such as a court decision or fair hearing, determination by DHCS that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control. Please refer to Appendix 6 for a list of DRCs. Please contact MEDCCC via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC to request a DRC. If you do not yet have access, please reach out to your designated county manager to request.

CHAPTER SIX – FUNDING

6.0 Introduction

Drug Medi-Cal services are financed with a combination of federal, state, and county funds. The proportion of the approved claim paid with federal, state, and county funds depends upon the service rendered and the member 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.

- Federal Share – FMAP Percentage and Aid Codes
- State Share and Proposition 30
- One Hundred Percent County Funded

6.1.0 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 member's aid code. If a member 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 member enrolled in Medi-Cal, including State Only Medi-Cal, who is pregnant is 65 percent of the total approved amount. The service line must set the pregnancy indicator to yes to indicate the member 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 member enrolled in the State Only Medi-Cal program is 0 percent. The federal government does not reimburse states for the cost of non-pregnancy services provided to members with unsatisfactory immigration status.

6.2.0 State Share and Proposition 30

The State realigned financial responsibility for Drug Medi-Cal Services to the counties in 2011 as part of 2011 Public Safety Realignment. The voters approved Proposition 30 in the November 2012 election, which added Section 36 to the California State Constitution. Proposition 30 requires the state to reimburse counties a portion of the

non-federal share of increased costs incurred to implement new requirements in the Drug Medi-Cal Program after the 2011 realignment. More specifically, the state must reimburse counties one hundred percent of the non-federal share for new requirements imposed by the State and fifty percent of the non-federal share for new requirements imposed by the federal government. This section of the billing manual discusses those Drug Medi-Cal services that counties must provide as a result of a state-imposed requirement and a federally imposed requirement; and how counties must submit claims for those services so that the State reimburses the county the appropriate portion of the non-federal share with State General Funds.

6.2.1 State Required Proposition 30 Services

The state will reimburse counties 100 percent of the non-federal share for DMC services provided as a result of a new state requirement implemented after 2011 realignment. Either the member 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 member's aid code to identify the service as a state requirement.

If a member 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 member 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 member is eligible as a result of Senate Bill (SB) 75, young adult expansion, older adult expansion, adult expansion, or is receiving continuum of care services, the state will be responsible for one hundred percent of the non-federal share.

6.2.1.1 Medi-Cal Optional Expansion Full Scope Members

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

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

The state will also reimburse DMC counties one hundred percent of the non-federal share for all warm linkage services with dates of service October 1, 2024 and later when those warm linkage services are provided to justice involved members 90 days before their release. Codes that can be claimed to SDMC as part of the Justice-Involved Reentry

Initiative are identified in the Service Table when column "JI Warm Linkage Code?" contains a yes.

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

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

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

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

Young Adult Expansion

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

Older Adult Expansion

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

Full-Scope Adults Aged 26 through 49 Medi-Cal Expansion

Adults ages 26 through 49 are eligible for full-scope Medi-Cal regardless of immigration status, as long as they meet all other eligibility requirements. As a result, adults who have unsatisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which members are eligible for the State Only Medi-Cal Program as a result of older adult expansion by the members' aid code. The state will reimburse counties 100 percent of the non-federal share for all services provided to members enrolled through Adult Expansion.

6.2.2 Community-Based Mobile Crisis Services

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

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

6.2.3 Federally Required Proposition 30 Services

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

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

6.2.4 One Hundred Percent County Funded

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

Qualified Non-Citizens

California provides full scope Medi-Cal benefits to Qualified Non-Citizens who are not federally eligible because they have not been in the United States for at least five years. Federal reimbursement is not available for non-pregnancy services provided to Qualified Non-Citizens enrolled through the State Only Medi-Cal Optional Expansion Program.

State reimbursement is not available for DMC services provided to Qualified Non-Citizens unless the service was provided as a result of a State Requirement as described in Section 6.2.1 or unless the member is pregnant. Counties are responsible for 100 percent of the cost of all other services provided to Qualified Non-Citizens.

Permanently Residing Under Color of Law (PRUCOL)

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

Minor Consent Members

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

CHAPTER SEVEN – 2025 CPT UPDATES

The American Medical Association's (AMA) CPT Professional Edition Codebook with Rules and Guidelines is updated annually. CPT codes 99441, 99442, and 99443 have been deleted effective January 1, 2025. A claim that contains any of the deleted codes will be rejected. Effective January 1, 2025, counties should replace CPT codes 99441-99443 as follows:

Deleted Code	Definitions	Replacement Code: Modifier	Definitions
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian.5-10 mins of medical discussion	99202:93/99212:93[1]	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination. 99202: 15-29 mins; 99212: 10-19 mins.
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian. 11-20 mins of medical discussion.	99202:93/99212:93[1]	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination. 99202: 15-29 mins; 99212: 10-19 mins.

[1] Please use CPT code 99202:93 if the patient is new and use CPT codes 99212 or 99213 if the patient is an existing patient.

Deleted Code	Definitions	Replacement Code: Modifier	Definitions
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian. 21-30 mins of medical discussion	99202:93/ 99213:93[1]	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination. 99202:15-29 mins; 99213: 20-29 mins.

Please refer to the CPT codebook for further information on how to use these codes.

The CPT Codebooks include the following information:

- Complete rules on how to claim for a specific code or code category;
- Complete code definitions;
- References to codebooks that contain documentation guidance associated with each code;
- Information on which codes have been deleted and the effective date of the deletion; and
- Instructions on which codes have been renamed and/or re-defined and how they should be claimed.

Counties are therefore encouraged to consult AMA's CPT codebooks regularly for appropriate coding practices.

[1] Please use CPT code 99202:93 if the patient is new and use CPT codes 99212 or 99213 if the patient is an existing patient.

Counties should note however that DHCS' rules may be more restrictive than the rules described in the CPT codebooks. As a result, the CPT codebooks should be used in conjunction with this billing manual.

CHAPTER EIGHT– ADDENDUM TO THE SERVICE TABLE

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

DMC - State Plan Counties:

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

The Service Table contains the following columns:

1. Code: This lists the procedure code.
2. Code Type: This column describes the service type that a particular code was placed in. A code may be grouped in the following service types:
    a. Assessment: Assessment consists of activities to evaluate and monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Assessment shall be conducted in accordance with applicable State and Federal laws, regulations, and standards. Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:
        - Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
        - Diagnosis of substance use disorders utilizing the current DSM assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under "Other

laboratory and X-ray services" benefit of the California State Medicaid Plan)

- Treatment planning, a service that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of a member to their best possible functional level.

b. Crisis Intervention: Crisis intervention services consist of contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD crisis intervention services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation and be provided in the least intensive level of care that is medically necessary to treat the condition.

c. Discharge Services: Discharge services include coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

d. Group Counseling: Group counseling consists of contacts with multiple members at the same time. Group counseling focuses on the needs of the participants and is provided to a group that includes 2-12 individuals.

e. Individual Counseling: Individual counseling consists of contacts with a member. Individual counseling can include contacts with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

f. Medication Services: Medication services include prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and Other non-Opioid Substance Use Disorders.

g. Mobile Crisis: Community-based mobile crisis services provide rapid response, individual assessment and community-based stabilization for Medi-Cal members who are experiencing a mental health and/or SUD (behavioral health) crisis. Mobile crisis services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and

stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

h. Peer Support Services: Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources and to educate members and their families about their conditions and the process of recovery.

i. Treatment Planning: Treatment Planning is a service activity that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of a member to their best possible functional level.

j. Supplemental Services: Supplemental service codes are codes that describe additional and simultaneous services that were provided to the member during the visit or codes that describe the additional severity of the patient's condition. For example, T1013 indicates that interpretation was provided during the visit while 90785 indicates that certain factors increase the complexity of a patient's treatment. Supplemental codes cannot be billed separately. They have to be billed with another (primary) procedure.

3. Service (Brief Definition) based on 2024 Rules: This column provides a **brief** description of the procedure. Most descriptions are self-explanatory but there are a few items that should be noted.

   a. New vs. established patients: Some evaluation and management (E/M) codes are described as being services for a new or established patient and should be billed accordingly. For these codes:

      i. A new patient means an individual who has not received any professional services from the physician/qualified healthcare professional; or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years

ii. An established patient is an individual who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

iii. Refer to the CPT Codebook, E/M Services Guidelines for additional information on new and established patients.

b. Qualified healthcare professional: In the context of E/M codes, "qualified healthcare professional" usually means a physician, physician assistant or advanced practice nurse. In general, E/M services can be rendered by a physician, physician assistant, or nurse practitioner. Please also note that the service descriptions provided in the Service Table are brief descriptions. For full descriptions of the services, please consult the CPT Codebook. CPT Codebooks are copyrighted to the American Medical Association (AMA) and are commercially available for purchase. AMA publishes CPT errata and technical corrections throughout the year on the AMA website dedicated to this purpose.

c. Time: Each code is associated with a length of time or time range as part of the service description. DHCS policy will only consider the time it takes to provide direct services associated with that code as part of time.

d. Add-on/Prolonged Codes: Codes that prolong other codes are considered dependent codes. They will state that they are additional or prolonged codes in the description.

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

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

6. Can This Code Be Extended With an Add-on or Prolonged Code?: This column specifies whether the code in column "Code" can be extended with an add-on or prolonged service code. A "Yes" in this column means that this code can be extended with an add-on or prolonged service code and a "No" in this column either means that it cannot be extended with an add-on or prolonged service code. A code may not be extended for one of two reasons: 1) the time

associated with the service is limited to the service associated with the service code and additional service time will not be reimbursed or 2) if additional time needs to be reported, it should be reported via the next code in the series. The column also specifies whether HCPCS code T2024 can be used to substitute for this code and at what point they may be used.

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 or five alpha-numeric characters of the relevant taxonomies is located in Appendix 1-Taxonomy Codes. The county is responsible for ensuring that providers deliver services within their scope of practice. If a service is performed by an individual registered with the appropriate board or resident, the service code should have 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. In addition, if an MFT/LPCC does not meet the requirements to register as a Medicare provider (e.g, if part of the MFT's 3,000 hours or two years of clinical supervised experience were accrued before the individual obtained the applicable doctor's or master's degree), they should use modifier HL. 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 procedure codes are allowed. Refer to Table 2-Place of Service Codes for Professional Claim for a description of the Place of Service codes. If a claim does not list a place of service, it will be denied. If a service is provided via telehealth, the place of service **must be** either 02 or 10 unless the service is mobile crisis. No service code may be claimed for place of service 09.
10. Outpatient Non-Overridable Lockout Codes: Some outpatient codes cannot be billed together under any circumstances. This column lists those outpatient codes that cannot, in any circumstances, be claimed with the code in column "Code".

11. Outpatient Overridable Lockouts with Appropriate Modifiers: Some codes can only be billed together in extraordinary circumstances. The codes that can be billed with the code listed in column "Code" under extraordinary circumstances are listed in this column. If a code 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 codes.
12. Locked Out Against Residential: This column indicates whether the outpatient code in column "Code" can be billed with a residential service. A "No" in this column means that the outpatient code can be billed with a residential service and a "Yes" in this column means that it cannot be billed with a residential service.
13. Dependent on Codes: Some codes can only be billed after certain other codes are billed. If there are codes listed in the "Dependent on Codes" column, those codes must be billed **before** the procedure in question. The dependent codes must be billed on the same claim as the primary code(s). If the column states "None," then the codes in column "Code" can be billed alone. Only one code can be submitted per line so dependent codes would need to be on the same claim but on a different line than the code they are dependent on.
14. Units of T1013 Associated with 1 Unit of Code: This column specifies how many units of sign language or oral interpretive services can be claimed with one unit of the code in column "Code". Sign language or oral interpretation must be submitted on the same claim as the code in column "Code". Claims for interpretation may not exceed the time associated with claims for the code in column "Code". One unit of sign language or interpretation is equal to 15 minutes.
15. Units of 96170 Associated with 1 Unit of Code: This column specifies how many units of initial health behavior intervention, family (without the patient present) can be claimed with the code in column "Code". Initial health behavior intervention must be submitted on the same claim as the code in column "Code". Claims for initial health behavior intervention may not exceed the time

associated with the claim for the code in column "Code". One unit of initial health behavior intervention is equal to 30 minutes.

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

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

18. JI Warm Linkage Code: This column specifies whether counties will be able to claim this warm linkage services code if that service is provided before a member's release through SDMC.

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

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

CHAPTER NINE– APPENDICES

Appendix 1-Taxonomy Codes

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

Taxonomy codes reflect the professions in the State Plan. Any taxonomy codes that describe a specific rendering provider can be used on an 837P form.

To indicate that the service was provided by a registrant 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 alphanumeric codes that can be used to describe that discipline. Please note that in the case of AOD Counselors, the first **five** alpha numeric characters are displayed.

The below taxonomy codes are effective for dates of service 1/1/2025 and after. For taxonomy codes that were in effect for dates of service before 1/1/2025, please refer to previous versions of this billing manual.

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Alcohol and Other Drug Counselors (AOD Counselors)	101YA
	146D
	146L
	146M
	146N
	171M
	374K
	2258
	2260
	4053
Licensed Vocational Nurse	164W
	164X
Marriage and Family Therapist (MFT) or Licensed Professional Clinical Counselor	1012
	101Y
	102X
	103K
	106H
	1714

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	222Q
	225C
	2256
Clinical Trainee	3902
Community Health Workers	172V
Other Qualified Provider	171R
	3726
	373H
	374U
	376J
Nurse Practitioner (NP)	363L
Occupational Therapist	225X
Medical Student in Clerkship	1744
Medical Assistant	363A**M**
Licensed Psychiatric Technician	106S
	167G
	3747

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Pharmacist (Pharma)	1835
Physician Assistant (PA)	363A
Physician (LP)	202C
	202D
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081
	2082
	2083
	2084
	2085
	2086
	2088
	208C
	208D
	208G
	208M

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

Appendix 2- Definitions

American Indian/Alaska Native (AI/AN): Any person defined in 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 CFR section 136.12.

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

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

Clerkship or Rotation: According to the Accreditation Council for Graduate Medical Education (ACGME), a clerkship is an educational experience of planned activities in selected settings, over a specific period, developed to meet specific goals and objectives of the program. A medical student in clerkship has been introduced to the core competencies of medical education at the beginning of their medical school curriculum and will have demonstrated competence in those skills prior to clerkship/rotation.

Clinical Trainee: A clinical trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provide rehabilitative mental health services, including, but not limited to, all coursework and supervised practice requirements.

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

Community Health Worker (CHW): CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served. Historically, CHWs have been employed across public health, medical, and behavioral health settings CHWs must demonstrate minimum qualifications through one of the following pathways:

- Certificate Pathway:
  - CHW Certificate: A certificate of completion, including but not limited to any certificate issued by the State of California or a State designee, of a curricula that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health, as determined by the supervising provider. Certificate programs shall also include field experience as a requirement.
  - Violence Prevention Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban peace institute.

    A Violence Prevention Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services shall demonstrate qualification through either the Work Experience pathway or by completion of a General Certificate.
  - Work Experience Pathway: An individual who has 2,000 hours working as a CHW in paid or volunteer positions within the previous three years, and has demonstrated skills and practical training in the areas described above, as determined by the supervisor, may provide CHW services without a certificate of completion for a maximum of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Medi-Cal beneficiary.
- All CHWs must complete a minimum of 6 hours of continuing education training annually.

Dependent Procedure: These are procedure codes that either indicate that time has been added to a primary procedure (i.e., add-on codes) or modify a procedure (i.e., supplemental codes). Dependent procedures cannot be billed unless the provider first bills primary procedure to the same member 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. Counties should only consider direct patient care time, as defined in the billing manual, when choosing the most appropriate code to bill. However, this does not mean that counties would not be reimbursed for activities such as chart review, documentation, and other activities associated with preparing to see a patient or post service time. The rates DHCS pays to counties are adjusted to incorporate the cost for staff time not spent on direct patient care, which includes activities the provider engages in before and after seeing a patient, and "no shows".

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

Indian: Means any individual defined at 25 USC 1603(13), 1603(28), 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian Tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those Tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian Health Care Provider (IHCP): Is a health care program operated by the IHS ("IHS facility"), an Indian Tribe, a Tribal Organization, or Urban Indian Organization (otherwise known as I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. Section 1603).

Indian Health Service (IHS) Facilities: Facilities and/or health care programs administered and staffed by the federal Indian Health Service.

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

Medical Assistant: A medical assistant is an individual who is at least 18 years of age, meets all applicable education, training and/or certification requirements, and provides administrative, clerical, and technical supportive services, according to their scope of practice, and provides services under the supervision of a licensed physician and surgeon as established by the corresponding state authority, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant.

Registrant: A registered, pre-licensed mental health professional who is registered with the appropriate licensing board and working in a clinical setting under supervision. A registrant 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 in order to bypass the Medicare COB requirement

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. A resident should use the GC modifier to bypass the Medicare COB requirement.

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

Services Provided by Registrants/Residents: To indicate that the service was provided by a registrant 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 enrolled in a post-secondary educational degree program in the State of California but who are not yet in practicum. These individuals should use a taxonomy code within the Alcohol and Other Drug Specialist or Certified Peer Specialist categories as appropriate.

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

Tribal 638 Providers: Federally recognized Tribes or Tribal organizations that contractors compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.

- Tribal 638 providers enrolled in Medi-Cal as an Indian Health Services Memorandum of Agreement (IHS-MOA) provider must appear on the "list of American Indian Health Program Providers" set forth in APL 17-020, Attachment 1 in order to quality for reimbursement as a tribal 638 Provider as specified in BHIN 22-020.
- Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC provider are governed by and must enroll in Medi-Cal consistent with the Tribal FQHC criteria established in Supplement 6, Attachment 4.19-B of the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal Federally Qualified Health Center Providers", which is set forth on Attachment 2 to APL 21-008.

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. Member's Last Name
11. Member's First Name
12. Member's Suffix
13. Member's Address
14. Eligibility Worker Code
15. Client Index Number
16. Government Responsibility
17. County Case ID

18. The aid code under which the member is eligible
19. Member's Serial Number
20. Recipient's Family Budget Unit
21. Member Person Number
22. Special Status-Federal Financial Participation Indicator
23. Special Status: Indicates if the member has ever been known to either California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP) or both.
24. Member's current eligibility year
25. Member's current eligibility month
26. Aid code under which member is eligible
27. County of responsibility
28. County of residency
29. Member's eligibility status
30. Share of cost amount the member is obligated to meet
31. Member's Medicare status: do they Medicare Part A, Part B, or Part D
32. Member'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 member's enrollment in an associated health plan

37. The Medi-Cal managed care plan in which the member has been enrolled or dis-enrolled
38. Member's health care coverage by an insurance company
39. Identifies if the member has been placed on or removed from restricted status
40. Identifies the aid code under which the member is eligible for the specific Special Program.
41. Identifies the county of responsibility for the specific Special Program aid code
42. Member'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 member 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. Member's gender
4. Member's primary ethnicity code
5. Member's spoken language code
6. Member's written language code
7. Government Responsibility indicator
8. Member's first and last name
9. Member's date of birth
10. Eligibility termination date
11. Member's current primary eligibility aid code and county identification
12. County of responsibility
13. County of residency
14. MEDS current renewal date
15. Reason for termination
16. Current eligibility status
17. County ID

18. Eligibility worker code
19. Case name
20. District code
21. Annual re-determination due month
22. Latest re-determination completed date
23. Member's address
24. Member's primary and alternate phone numbers
25. Member's primary aid code history by month
26. Member's eligibility status and history by month
27. County of responsibility and history by month
28. Share of cost amount, current and by previous months
29. Share of cost certification day, current and in previous months
30. Health insurance claim number
31. Health care plan status reason code (current and by previous months)
32. Health care plan enrollment status (current and by previous months)
33. Health care plan code (current and by previous months)
34. Other coverage (current and by previous months)
35. First, last name and middle initial of the authorized representative
36. Authorized representative's address
37. Date of Death

38. Source of the date of death information
39. Country of origin
40. Current Special Program 1 County identification
41. Special Program 1 worker code
42. Special program 1 district
43. Special program 1 case name
44. Special program 1 annual redetermination due month
45. Special program 1 latest re-determination completed date
46. Special program 1 eligibility status (current and by previous months)
47. Special program 1 county code by month
48. Special program 1 aid code by month
49. Current Special Program2 County identification
50. Current Special Worker 2 Code
51. Special Program 2 District
52. Special Program 2 Case Name
53. Special program 2, annual redetermination due month
54. Special program 2 latest redetermination completed date
55. Special program 2 eligibility status (current and by previous month)
56. Special program 2 county code by month
57. Special program 2 aid code by month

58. Mail delivery address data
59. Last line of mailing address
60. Current Special Program 3 County Identification
61. Current Special Worker 3 Worker code
62. Special program 3 eligibility status (current and by previous month)
63. Special program 3 county code (current and by previous month)
64. Special program 3 aid code (current and by previous month)
65. Special program termination reason
66. Medicare Part A change date
67. Source of the information about Medicare Part A change
68. Source of the information about Medicare Part A change
69. Medicare Part B change date
70. Source of information about Medicare Part B change
71. Medicare Part D change date
72. Source of information about Medicare Part D change
73. Medicare Parts A/B status (current and by previous months)
74. Medicare Part D status (current and by previous months)
75. Medicare Part A entitlement start date
76. Medicare Part B entitlement start date
77. Restricted special program services code (current and by previous month)

78. Current food stamp identification number
79. County case name/current food stamp information
80. Food stamp eligibility status (current and by previous month)
81. Food stamp county identification by month
82. Special Program 1 termination reason
83. Special program 1 termination date
84. Special program 2 termination reason
85. Special program 2 termination date
86. Medicare member identifier
87. Date Medi-Cal application filed
88. Medi-Cal application flag
89. Date Medi-Cal application denied
90. Reason Medi-Cal application denied
91. Family size in Medi-Cal application
92. Medi-Cal application status
93. Medi-Cal application status date
94. Relationship to applicant
95. Special program 3 district
96. Special program 3 case name
97. Special program 3 annual redetermination due month

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

Appendix 5- Covered Diagnoses

ICD-10 Code	Code Description
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.130	Alcohol abuse with withdrawal, uncomplicated
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium

ICD-10 Code	Code Description
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid use, uncomplicated
F11.11	Opioid use, in remission
F11.120	Opioid use with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.13	Opioid abuse with withdrawal

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

ICD-10 Code	Code Description
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.13	Cannabis abuse with withdrawal
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.23	Cannabis dependence with withdrawal
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission

ICD-10 Code	Code Description
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced mood disorder
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic, or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium

ICD-10 Code	Code Description
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.11	Cocaine abuse, in remission
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.13	Cocaine abuse, unspecified with withdrawal
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated

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

ICD-10 Code	Code Description
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.11	Hallucinogen abuse, in remission
F16.120	Hallucinogen abuse with intoxication, uncomplicated

ICD-10 Code	Code Description
F16.121	Hallucinogen abuse with intoxication with delirium
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.11	Inhalant abuse, in remission
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified

ICD-10 Code	Code Description
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.11	Other psychoactive substance abuse, in remission
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances

ICD-10 Code	Code Description
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19.131	Other psychoactive substance abuse with withdrawal delirium
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance
F19.14	Other psychoactive substance abuse with psychoactive substance-induced disorder
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance abuse-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance

ICD-10 Code	Code Description
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder

Appendix 6- Drug Medi-Cal Delay Reason Codes (DRC)

DRC No	DRC Reason	Examples	Requirements	Notes
1	Proof of Eligibility Unknown or Unavailable	Patient or legal representative's failure to present Medi-Cal identification	Proof of eligibility indicating the date eligibility was received	N/A
2	Litigation	Initiation of legal proceedings to obtain payment from a liable third party pursuant to Welfare & Institutions Code Section 14115(a)	Written copies of pleadings	N/A
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules	Errors due to 5010 Conversion Delays	Letter from County Director	Can be used on a replacement claim

DRC No	DRC Reason	Examples	Requirements	Notes
10	Administration Delay in the Prior Approval Process	Special circumstances that cause a billing delay such as a court or fair hearing decision or retroactive SSI/SSP	a) County Letter of Authorization (LOA) indicating a court order or fair hearing decision b) County LOA indicating SSI/SSP eligibility and the SSA award letter c) Written explanation from the County describing the circumstances and date of occurrence.	No date limit

Appendix 7- Determining Hard and Over-ridable Lockouts

DHCS updates outpatient lockouts on an annual basis. To do so, DHCS looks up the non-overridable and over-ridable lockouts on the CMS website which is located at Medicaid NCCI Edit Files | CMS . DHCS uses the first Quarter (Q1) files titled 20XX_Q1_PTP_Edits -Practitioner Services and 20XX_Q1_NCCI_PTP_Edits-Outpatient Hospital Services.

In these files, DHCS looks at the relationship between codes in Column 1 and Column 2. Column 1 has the primary code and Column 2 has the secondary code. The secondary code is the *only* code that must be claimed with an appropriate modifier if the lockout can be over-ridden. If the indicator for the codes in Column 1 and Column 2 is 0, the two codes can never be claimed together. If the indicator is 1, the two codes can be claimed together if the code in Column 2 has an over-ridable modifier. If the indicator in Column 2 is 9, the indicator was ignored. The relationship between the two codes is only examined when the deletion date is null (blank).

For example, in a situation where 90791 is the primary code and 90832 and 99605 are the potential secondary codes, the Practitioner Service table displays the relationships as follows:

Column 1	Column 2	Effective Date	Deletion Date	Indicator 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
90791	90832	20201001		0	CPT Manual or CMS manual coding instruction
90791	90832	20141001	20191231	0	CPT Manual or CMS manual coding instruction

Column 1	Column 2	Effective Date	Deletion Date	Indicator 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
90791	99605	20201001		1	Misuse of Column Two code with Column One code
90791	99605	20130101	20191231	1	Misuse of Column Two code with Column One code

In both cases, only the top row is examined because the bottom row's deletion date is null or blank. The top rows are however analyzed. 90791 can never be claimed with 90832 but it can be claimed with 99605 so long as 99605 is claimed with modifier 27, 59, XE, XP, or XU.

In a situation where 90832 is the primary code and 90791 and 99605 are the potential secondary codes, the results are as follows:

Column 1	Column 2	Effective Date	Deletion Date	Indicator 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
90832	90791	20130101	20140930	0	Standards of medical/surgical practice

And

Column 1	Column 2	Effective Date	Deletion Date	Indicator 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
90832	99605	20201001		1	Misuse of Column Two code with Column One code

Column 1	Column 2	Effective Date	Deletion Date	Indicator 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
90832	99605	20130101	20191231	1	Misuse of Column Two code with Column One code

Since we ignore rows where the deletion date is not null, the relationship where 90832 is the primary code and 90791 is the secondary code is ignored altogether since it's the only relationship present. In the case where 90832 is the primary code and 99605 is the secondary code, the two codes can be claimed together so long as 99605 is claimed with modifier 27, 59, XE, XP, or XU.

There may be rare occasions when the relationship between two codes in files titled 20XX_Q1_PTP_Edits -Practitioner Services and 20XX_Q1_NCCI_PTP_Edits-Outpatient Hospital Services differs, with one file showing that the relationship is a hard lockout and the other showing that the relationship is an over-ridable lockout. In that instance, DHCS will use the overridable lockout scenario as there are occasions when the two codes can be claimed together.