Short Doyle / Medi-Cal Test Plan

for the Transition to CPT Codes Claiming and Intergovernmental Transfers

Department of Health Care Services

January 2023

Table of Contents

1 - Overview

The Department of Health Care Services (DHCS) is working on the Behavioral Health Payment Reform initiative to change the way DHCS reimburses counties for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Beginning July 1, 2023, Payment Reform will transition counties from a cost-based reimbursement methodology funded via Certified Public Expenditures (CPEs) to a fee-for-service reimbursement methodology funded via Intergovernmental Transfers (IGTs). This transition will eliminate the need for reconciliation to actual costs. As part of Payment Reform, SMHS, DMC, and DMC-ODS services will transition from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, also known as Current Procedural Terminology (CPT) coding, when possible.

To support this transition, user acceptance testing (UAT) of the Short Doyle / Medi-Cal (SD/MC) system will be made available to trading partners (counties and direct providers) beginning January 23, 2023. The UAT environment will mirror the billing system environment that will be in place beginning July 1, 2023. UAT consists of three phases. The requirements for each phase are described in more detail below. From January 23, 2023 to June 9, 2023, trading partners will be able to submit test claims using a combination of CPT and HCPCS codes in the SD/MC UAT environment and receive confirmation of approved and/or denied test claims. During phase 3 of UAT, counties will also be able to test the IGT process.

The purpose of this document is to provide information on the UAT process and guidance for submission of test data to DHCS. For billing standards and requirements under the new CPT coding system, please refer to the Medi-Cal billing manuals available on the MEDCCC Library under “CalAIM References and Manuals.”

2 - UAT Timeline

UAT is divided into three main test phases. The table below provides a summary of the focus of each test phase and the general timeframes for testing. Timeframes are estimates based on DHCS resources. Each testing phase is described in more detail in the “Testing Process” section. Testing is expected to begin January 23, 2023 and conclude on June 9, 2023. Trading partners may start testing at any time within this testing window and should allocate sufficient time for successful completion of each test phase.

Table 1: UAT Timelines for SD/MC Claiming and IGT

Test Phases	Testing Timelines
Phase 1 – Testing successful file submission of 10 claims and receiving the following acknowledgment reports: TA1, SR Report, and 999.	January 23 – June 9
Phase 2 – Testing CalAIM business rules and submitting claims using CPT codes.	February 1 – June 9
Phase 3 – Testing add-ons and IGT process.	March 1 – June 9

3 - Testing Process

Trading partners are encouraged to participate in user acceptance testing to allow for proper claiming for behavioral health services come July 1, 2023. Beginning January 23, 2023, trading partners may submit test claims into the UAT environment, also referred to as the CalAIM Staging environment. Test claims will utilize the 837 format and Client Index Numbers (CIN) that have been de-identified to protect Personal Health Information (PHI) data. Trading partners will receive confirmation of accepted and/or denied claims, and 835 files will be generated as part of the file validation process.

Participation in UAT and the number of scenarios trading partners test during the testing period is at the trading partners' discretion. DHCS will provide testing support via written resources, weekly office hours during the testing period, and response to questions via the MEDCCC email box. However, DHCS will not monitor whether trading partners have completed each test phase.

This section provides information on the testing process which includes:

- Client Index Number (CIN) requests for CIN de-identification
- Submission of test files
- The file validation process
- General testing criteria
- Phase 1, phase 2, and phase 3 of testing

Each component of the testing process is described in more detail below.

3.1 - Client Index Number (CIN) Requests

Due to Health Insurance Portability Accountability Act of 1996 (HIPAA) privacy considerations, DHCS intends to minimize the Personal Health Information (PHI) data in UAT. This will require the use of client index numbers (CIN) that have PHI data altered, or de-identified CINs. Trading partners will use the altered data assigned to those CINs in their test claims.

To obtain a CIN for use on test claims in the UAT environment, trading partners will need to submit one or more CIN-REQUEST file to DHCS via secure file transfer on the DHCS Application Portal. DHCS will move specific CINs into the MEDS ExITE Region (UAT version of the Medi-Cal Eligibility Determination System in production). For each CIN-REQUEST file received, DHCS will generate a CIN-RESPONSE file within 1-3 business days.

3.1.1 - Steps for Requesting CINs in the MEDS ExITE Region:

- Step 1: Submit one or more CIN-REQUEST files for the CINs intended for testing in Staging.
- Step 2: Upload CIN-REQUEST files to the appropriate program and county Staging – SDMC file transfer folder in the DHCS Application Portal.
- Step 3: Each CIN-REQUEST file must be zipped.
- Step 4: Each zipped file must contain only one CIN-REQUEST file.
- Step 5: Each zipped file's name must match the name of the CIN-REQUEST file that it contains.
- Step 6: The CIN-RESPONSE file will appear in the Production DHCS file transfer portal in 1-3business days.

Note: You will not be allowed to upload a CIN-REQUEST file to your Production DHCS file transfer portal.

3.1.2 - CIN Request Requirements

CIN requests must meet the following requirements:

- Save each CIN-REQUEST as a .txt file
- Each zipped file must contain only one CIN-REQUEST file
- Each CIN-REQUEST file must be zipped
- Each zipped file's name must match the name of the CIN-REQUEST file that it contains

The CIN request file must be formatted as follows:

- program (ADP or DMH)
- County 2 digit code
- 2 Spaces
- The CIN

Example for San Mateo County SUD: “ADP41 123456789”

3.2 – 837 Test File Submission

Completed 837 test claims will be submitted via secure file transfer on the DHCS Application Portal. The specific folder to upload test files can be found by logging into the DHCS Application Portal and selecting the SDMC CalAIM (Staging) application. This will take users to the CalAIM UAT environment web application. Next, under “File Transfer,” access the link for “Upload/Download Folders.” Select the “DHCS-BHIS” folder, then select the “Staging” folder, and select the “SDMC-CalAIM” folder. Within the SDMC-CalAIM folder, users will be able to access the ADP, DMH, and System Documentation folders. Trading partners can upload their 837 test files into the respective folder for their program. Test claims for DMC should be uploaded to the ADP folder. Test claims for SMHS should be uploaded to the DMH folder.

3.3 - Processing File Validation

Once a test file has been submitted, SD/MC will validate the file in accordance with the SNIP edit rules. Test claims that pass SNIP edits will be adjudicated in accordance to the business rules under the CPT coding system. Please refer to the billing manual for business rules.

SDMC-CalAIM (Staging) has the option for checking file validation errors as well as statuses. Acknowledgement files (TA1, 999, SR and 835) can be downloaded in the DHCS Application Portal under DHCS-BHIS/STAGING /SDMC-CalAIM/ADP or DMH/County/Download. To view the status of a file, select the “File Processing Status” in the SDMC-CalAIM (Staging) app to see the status of 837, 835/277PSI and 276/277 files.

When reviewing 835 files, please note the following:

- Adjustment code CO 137 for county responsibility amount will be changed to CO 143 for CalAIM 835s for ADP.
- The system creates adjustment for County Responsibility Amount on the Service Line when funding is paid with 100% county funds or when funding is shared with only State General Funds (SGF) and county funds.

- The system does not create adjustment for County Responsibility Amount on Service Line when funding is paid with Federal Financial Participation (FFP) and county funds.

3.4 - General Testing Criteria and Reminders

To avoid claims being rejected or denied, the following points should be noted when submitting test claims.

- **Date of service** – When indicating a date of service on test claims, select any date from July 1, 2022 to present day as applicable to the claim being submitted. Depending on the specific scenario being tested e.g., if testing delay reason code, a specific date of service can be indicated on the claim. For all test claims, the date of service must be a valid date within the date range specified above, or the claim will be denied. Please be mindful of the date of service indicated on test claims.

- **Medi-Cal eligibility check** – Please note the following requirements.
    - CIN on claim must match CIN in MEDS ExITE Region.
    - Date of birth month and year must match information in MEDS ExITE Region**.**
    - Name does not have to match. Do not put PHI data such as beneficiary's real last name, address, or CIN in loops 2010BA - Subscriber Name or 2330A - Other Subscriber Name.

- **Service address check** – Please note the following requirements.
    - Address can be any non-PO Box address, however be mindful of claims that require zip code verification in which case the zip code must be a valid zip code.
    - SD/MC will deny the service line if a PO Box, Lock box, Lock bin, or Post Office Box address is used for the service facility address.

3.5 - Test Phase 1 and Criteria

Phase 1 testing (January 23 – June 9, 2023) will consist of submission of 10 claims that meet the Workgroup for Electronic Data Interchange Strategic National Implementation Process HIPAA Transaction and Code Sets Final Rules i.e., passed "SNIP edits." SD/MC will post the 999 Functional Acknowledgement report, the TA1 Interchange Acknowledgement Report, and the SR Acknowledgement Report to the county's folder in the DHCS Portal after completing the SNIP edits. Trading partners can download the Acknowledgment files (TA1, 999, SR and 835) in the DHCS Application Portal under DHCS-BHIS/STAGING /SDMC-CalAIM/ADP or DMH/County/Download.

Table 2: Recommended Test Scenarios for Phase 1

Test Scenario #	Description	Requirement
Test Scenario 1	Pass SNIP	Submit a claim with a valid outpatient HCPCS procedure code. See service tables in corresponding billing manual for examples.
Test Scenario 2	Pass SNIP	Submit a claim with a valid day service HCPCS procedure code. For example, H2012 with modifier HE (Day Rehabilitation).
Test Scenario 3	Pass SNIP	Submit a claim with a valid outpatient CPT code. For example, 90791 (Psychiatric Diagnostic Evaluation).
Test Scenario 4	Pass SNIP	Submit a file with two claims, one being a HCPCS procedure code and the other claim with a CPT procedure code.
Test Scenario 5	DMC, DMC-ODS: Levels of Care	Claim using the appropriate level of care modifier (U1, U2, U3, UB, U8, U9, UA/HG if DMC-ODS and U1, U2, U3, U7, U8, UA / HG if DMC-State Plan.
Test Scenario 6	DMC, DMC-ODS: Levels of Care	Claim for NTP services using appropriate modifiers (HG and/or UA).
Test Scenario 7	DMC, DMC-ODS: Perinatal Services	Claim for perinatal services with the appropriate modifier and indicator (HD modifier and pregnancy indicator set to yes).
Test Scenario 8	DMC, DMC-ODS: Fractional Units (Medication Assisted Treatment-MAT)	Claim for fractional units in MAT services. Remember, the service line will be denied if the fractional service does not equal one unit per drug type.
Test Scenario 9	DMC-ODS: Recovery Services	Claim for recovery services and another level of care using the appropriate modifiers. (Recovery services must be submitted with a U6 modifier and a level of care modifier.).

3.6 - Test Phase 2 and Criteria

Phase 2 testing (February 1 – June 9, 2022) will focus on testing the business rules associated with the use of CPT codes for claiming. DHCS recommends that counties prioritize testing add-on codes, supplemental codes, and dependent codes.

3.6.1 – CPT Transition and Summary

Effective July 1, 2023, claiming for direct outpatient services in SD/MC will utilize CPT codes for Mode 15 services and new HCPCS codes. HCPCS codes are included because not all services covered under Medi-Cal behavioral health are described by CPT codes.

Note: Services that are excluded from the transition to CPT codes include Medi-Cal administrative activities, inpatient services (Mode 05), and 24-hour services (Mode 10).

CPT codes are five-digit, numeric codes that identify specific procedures or services performed by specific providers in specific places of service. The CPT coding system has the following key features:

- **Modifiers** – A two-letter or two-digit code that can be added to a CPT code to provide additional information about the service such as how the service was provided, who provided the service, and whether there are proposition 30 implications.
- **Add-on codes** – Codes that can be added to a CPT code to describe time extensions.
- **Supplemental Codes** – Codes that can be added to a CPT code to describe additional and simultaneous services provided or that indicate the severity of the patient's condition.
- **Additional Verification when using CPT Codes**
    - The provider type of the rendering provider is verified using the first four alpha-numeric characters of the taxonomy. The taxonomy code must be a taxonomy code identified as able to provide the service under the CPT code or the claim line will be denied. Please refer to the billing manual for a list of taxonomy codes and allowable disciplines for each CPT code.
    - The place of service must be a valid place of service. Please refer to the billing manual for the list of CPT codes and valid place of service codes.
    - Units of service claimed will be validated to ensure units indicated on the claim does not exceed the allowable maximum for the combination of CPT codes on the claim.

3.6.2 – CPT Codes User Acceptance Testing

When using CPT codes in claiming, chose the codes that best describe the activity performed by the rendering provider and the time (how long services are provided). Please refer to the Specialty Mental Health billing manual, DMC-ODS billing manual, or DMC State Plan billing manual as appropriate for CPT codes and billing business rules (codes that are locked out against other codes, allowable modifiers, add on codes, etc.). When determining the time, use the time specified in the 2022 CPT manual published by the American Medical Association.

The table below lists some recommended test scenarios for phase 2 of UAT. Trading partners may choose to test any number of the listed test scenarios. Trading partners are encouraged to create and test other scenarios not listed in this document as applicable to their billing needs.

Table 3: Recommended Test Scenarios for Phase 2

Test Scenario #	Description	Requirement
Test Scenario 1	DMC, DMC-ODS, SMHS: Lockouts	Claim using over-ridable lockouts with appropriate modifiers. For example 90791 (Psychiatric diagnostic evaluation) and 90792 (Psychiatric diagnostic evaluation with medical services) can only be claimed together under extraordinary circumstances. Those circumstances would be indicated by appending one of the following modifiers: XE (separate encounter, a service that is distinct because it occurred during a separate encounter), XP (separate practitioner, a service that is distinct because it was performed by a separate practitioner), or XU (unusual, non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.).
Test Scenario 2	DMC, DMC-ODS, SMHS: Lockouts	Claim outpatient and 24-hour services. For example, 90847 with H2013:HE,

		T1017 (case management) with S5145 (Therapeutic Foster Care) ***OR*** Revenue Code 0100 (hospital inpatient).
Test Scenario 3	DMC, DMC-ODS, SMHS: Medicare COB	Claim for a Medicare-recognized service (eg 90791) with a Medicare-recognized provider (eg Social worker) but with HL (intern) modifier. For example, use taxonomy code 103T (psychologist) and claim for 90791 (Psychiatric diagnostic evaluation). Add HL after 90791 to indicate that the service was performed by an intern.
Test Scenario 4	DMC, DMC-ODS, SMHS: Medicare COB	Claim for a Medicare-recognized service with a Medicare-recognized provider (eg Social worker). For example, use taxonomy code 1041 (social worker) and claim for 90791 (Psychiatric diagnostic evaluation).
Test Scenario 5	DMC, DMC-ODS, SMHS: Supplemental	Claim for supplemental services (eg, interpretation T1013) with several primary codes. For example, claim for 96130 (psychological testing evaluation, first hour), claim for 4 units of T1013 (sign language or oral interpretive services, per 15 minutes) and then claim for 96105 (Assessment of Aphasia, 60 min.)and claim for 4 units of T1013.
Test Scenario 6	DMC, DMC-ODS, SMHS: Telehealth	Claim using CPT code and telephone using the appropriate modifier (93). For example, claim using 99441 (telephone evaluation and management service, 5-10 minutes) with modifier 93.
Test Scenario 7	DMC, DMC-ODS, SMHS: Telehealth	Claim using HCPCS code and telephone using the appropriate modifier (SC). For example, claim using T1006 (alcohol and/or substance abuse services, family/couple counseling) using modifier SC. Include an appropriate Level of Care Modifier with T1006. As T1006 can be used in both DMC-SPA and in DMC-ODS counties,

		allowable LOC modifiers are: U1, U2, U3, U7, U8, U9, UA/HG, and UB if the claim is from a DMC-ODS county and U1, U2, U3, U7, U8, UA, and HG if from a DMC-State Plan county.
Test Scenario 8	DMC, DMC-ODS, SMHS: Telehealth	Claim using CPT code and real-time, interactive audio and video telecommunication system using the appropriate modifier (95). For example, claim for 90849 (multiple-family group psychotherapy) and use modifier 95.
Test Scenario 9	DMC, DMC-ODS, SMHS: Telehealth	Claim for 24-hour services provided via telehealth using the appropriate modifier (GT). For example, claim for H2011 with Place of Service 15 and Modifier GT. For SMHS claims, be sure to include the HE modifier. Please also note that in DMC and DMC-ODS, H2011 with Place of Service 15 is the only code that can take the GT modifier. Also include an appropriate level of care modifier. As H2011, place of service 15 is allowed in both DMC-SPA and in DMC-ODS counties, allowable LOC modifiers are: U1, U2, U3, U7, U8, U9, UA/HG, and UB if the claim is from a DMC-ODS county and U1, U2, U3, U7, U8, UA, and HG if from a DMC-State Plan county.
Test Scenario 10	DMC, DMC-ODS, SMHS: Telehealth	DMC-ODS: Claim for clinical consultation via asynchronous telecommunication system. For example, claim for 99368 and the GQ modifier. Since 99368 (clinical consultation) is a benefit available only in DMC-ODS counties, use one of the following level of care modifiers U1, U2, U3, U7, U8, U9, UA/HG, or UB.
Test Scenario 11	SMHS: Proposition 30	Claim for continuum of care reform services using the appropriate modifier (HW). For example, claim for 90885 (psychiatric evaluation of

		hospital records) and use the HW modifier.
Test Scenario 12	DMC, DMC-ODS, SMHS: Proposition 30	Claim for SB 75 services using the appropriate modifier (HW). For example, claim for 98968 (telephone assessment and management) with modifier HW.
Test Scenario 13	DMC, DMC-ODS, SMHS: Proposition 30	Claim for Young Adult Expansion services using the appropriate modifier (HW). For example, claim for H0031 (mental health assessment by non-physician) using modifier HW.
Test Scenario 14	DMC, DMC-ODS, SMHS: Proposition 30	Claim for Older Adult Expansion services using the appropriate modifier (HW). For example, claim for 96112 (Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed).. first hour) with an HW modifier.
Test Scenario 15	DMC, DMC-ODS, SMHS: Proposition 30	SMHS: Claim for Family First Prevention Services using the appropriate modifier (HV). For example, claim for 90832 (psychotherapy 30 minutes) with modifier HV.
Test Scenario 16	DMC, DMC-ODS, SMHS: Proposition 30	DMC-State Plan: Claim for MAT services in an NTP setting using modifier HV. For example, claim for H0033 (oral medication administered, direct observation) with appropriate National Drug Code (NDC) and the HV modifier.
Test Scenario 17	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Outpatient Treatment Services (modifier U7). For example, claim for 90791 (psychiatric diagnostic evaluation) using the U7 modifier.

Test Scenario 18	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Narcotic Treatment Program (modifiers UA/HG). For example, claim for S5001 (prescription drug, brand name) with appropriate NDC and modifiers UA/HG.
Test Scenario 19	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Intensive Outpatient Treatment services (modifier U8). For example, claim for H0003 (alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs) with modifier U8.
Test Scenario 20	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Residential Treatment, level of care 3.1 (modifier U1). For example, claim for 99409 (alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention services, greater than 30 minutes) with modifier U1.
Test Scenario 21	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Residential Treatment, level of care 3.3 (modifier U2). For example, claim H0005 (alcohol and/or drug services; group counseling by a clinician) with modifier U2.
Test Scenario 22	DMC-ODS: Claim for full –scope beneficiaries enrolled through the ACA in one of the following levels of care:	Residential Treatment, level of care 3.5 (modifier U3). For example, claim 99306 (initial nursing facility care, per day, for the evaluation and management of a patient) with modifier U3.
Test Scenario 23	DMC-ODS: Claim for full-scope non-federally eligible beneficiaries who receive services in one (or more) of the following levels of care:	Intensive Outpatient Treatment (modifier U8). For example, claim for 99347 (home or residence visit for the evaluation and management of an established patient) with modifier U8.
Test Scenario 24	DMC-ODS: Claim for full-scope non-federally eligible beneficiaries who receive services in one (or more) of the following levels of care:	Residential Treatment, level of care 3.1 (modifier U1). For example, claim T1006 (alcohol and/or substance abuse services, family/couple counseling) with modifier U1.
Test Scenario 25	DMC-ODS: Claim for full-scope non-federally eligible beneficiaries who receive	Residential Treatment, level of care 3.3 (modifier U2). For example, claim for 90791 (psychiatric

	services in one (or more) of the following levels of care:	diagnostic evaluation) with U2 modifier.
Test Scenario 26	DMC-ODS: Claim for full-scope non-federally eligible beneficiaries who receive services in one (or more) of the following levels of care:	Residential Treatment, level of care 3.5 (modifier U3). For example, claim for 90791 (psychiatric diagnostic evaluation) with U3 modifier.
Test Scenario 27	DMC, DMC-ODS, SMHS: Evaluation and Management and Associated Codes	Code Evaluation and Management Codes (E/M) with appropriate non-E/M codes. For example, 99202 should be coded with 90792, not 90791.
Test Scenario 28	SMHS: Co-Practitioner Claim	Claim for two practitioners rendering services to the same beneficiary at the same time.
Test Scenario 29	DMC, DMC-ODS: Levels of Care	Claim for care coordination services and another level of care. For example, claim 90882 (Environmental intervention for medical management purposes) with modifier U7 on one service line. Then, bill 90865 (Nacrosynthesis for psychiatric diagnostic and therapeutic purposes) with modifier U8 on a separate service line.
Test Scenario 30	DMC, DMC-ODS: Levels of Care	Claim for peer support services and another level of care. For example, claim H0025 or H0038 with modifier U2.
Test Scenario 31	DMC, DMC-ODS: Levels of Care	Claim for MAT services and another level of care. For example, claim H0033 (Oral medication administration, direct observation) with modifier U3.
Test Scenario 32	DMC-ODS: Withdrawal Management	Claim for withdrawal management level of care 1, 2, or 3.2 and MAT services. For example, claim H0014 with modifier U4 and U7 (WM 1.0), and claim H0033 with modifier U7.
Test Scenario 33	DMC-ODS: Withdrawal Management	Claim for withdrawal management level of care 1, 2, or 3.2 and care coordination. For example, claim H0014 with modifier U4 and U7 (WM

		1.0), and claim 90889 (Preparation of report of patient's psychiatric status, history, treatment, or progress) with modifier U7.
Test Scenario 34	DMC-ODS: Withdrawal Management	Claim for withdrawal management level of care 1, 2, or 3.2 and clinical consultation. For example, claim H0014 with modifier U4 and U7 (WM 1.0), and claim 99367 (Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician) with modifier U7.

3.6.3 – Special Cases and Circumstances Requiring Separate Claims

Certain CPT codes can serve as add-on codes to multiple primary CPT codes. An example of such as code is G2212 (prolonged office or other outpatient evaluation and management services beyond the maximum time) which is a code used to claim an additional 15 minutes of time spent on patient care should treatment time extend beyond the time specified by the primary CPT code being billed. During the claim adjudication process, SD/MC validates that the total units of G2212 on a claim is valid for the number of primary CPT codes present. However, SD/MC cannot distinguish which G2212 is extending which primary CPT code within the same claim. The number of units of G2212 must be valid for the number of primary CPT codes being approved, or the claim will be denied.

When submitting a claim containing multiple claim lines and multiple generic add-on codes such as G2212, it is recommended that the primary CPT code and its G2212 pair be split into separate claims. This ensures that if a claim line for the primary CPT code and its G2212 pair is denied, only that specific primary CPT code and G2212 pair is denied. The other primary CPT codes and their G2212 pairs are unaffected as they are listed on separate claims.

3.7 - Test Phase 3 and Criteria

Phase 3 testing (March 1 – June 9, 2023) will consist of testing of the IGT process and add-on codes. This section provides background on IGT and what trading partners will expect to see IGT user acceptance testing.

3.7.1 - IGT Transition and Summary

Effective July 1, 2023, the current CPE reimbursement methodology with be replaced with a reimbursement methodology using IGT funds for the county share of payments. An IGT is a transfer of funds from a county to DHCS. DHCS will use the IGT as the State's non-federal share in claiming Federal Financial Participation (FFP) for Medi-Cal covered services.

IGT Funds will be used to pay both electronic (Short-Doyle Medi-Cal 837 claim) and manual claims (County Administrative and Quality Assurance/Utilization Review) that require both Federal and County portions to complete a payment. This includes claims paid with 100% State General Funds (SGF), claims paid with 100% Federal Funds (FFP), and claims paid with only FFP and SGF. Claims that are approved with county funds only, or when county funding is shared with only SGF, will not be included in the IGT process. Mental Health Medi-Cal Administrative Activities (MH-MAA) and Fee for Service (FFS) Hospital claims paid through the Fiscal Intermediary (FI) will not be included in the IGT process. MH-MAA claims will continue as a CPE program with Medi-Cal FFP paid based on actual costs. FFS Hospital claims will continue to be paid directly to the hospital with a monthly offset to the county's 1991 realignment distribution to recover the county share.

More information about IGT can be found on the IGT FAQ on the DHCS website.

3.7.2 - IGT User Acceptance Testing

IGT user acceptance testing will be available March 1, 2023. Each county will have a UAT County Funds Account (CFA) that contains an amount of funds pre-determined by DHCS for UAT testing purposes only. For test claims accepted by SD/MC between March 1 and June 9, 2023, funds will be withdrawn from the UAT CFA. DHCS will provide counties monthly adhoc reports of their UAT CFA balance. Information in the report will include the starting balance of the CFA, the month's transactions (inbound IGTs and outbound payments), warrant number, and ending balance.

3.7.3 - Testing of Add-on Codes and IGT Process

Table 4: Recommended Test Scenarios for Phase 3

Test Scenario #	Description	Requirement

Test Scenario 1	DMC, DMC-ODS, SMHS: Add-Ons	Claim using a code with designated add-on codes. For example, if psychological testing evaluation takes two hours, the claim would need to include 1 unit of procedure code 96130 for the first hour and 1 unit of procedure code 96131 for the second hour.
Test Scenario 2	DMC, DMC-ODS, SMHS: Add-Ons	Claim using a code without a designated add-on code. Any code tested above without the designated add-on code.
Test Scenario 3	SMHS: Add-Ons	Claim for an evaluation and management code and an add-on. For example, 90791 for Psychiatric Diagnostic Evaluation with add-on code G2212. All evaluation and management codes and CPT codes that do not have a dedicated add-on code use G2212 as the add-on code.
Test Scenario 4	SMHS: Add-Ons	Claim for a code that depends on more than one code. For example, 96375 can be coded after 96365 or 96374.
Test Scenario 5	DMC, DMC-ODS, SMHS: IGT Process	Claim with H2011 (add HE for SMHS) with Place of Service 15
Test Scenario 6	DMC, DMC-ODS, SMHS: IGT Process	Claim for an SB 75 beneficiary
Test Scenario 7	DMC, DMC-ODS: IGT Process	Claim for Intensive Outpatient (modifier is U8), and beneficiary is not EPSDT and/or beneficiary is not pregnant
Test Scenario 8	DMC, DMC-ODS: IGT Process	Claim Service is Residential Treatment with modifier U1 or U2 or U3 and provided in the non-perinatal Drug Medi-Cal program (Procedure Modifier HD is not present)

Test Scenario 9	SMHS: IGT Process	Claim for continuum of care reform services using the appropriate modifier (HW).
Test Scenario 10	DMC, SMHS: IGT Process	Claim for Family First Prevention Services using the appropriate modifier (HV).

4 - Testing Support

During the testing period, assistance with accessing county folders and all testing related questions can be sent to MEDCCC@dhcs.ca.gov.

Beginning early February, DHCS will hold weekly Q&A and UAT troubleshooting sessions with counties.

In addition, the following resources are available on the MEDCCC Library under "CalAIM References and Manuals"

- Behavioral Health Information Notice 22-046: Technical Documents to Implement CalAIM
- Specialty Mental Health Billing Manual
- Drug Medi-Cal State Plan Billing Manual
- Drug Medi-Cal ODS Billing Manual
- CalAIM Reference Guide for CPT Codes – SMHS
- CalAIM Reference Guide for CPT Codes – Drug Medi-Cal Counties
- CalAIM Reference Guide for CPT Codes – Drug Medi-Cal Organized Delivery System

Additional Resources:

- CIN de-identification document (SDMC Testing Strategy File)

- DHCS Companion Guides for DMC and SMHS

  Note: These documents can be downloaded from the System Documentation folder on the DHCS Application Portal.