Drug Medi-Cal ODS Billing Manual

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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-Organized Delivery System (DMC-ODS) services provided by Drug Medi-Cal enrolled and certified providers to Medi-Cal-eligible beneficiaries. The Department of Health Care Services (DHCS) Local Governmental Financing Division (LGFD) oversees the SD/MC claims processing system. This manual provides guidance on how to ensure that a claim and the service lines in that claim are approved by the SD/MC claims processing system. This manual does not include clinical guidance on when specific procedure codes or modifiers are appropriate or on the documentation that must accompany the procedure codes submitted on a claim.

This chapter includes:

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

1.1 About This Billing Manual

This DMC-ODS Billing Manual is a publication of DHCS. DHCS administers the DMC-ODS program. This Billing Manual provides stakeholders with a reference document that describes the processes and rules relative to SD/MC claims for DMC-ODS services. Stakeholders include Counties and DMC-ODS 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:
        i. SD/MC User Manual
        ii. Companion Guides
        iii. Companion Guide Appendix

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

1.1.2 Internet Addresses and Links

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

1.2 Program Background

Title XIX of the Social Security Act, enacted in 1965, authorized Federal grants to States for medical assistance to low-income persons who are 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women and children. The Affordable Care Act (ACA) expanded

Medicaid eligibility to all persons in households with income below 138 percent of the federal poverty level in states that chose to expand Medicaid. California chose to expand Medicaid. The Medicaid program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types, and range of services, and administrative and operating procedures.

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

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

1. Determination of Aid Codes[1]
2. Maintenance of eligibility information technology systems (e.g., Medi-Cal Eligibility Determination System [MEDS])
3. Adjudication of DMC-ODS claims
4. Processing of claims for Federal Financial Participation (FFP) payments
5. Submission of expenditures to CMS to obtain FFP

For DMC-ODS services provided to a beneficiary by a certified provider, the cost of these services is paid by a combination of State, County, and Federal funds. The FFP sharing ratio (the percentage of costs reimbursed by the Federal government) is determined on an annual basis and is known as the Federal Medical Assistance Program (FMAP) percentage. County expenditures represent a combination of State realignment funds, local county funds and other sources such as grants.

1.3 Authority

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

1.3.1 Social Security Act, 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 Federal Social Security Act Title XXI, Children's Health Insurance Program State Plan

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

1.3.3 Health Insurance Portability and Accountability Act of 1996

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

1.3.4 Federal Regulations

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

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 Drug Medi-Cal program.

1.3.6 California Code of Regulations (CCR)

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

1.3.7 Drug Medi-Cal Organized Delivery System (DMC – ODS)

The DMC-ODS is a program authorized and financed under the authority of the California Medicaid State Plan,[2] the State's 1915(b) Cal AIM Waiver, and the State's 1115 CalAIM Demonstration Waiver. .

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

1.3.9 Health Care Claim Payment/Advice ("837 Companion Guide" and "835 Companion Guide")

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

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

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

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

1.4 Medi-Cal Claims Customer Service Office (MedCCC)

MedCCC was created to provide 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
- The most current information on a DMC – ODS Medi-Cal claim
- Assistance with troubleshooting claim and/or payment issues
- Helpful answers to policy and procedure questions

[2] See State Plan Amendment 21-0058.

Counties will receive an acknowledgement email within 48 hours of receipt. MedCCC will generally respond to inquiries within five business days. However, some responses may take more time.
To ensure the accuracy of the inquiry and responses, MedCCC requests that counties email inquiries to MedCCC@dhcs.ca.gov. Counties may also call (916)650-6526.

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-ODS 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 website. If the Approver's organizational domain name is already associated with a Microsoft or Office 365 AAD account, the approver will be able to select that account when logging in at the login website. Otherwise, the 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

Federal regulations require that individual healthcare providers and organizations obtain NPIs. DHCS maintains a website designed to assist providers and share the resources available to understand provider processes including information about obtaining an NPI. DHCS also makes available Drug Medi-Cal Provider Enrollment information related to provider obligations. Providers must identify, by NPI, the rendering provider and the billing and service facility locations in healthcare claim transactions. To request a provider number, use the Provider Application and Validation for Enrollment 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. In order to provide DMC-ODS services, providers must first be DMC certified by DHCS PED. Certification is unique to a particular facility location and specifies the DMC services that can be provided at that location. Certification also distinguishes between services that can

be provided within the regular (non-perinatal) DMC program, and those that may be provided within the perinatal DMC program for substance use disorder services for pregnant and postpartum women. For more specific certification information, contact PED by email, DHCRecert@dhcs.ca.gov , or visit the DHCS Provider Enrollment website. Additionally, DHCS requires that DMC providers complete a recertification process every five years in order 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. DMC certified providers serving beneficiaries in one of the seven DMC-ODS regional counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) must have a contract with at least one of the seven regional counties. If a DMC certified provider serves an EPSDT beneficiary from a DMC State Plan county, the provider must have an association with any county within the state to be able to render services to EPSDT beneficiaries. DMC certified providers that are Indian Health Care Providers may serve a beneficiary from any county.

2.4 Companion Guide and Appendix

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

CHAPTER THREE: CLIENT ELIGIBILITY

3.0 Introduction

This chapter contains information about Medi-Cal eligibility including:

- Client Eligibility
- Aid Codes

3.1 Client Eligibility

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

3.1.1 Medi-Cal Eligibility Determination

DHCS is responsible for instituting procedures for establishing Medi-Cal eligibility criteria. The determination of beneficiary eligibility and the collection of beneficiary eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding beneficiary eligibility criteria may be obtained through the DHCS 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. For this reason, the Drug Medi-Cal claim process requires frequent review and management of beneficiary Medi-Cal eligibility data.
- External auditors can review verification of beneficiary Medi-Cal eligibility after the claimed month of service.
- Medi-Cal eligibility may require that a beneficiary's Share of Cost (SOC) be met before Medi-Cal will pay for any services.
- Clients who are eligible for Supplemental Security Income (SSI) are Medi-Cal eligible.
- Medi-Cal eligibility may be established retroactively through legislation, court hearings, and/or decisions.
- HIPAA 270/271 transactions are available from DHCS to verify beneficiary Medi-Cal eligibility.
- Counties and/or providers should verify beneficiary Medi-Cal eligibility prior to rendering DMC services.

3.1.2 Eligibility Review

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

3.1.3 MEDS

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

3.1.4 MEDSLITE

MEDSLITE is an Internet-based program that allows users to verify eligibility information but does not allow users to view the Social Security Administration data that is contained within MEDS. For additional

information about MEDSLITE such as how to gain access to it, contact the MEDSLITE Coordinators at BHMEDSLITE@dhcs.ca.gov

3.2 Aid Codes

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

- FFP
- Aid Codes
- Types of benefits
- Share of cost
- Code description
- Indication of reimbursement through the DHCS Fiscal Intermediary, Drug Medi-Cal Program (DMC)[3], Mental Health Programs, and/or EPSDT[4] programs.

[3] Drug Medi-Cal Overview

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

CHAPTER FOUR: COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered DMC-ODS services.

- DMC-ODS Covered Services
- DMC-ODS Levels of Care

4.1 DMC-ODS Covered Services

Expanded SUD treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All expanded SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. Expanded SUD treatment services are provided by Drug Medi-Cal (DMC) certified providers and are based on medical necessity. The following services, per State Plan Amendment 21-0058, are reimbursable under the DMC-ODS Waiver.

4.1.1 Assessment:

Assessment consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current 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.
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

4.1.2 Care Coordination:

Care coordination was previously referred to as "case management" in the Section 1115 STCs that were used to describe the DMC-ODS program for the years 2015-2021. Per CMS feedback, DHCS has retitled and re-described this benefit as "care coordination."

Care Coordination is covered as a service component of most DMC-ODS levels of care (i.e. outpatient, intensive outpatient, partial hospitalization, residential, inpatient, narcotic treatment program, withdrawal management, MAT, recovery services). When DMC-ODS providers provide Care Coordination services to a beneficiary receiving treatment at a residential or inpatient levels of care, the appropriate procedure code for that level of care can be used to claim for Care Coordination, as it is included within the level of care. Alternately, care coordination can be claimed using the dedicated codes in Service Table 7, on the same day as other outpatient, residential, or inpatient services appropriate for the client's level of care.

Care Coordination is also covered as a standalone DMC-ODS service. When DMC-ODS providers provide Care Coordination services to a beneficiary who is not actively receiving treatment at a level of care (e.g., they are attempting to engage in treatment or are coordinating a referral), the Care Coordination procedure code (see Service Table 7 for list of care coordination codes) can be used to claim for Care Coordination.

Care Coordination can be provided in clinical or non-clinical settings and includes one or more of the following components:

- Coordinating with primary care and mental health care providers to monitor and support comorbid health conditions.
- Discharge planning, including 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/ specialty medical providers.
- Ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, and mutual aid support groups.

4.1.3 Clinician Consultation*:*

Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to in the Section 1115 STCs that were used to describe the DMC-ODS program during the years 2015-2021.

Clinician Consultation consists of DMC-ODS Licensed Practitioners of the Healing Arts (LPHAs) consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.

Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.

DMC-ODS providers directly rendering care to the beneficiary can only bill clinician Consultation. The "consulting" clinician cannot bill clinician Consultation. When a rendering DMC-ODS clinician needs to consult with another clinician to support care delivery, the rendering DMC-ODS provider can use the Clinician Consultation procedure codes (99367, 99368, or 99451) to claim for the activity. Refer to service Table 7 to see how these codes can be billed.

4.1.4 Family Therapy:

Family Therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

4.1.5 Group Counseling:

Group Counseling consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants.

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

4.1.7 Medical Psychotherapy:
Medical Psychotherapy is a counseling service conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.

4.1.8 Medication Services:
Medication Services includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication

4.1.9 Medication for Addiction Treatment (also known as medication assisted treatment (MAT) for Opioid Use Disorders (OUD) :
Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (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 7 to Attachment 3.1-B.

4.1.10 "Medication for Addiction Treatment (also known as medication assisted treatment (MAT) for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders":
"Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders" includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs. MAT for AUD and non-opioid SUDs may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the "Levels of Care" section. This service includes:

- Assessment (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- Patient Education (as defined below)
- Recovery Services (as defined below)
- SUD Crisis Intervention Services (as defined below)
- Withdrawal Management Services (as defined below)
- Prescribing and monitoring MAT for AUD and Other Non-Opioid Substance Use Disorders, which consists of prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT services for AUD and Other Non-Opioid Substance Use Disorders

4.1.11 Medications for Addiction Treatment – Medications:

As described in DHCS BHIN 21-075, DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit (in other words, purchased by providers and administered or dispensed onsite or in the community, and billed to the county DMC-ODS plan). DMC-ODS counties that make this election could reimburse providers for the medications, including naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities, and non-clinical or community settings.

DMC-ODS providers delivering MAT services in DMC-ODS counties that choose to cover MAT medications can use the MAT medication procedure code to claim for MAT medications. However, DMC-ODS providers are not required to do so. DMC-ODS providers can continue to use the pharmacy benefit to seek reimbursement for MAT medications delivered as part of DMC-ODS care.
However, consistent with the DMC-ODS State Plan and as described above in the "Covered DMC-ODS Services" section, even if DMC-ODS counties do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to reimburse for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service. The "Medications for Addiction Treatment – services" section above provides guidance for claiming MAT services.

4.1.12 Patient Education:

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

4.1.13 Peer Support Service:

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

- Educational Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.

- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Peer Support Services can only be claimed as a standalone service. DMC-ODS 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-ODS levels of care. Peer Support Services are covered under the DMC-ODS program even if the beneficiary is not receiving treatment at a DMC-ODS level of care (e.g., the "Engagement" service component is designed to support outreach and engagement efforts prior to initiation and treatment).

However, DMC-ODS providers may deliver Peer Support Services to beneficiaries receiving treatment at all DMC-ODS levels of care, including residential or inpatient levels of care. Beneficiaries may concurrently receive Peer Support Services while receiving other DMC-ODS services. Peer Support Services must be claimed separately.

*Peer Support Services will be implemented and have an effective date of July 1, 2022

4.1.14 Recovery Services:

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Recovery Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group counseling as defined above)
- Family Therapy (as defined above)
- Recovery Monitoring, which includes recovery coaching and monitoring, designed for the maximum reduction of the beneficiary's SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.

Recovery Services are covered as a service component of most DMC-ODS levels of care (i.e. outpatient, intensive outpatient, partial hospitalization, residential, inpatient, narcotic treatment program, withdrawal management, MAT). When DMC-ODS providers provide Recovery Services to a beneficiary receiving treatment in a residential or inpatient level of care, the appropriate procedure code for that

level of care can be used to claim for Recovery Services, as it is included within the level of care. . Alternately, recovery services can be claimed using the dedicated codes in Table 8, on the same day as other outpatient, residential, or inpatient services appropriate for the client's level of care.

Recovery Services are also covered as a standalone DMC-ODS service. When DMC-ODS providers provide Recovery Services to a beneficiary who is not actively receiving treatment at a level of care (e.g., they are in recovery and do not need or want to engage in intensive treatment but feel they may benefit from Recovery Services), the Recovery Service procedure codes (see Service Table 8 for a list of recovery services codes) can be used to claim for Care Coordination.

4.1.15 SUD Crisis Intervention Services:

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

4.1.16 Withdrawal Management Services:

Withdrawal Management Services are provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level. Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined above)
- MAT for AUD and non-opioid SUDs (as defined above)
- Peer Support Services (as defined above)
- Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

4.1.17 Contingency Management Services:

DHCS implemented a new contingency management benefit for eligible DMC-ODS beneficiaries with a substance use disorder in DMC-ODS counties that elect and are approved by DHCS to pilot the benefit. The pilot will allow California to evaluate and assess the effectiveness of a contingency management benefit before determining whether it should be available statewide. Under the pilot, the contingency management benefit will be available in participating DMC-ODS counties that opt and are approved by DHCS to provide this service. Only non-residential DMC-ODS providers can provide contingency management services. To participate in the contingency management pilot, DMC – ODS counties must submit an application to DHCS. The pilot will begin in fall 2022 and will end December 31, 2026. Contingency management services include the following services:

a. Contingency management benefit consists of a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash or cash equivalents, e.g., gift cards of low retail value, consistent with evidence-based clinical research for treating a substance use disorder and as described below. These motivational incentives are central to

contingency management, based on the best available scientific evidence for treating a substance use disorder and not as an inducement to use other medical services.

b. The contingency management benefit utilizes an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with non-use or treatment/medication adherence. The contingency management benefit provides motivational incentives for non-use of substances or treatment/medication adherence as evidenced by, for example, negative drug tests.

c. Contingency management is offered along with other therapeutic interventions, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d).

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified, recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal antikickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries that meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode.

f. To qualify for a contingency management motivational incentive, a beneficiary must demonstrate treatment/medication adherence or non-use of substances through evidence for a substance.

g. The size, nature, and distribution of all contingency management motivational incentives shall be determined in strict accordance with DHCS procedures and protocols. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste or abuse associated with the motivational incentive:
    - Providers have no discretion to determine the size or distribution of motivational incentives, which will be determined by DHCS.
    - Motivational incentives may be managed and disbursed through a mobile or web-based incentive management software program that includes strict safeguards against fraud and abuse that will be detailed in DHCS guidance and listed in the Procedures and Protocols Attachment V (as listed above).
    - To calculate and generate the motivational incentives, providers shall enter the evidence of the Medi-Cal beneficiary receiving the contingency management benefit into a mobile or web-based incentive management software program.

h. The following practitioners delivering care at qualified DMC-ODS providers can deliver the contingency management benefit through activities, such as administering point-of-care urine drug tests, informing beneficiaries of the results of the evidence/urine drug test, entering the

results into the mobile or web-based application, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

- Licensed Practitioner of the Healing Arts (LPHAs);
- SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies;
- Certified peer support specialists; and
- Other trained staff under supervision of an LPHA.

4.2 DMC – ODS Levels of Care

4.2.1 Outpatient Treatment Services (ODF):

Outpatient Treatment Services (also known as Outpatient Drug Free or ODF services) (ASAM Level 1) are provided to beneficiaries when medically necessary. Outpatient Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1-A[5])
- MAT for AUD and non-opioid SUDs (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- Crisis Intervention Services (as defined above)

4.2.2 Intensive Outpatient Treatment Services (ASAM Level 2.1)

Intensive Outpatient Treatment Services (ASAM Level 2.1) are provided to beneficiaries when medically necessary in a structured programming environment. Intensive Outpatient Services include the following services:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1-A[6])
- MAT for AUD and non-opioid substance use disorders (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- Crisis Intervention Services (as defined above)

4.2.3 Partial Hospitalization:

[5] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf
[6] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

Partial Hospitalization Services (ASAM Level 2.5) are delivered to beneficiaries when medically necessary in a clinically intensive programming environment. Partial Hospitalization Services include the following services:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1[7])
- MAT for AUD and non-opioid SUDs (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- SUD Crisis Intervention Services (as defined above)

4.2.4 Residential Treatment Services:

Residential Treatment Services are delivered to beneficiaries when medically necessary in a, short-term treatment program corresponding to at least one of the following levels:

- Level 3.1 - Clinically Managed Low-Intensity residential Services
- Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
- Level 3.5 - Clinically Managed High Intensity Residential Services
- Level 3.7 - Medically Monitored Intensive Inpatient Services
- Level 4.0 - Medically Managed Intensive Inpatient Services

Residential Treatment Services include the following services:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Counseling (individual and group as defined above)
- Family Therapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1[8])
- MAT for AUD and non-opioid SUDs (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- SUD Crisis Intervention Services (as defined above)

4.2.5 Narcotic Treatment Program:

Narcotic Treatment Program is an outpatient program that provides FDA-drugs approved to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

Narcotic Treatment Program Services include the following services:

- Assessment (as defined above)

[7] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

[8] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

- Care Coordination (as defined above)
- Counseling (individual and group as defined above)
- Family Therapy (as defined above)
- Medical Psychotherapy (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1[9])
- MAT for AUD and non-opioid substance use disorders (as defined above)
- Patient Education (as defined above)
- Recovery Services (as defined above)
- SUD Crisis Intervention Services (as defined above)

4.2.6 Withdrawal Management Services:

Withdrawal Management Services are provided to beneficiaries experiencing withdrawal in the following outpatient and residential settings:

- Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
- Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
- Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)
- Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits)
- Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability)

Withdrawal Management Services include the following service components:

- Assessment (as defined above)
- Care Coordination (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1[10])
- MAT for AUD and non-opioid SUDs (as defined above)
- Observation (as defined above)
- Recovery Services (as defined above)

[9] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf
[10] State Plan Amendment 21-0058
https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf

CHAPTER FIVE: CLAIMS PROCESSING

CHAPTER 5: CLAIMS PROCESSING

5.0 Introduction

Drug Medi-Cal codes are billed using Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) Level II, and Revenue codes[11]. The SD/MC DMC claim process uses the Health Insurance Portability and Accountability Act (HIPAA) 837 (Electronic Healthcare Claim) standard for claims submission. HIPAA requires the use of these standardized procedure codes when submitting the 837 (Electronic Healthcare Claim) transaction files. The Companion Guide can be referenced to more fully understand how to create compliant DMC claims. The Implementation Guide describes the standard rules that are necessary to submit healthcare billing information, encounter information or both. The Companion Guide describes the exceptions and/or additions to these traditional requirements.

The business rules described below define adjudication rules in SD/MC. Claims or services that do not meet the business rules will be denied. When a claim or service is denied, the 835 transaction (Healthcare Claim and Remittance Advice) will communicate to the county how DHCS processed the claim/service, including why it was denied. To gain more detailed information about the meaning of the denial codes, refer to the DMC Claim Adjustment Reason Codes-Remittance Advice Remark Codes (CARC-RARC) on the MedCCC Library website. The following rules must be adhered to for the claim to be adjudicated.

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 Original Claims

[11] Revenue codes are four-digit numbers that are used on hospital inpatient claims to let SD/MC know where the patient was when they received treatment. A claim will not be paid if this code is missing.

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 Beneficiary Share of Cost

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

5.2.3 Beneficiary Eligibility

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

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

5.2.4 County of Residency/County of Responsibility

A DMC - ODS county must only submit claims for beneficiaries who are under its responsibility and/or for beneficiaries who reside in that county. Claim will be denied if the billing county for the claim is not the beneficiary's county of responsibility or the beneficiary county of residence. This rule does not apply for the following services: NTP dosing, individual counseling and group counselling services (H0004, H0005, H0020, S5000, and S5001) if those services claimed with modifiers UA (ASAM OTP/NTP) and HG (Opioid treatment program).

5.2.5 Beneficiary Date of Birth

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

5.2.6 Beneficiary Date of Death

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

5.2.7 Dates of Services Within a Claim

For any single claim, all dates of service must be within the same calendar month, except for claims for inpatient hospital services. The discharge date on the claim for inpatient hospital services may occur on the first day of the following month. For example, a claim for an individual who was admitted to the

hospital on October 28 and discharged on November 1 would be admissible. SD/MC will deny service lines submitted with dates of service that do not conform to this guidance.

5.2.8 Claims for Inpatient Stays that Cross One or More Months

A county must submit multiple claims for inpatient hospital stays that crossover one or more months, unless the date of discharge is on the first day of the month following the month in which the beneficiary was admitted to the hospital. For example, a claim for an inpatient hospital stay that began on October 15th and ended on November 15th would need two claims. The first claim would be for the date of admission (October 15th) through October 31st. The first claim would not include a date of discharge. Since the claim does not include a discharge date, it needs to be identified as an interim claim. A service line for an inpatient hospital service that does not have a discharge date or is not identified as an interim claim will be denied. The second claim would be for November 1st through November 15th. The second claim would have a discharge date of November 15th and would not be identified as interim claim.

5.2.9 Service Lines and Date Ranges

All service lines, except for inpatient services and NTP dosing services, must have a single date of service. Service lines for inpatient services and 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 recovery support services with a start date of November 3, 2023 and an end date of November 5, 2023, the service line will be denied.

5.2.10 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.

5.2.11 Duplicate Services

<u>Inpatient and 24 Hour Services</u>

Inpatient and 24 hour service procedure codes are listed in service table 13. Duplicate inpatient and 24 hour services are not allowed. For inpatient and 24 hour services, a procedure is considered a duplicate if all of the following data elements associated with two services are the same:

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

<u>Outpatient Services</u>

Outpatient services are listed in service tables 1-12 and duplicate billing is not allowed for outpatient services. For outpatient services, a procedure is considered a duplicate if all of the following data elements are the same:

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

While each procedure code is associated with a time, that time does not have to be consecutive.
If a provider renders the same service to the same beneficiary on the same day more than once, the provider should submit the claim as one service rather than two services. For example, a provider may render 60 minutes of recovery services in the morning and an additional 30 minutes of recovery services

in the evening to the same beneficiary, in this particular scenario, the county would submit one claim for 90 minutes of recovery services.

The following are exceptions to the Duplicate Services Rule for Outpatient Services: Sign language or oral interpretive services (T1013), Interactive complexity (90785), and health behavior interventions, for the family without the patient present (96170 and 96171). A provider may render two different services to the same beneficiary on the same day and use these codes to provide both services. For example, a provider may conduct a psychiatric diagnostic evaluation (90791) and then provide individual counseling (H0004). If we assume that both services required an interpreter, the provider would submit a claim with a service line for psychiatric diagnostic evaluation using code 90791, a service line for individual counseling using code H0004, a service line for the interpretation services associated with the psychiatric evaluation using T1013, and a service line for the interpretation services associated with the individual counseling using T1013. SD/MC would **not** deny the second service line with T1013 as a duplicate service.

CPT code 96160 (**Administration of patient-focused health risk assessment instrument**) describes an annual wellness visit as per Section 4103 of the Affordable Care Act. As such, CPT code 96160 can only be claimed once per calendar year regardless of the billing or rendering provider. If another county or a different provider has previously approved a wellness visit (CPT code 96160) for that beneficiary during the same calendar year, the second CPT code 96160 will be denied. The SD/MC claiming system can only track if a patient received this service once the claim has been submitted to the system. So, if a patient receives a wellness visit in one county, moves and receives a second in another county within the same calendar year, the second wellness visit will be denied. This limitation is specific to the annual wellness visit in accordance with Section 4103 of the Affordable Care Act and does not apply to any other services. If the assessment includes a condition, that is part of an on-going treatment and that would not be performed only once per year, it may be advisable to use a different code.

5.2.12 Claiming for Interpretation and Interactive Complexity

Sign language or oral interpretation (T1013) and Interactive Complexity (90785) occurs along with another service, such as counseling. These codes must be submitted on the same claim as the primary service. For example, an AOD counselor can submit a claim for 90785 when there is a need to manage maladaptive communication related to high anxiety, high reactivity, repeated questions, or when the patient is under the influence of alcohol or other substances. AOD counselors (and other DMC eligible providers) can also submit claims for T1013 when they use an oral interpreter to provide counseling to a patient who is unable to speak. The claim must include a service line for counseling and a service line for T1013 or 90785. Only one unit of T1013 or 90785 is allowed with any service.

Claims for interpretation and interactive complexity may not exceed the claims for the primary service. One unit of T1013 and one unit of 90785 are equal to 15 minutes. SD/MC will deny those service lines with interpretation or interactive complexity whose units of service multiplied by 15 minutes exceed the total amount of time claimed for all primary services on the same claim. For example, when a Licensed Professional Clinical Counselor (LPCC) is performing a Psychiatric Diagnostic Evaluation (90791) to determine if a beneficiary has a substance use disorder problem and the provider has difficulties communicating with the patient because he/she is under the influence of a substance. In this case, the provider would submit services for 90791 and a separate service for 90785. Both services have a 15 minute assigned time and 15 minutes is equal to one unit of service. If the encounter lasted 30 minutes, the provider would claim two units for each code.

5.2.13 Claim Timeliness – Original Claims

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

5.2.14 Service Facility Location

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

5.2.15 Service Facility Validation

SD/MC verifies that the service facility identified on the claim was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided. As discussed in Section 2.3, DHCS records in the Provider Application and Validation for Enrollment portal each organizational provider's NPI number and the expanded 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, as determined by the procedure code on the service line.

5.2.16 Date of Admission and Date of Discharge

All claims for inpatient hospital services must include the beneficiary's date of admission. As discussed in section 5.2.8, interim claims for inpatient hospital services do not require a discharge date. SD/MC will deny all service lines for inpatient hospital services that do not include an admission date.

5.2.17 Rendering Provider Taxonomy Code

Outpatient services are listed in service tables 1-12. SD/MC will deny service lines for outpatient services that do not contain the rendering provider's taxonomy code.

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. Service Tables 1-12 identify SD/MC Allowable Disciplines for each procedure code. Appendix 1 lists each discipline that is eligible to provide one or more expanded substance use disorder treatment service 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.

5.2.18 Telehealth Modifiers and Place of Service Codes

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

5.2.19 Level of Care Modifiers

All services are required to be submitted with only one level of care modifier. The following level of care modifiers are used by DMC - ODS Counties: U1, U2, U3, U7, U8, U9, UA/HG, and UB. 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). See Service Tables 1-12 for a

list of the valid procedure/modifier combinations. Claims for NTP services must be submitted with both HG and UA modifiers to be valid.

Multiple Levels of Care on Same Day
Services for one level of care will not be allowed in combination with other services in another level of care for the same beneficiary, same date of service except for care coordination services, recovery services, peer support services, and MAT services.

Recovery Services and Level of Care Modifiers
Service lines for recovery services must be submitted with the U6 modifier as well as a level of care modifier. Please see service table 8 for a list of recovery services codes. Service lines submitted for a recovery service that do not contain the U6 modifier will be denied.

5.2.20 Perinatal and Non-Perinatal Services

All service lines on a claim must be either perinatal or non-perinatal. SD/MC will deny a claim with service lines that are identified as perinatal and service lines that are not perinatal.

To indicate that a service is perinatal, 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.

5.2.21 Place of Service Codes

Outpatient services are listed in Service Tables 1-12. SD/MC will deny all claims for outpatient services that do not include a place of service code. Service Tables 1-12 also list all of 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.

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

5.2.22 Dependent Codes

Service Tables 1-12 list all outpatient procedure codes. The procedure codes listed in the first column labeled “Service” are considered primary procedure codes. The procedure codes listed in the sixth column labeled “Dependent on Codes” identifies procedure codes that must be billed before the primary procedure can be billed. SD/MC will deny a service line with the primary procedure code if a Dependent on Code was not billed on the same claim or approved on the same day for the same beneficiary.

5.2.23 One Hundred Percent County Funded

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

5.2.24 Units of Service - Outpatient Services

All claims for outpatient services must bill using units. SD/MC will deny a service line that is not billed in units

5.2.25 Maximum Units - Outpatient Services

Column 8, labeled "Maximum Units that Can be Billed", in Service Tables 1-12 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 exceeds the unit maximum as displayed in the "Maximum Units that Can Be Billed" Column in Service Tables 1-12. Only the time it takes to provide direct services associated with that code can be counted toward a unit of service**.**

5.2.26 Fractional Units – Outpatient Services

Units of service for all outpatient codes must be billed in whole numbers. For example, if service code 90791 (Psychiatric diagnostic evaluation) is billed for 1.5 units, the service will be denied.

Medication Addiction Treatment (MAT) services billed with fractional units must total one unit per drug type per day on a claim. Service will be denied if fractional units do not total one unit per drug type. MAT services for the same drug type and day of service billed with fractional units on a claim will either be approved or denied together. Non-NTP providers may use code H0033 (Oral Medication Administration) and an NDC code to bill for MAT services. For additional information about billing for MAT services, please see BHIN 20-064.

5.2.27 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 covered by Medicare and performed by Medicare-certified providers in a Medicare certified facility 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. SD/MC will deny service lines submitted without OHC information when the service was provided to a beneficiary enrolled in Medicare, Medicare covered the service, and a Medicare certified provider rendered the service.

Medicare Eligible Services

The Medi-Cal state plan covers some Drug Medi-Cal services that Medicare does not cover. The seventh column in service tables 1-12, labeled "Medicare COB Required?" identifies the specific services that may be billed directly to Medi-Cal. 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 Medicare does not cover HCPCS code, the service. Medicare must be billed first when the Medicare covered services is rendered by a Medicare eligible provider. The claim submitted to Medi-Cal must contain information about the Medicare claim. If Medicare does not respond within 90 days, the provider may submit a claim to Medi-Cal on the 91st day.

Procedures codes H0004 (Individual Counseling), H0005 (Group Counseling), and 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 codes 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). Medicare does not cover drug types 3, 6, 7, and 10.

Medicare Certified Providers

The Medi-Cal state plan identifies some provider types that are eligible to render Drug Medi-Cal services, which are not eligible to render Medicare services. If the rendering provider is not eligible to render Medicare services, the county may bill Medi-Cal directly (i.e., the service line does not need to contain OHC information). Medicare must be billed first when one of the following licensed provider types provides the Medicare eligible service:

1. Physician
2. Physician assistant
3. Nurse practitioner
4. Licensed clinical social worker
5. Clinical psychologist, or

NTP services and Medicare Part B beneficiaries:

Medicare Part B reimburses Opioid Treatment Programs (OTPs) a weekly rate for a bundle of services that includes dosing, individual counseling, and group counseling. When billing NTP services for a beneficiary that has Medicare Part B, all dates of service on the claim must fall within a 7-day calendar window associated with the Medicare Part B payment. Services submitted outside of the 7-calendar day window will be denied. For example, if a claim submitted for NTP services rendered to a Medicare Part B beneficiary, indicates services were rendered on dates of service between November 3 and November 12 (10 calendar days), services with dates of service November 10 and after, which fall outside the 7-calendar day window, will be denied. Please see BHIN 21-065 for additional guidance on billing for NTP services for dual eligible beneficiaries.

5.2.28 Other Health Care Coverage – Non-Medicare

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

Eligible Services

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

1. Claims for Recovery Services
2. Claims for Treatment Planning
3. Claims for services where the rendering provider's taxonomy indicates that they are *not* a Licensed Physician, Physician Assistant, Psychologist, Licensed Certified Social Worker, Registered Nurse, and Nurse Practitioner.
4. Claims for services that were provided by an intern or resident and therefore carry an HL or GC modifier.

This rule does not apply to claims submitted for beneficiaries who are enrolled in minor consent aid codes. Claims for these beneficiaries do not have to have OHC information.

5.2.29 Lockout Rules

Outpatient Lockouts:
SD/MC enforces two types of lockout rules. The California Code of Regulations prohibits some Drug Medi-Cal services from being provided to a beneficiary on the same day. SD/MC will deny a service line when the California Code of Regulations prohibits that service from being provided to a beneficiary on the same day as a service approved in history. The Centers for Medicare and Medicaid Services (CMS) also requires states to implement the National Correct Coding Initiative (NCCI). NCCI identifies procedure codes that should not be billed on the same day for the same beneficiary unless certain conditions are met[12]. SD/MC will also deny a claim for a service when NCCI prohibits that service from being provided to a beneficiary on the same day as a service approved in history unless certain conditions are met.

Service tables 1-12 identify the combinations of procedure codes that cannot be billed for the same beneficiary on the same day. Column 1, labeled "Code", lists each outpatient procedure code. Column 5, labeled "Lockout Codes," lists all procedure codes that are locked out for the procedure code in Column 1 when provided to the same beneficiary on the same day. The combination of the Code in Column 1 and each Lockout Code in Column 5 represents a lockout situation when both are provided to the same beneficiary 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 are identified in Column 5 of Service Tables 1-12 by one or two asterisks (*). Target codes with one asterisk are not locked out when combined with the procedure code in Column 1 if the target code is billed with one of the following over-riding modifiers: 59, XE, XP or XU. Target codes with two asterisks are not locked out when combined with the procedure code in Column 1 if the target code is billed with one of the following over-riding modifiers 27, 59, XE, XP, or XU.

Withdrawal Management 1, 2 and 3.2 Lockouts:
The only services that can be billed on the same day as Ambulatory Withdrawal Management services are additional MAT, methadone dosing, care coordination and clinical consultation. The only services that can be billed with Residential Withdrawal Management 3.2 are additional MAT, methadone dosing, care coordination, clinical consultation, and recovery services.

Medication Services Lockouts:
Procedure codes used to claim reimbursement for Medication Services are listed in Service Table 3. Certain medication services have lockouts and are not allowed to be billed on the same day**.** Below is a list of these lockouts.

- Buprenorphine, Buprenorphine combination, and Buprenorphine-Naloxone: Sublingual film cannot be billed the same day with Disulfiram, Naloxone, or Acamprosate.
- Disulfiram cannot be billed the same day with Vivitrol or Acamprosate.
- Naloxone, Disulfiram, Acamprosate, methadone, and vivitrol cannot be billed more than once on the same day.
- Vivitrol cannot be billed on the same day with Acamprosate.
- Methadone cannot be billed on the same day with Buprenorphine, Vivitrol, Acamprosate, Buprenorphine Combination, or Buprenorphine-Naloxone: Sublingual film.

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

- Methadone cannot be billed in the same calendar month as Buprenorphine: Long-Acting Injection or Naltrexone: Long-Acting Injection.
    - Only Disulfiram, Naloxone, and Acamorosate are allowed to be billed in same calendar month as Buprenorphine: Long-Acting Injection.
    - Only Naloxone is allowed to be billed in same calendar month as Naltrexone: Long-Acting Injection.
- Buprenorphine: Long-Acting Injection and Naltrexone: Long-Acting Injection are limited to no more than two units each per beneficiary per calendar month.

5.2.30 Pregnancy Indicator

If the beneficiary is enrolled in an aid code that is restricted to pregnancy services, the pregnancy indicator must be set to yes or the claim will be denied. For postpartum extension aid codes with restricted status (except aid code 76), the pregnancy indicator must be included or claim will be denied.

Note: Emergency services is not covered benefits in the DMC -ODS programs. Counties should use aid codes related to "pregnancy/emergency services" for pregnancy services only.

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

EPSDT beneficiaries in DMC - State Plan counties are eligible for all DMC – ODS services. The county of residency or county of responsibility must submit claims for expanded DMC – ODS services provided to EPSDT beneficiaries in DMC – State Plan counties.

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

5.2.32 Withdrawal Management 3.7 and 4.0 Claims

DMC-ODS counties are able to voluntarily cover and receive reimbursement through the DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, FAPHs, or CDRHs. Regardless of whether the DMC-ODS County covers ASAM Levels 3.7 or 4.0, the DMC-ODS County implementation plan must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0. BHIN 21-075 clarifies coverage of voluntary inpatient detoxification through the Medi-Cal Fee-For-Service program.

These services are classified as institutional services and any related claims must be submitted on an inpatient claim. Withdrawal Management 3.7 and 4.0 must be submitted using only Revenue Code 0953, a Procedural Code System (PCS) Code, and Demonstration Project Indicator as outlined in BHIN 19-032 Exhibits A and B. Inpatient claims must be submitted using one unit per day. Claim will be denied if the number of units billed exceeds the max days allowed. For example, if withdrawal management is billed for dates of service November 1, 2021 – November 4 and the units billed are six, claim will be denied.

5.2.33 Covered Diagnosis

Inpatient and residential claims must have a DMC **covered** substance use disorder ICD-10 diagnosis code as indicated in BHIN 20-074E. Covered diagnosis codes are a subset of valid ICD-10 codes. Counties are required to use the appropriate ICD-10 codes to submit Inpatient and residential claims for reimbursement. If the diagnosis code is not a covered ICD-10 code, the claim will be denied

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

5.3.0 Replacing Approved and Denied Claims

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

Replacement claims for **previously denied claims** must be submitted within 6 months from the date that 835 file was sent. If claim is submitted after this 6 months 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 being voided. Replacement claims for outpatient services, day services, or 24-hour services must have the Billing Employer Identification number.

5.4.0 Voiding Approved Claims

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

5.5.0 Requesting Delay Reason Codes

Counties may request a Delay Reason Code (DRC) to submit an original claim more than six months from the month of service or a replacement claim more than six months from the date of initial payment issued/date the 835 was sent if the delay in submitting the original or replacement claim is because proof of eligibility was unknown or unavailable, there was an administrative delay in the prior approval process, litigation, there was a delay in certifying the provider, there was a third party processing delay, there was a delay in eligibility determination, or other, by contacting MedCCC at MedCCC@dhcs.ca.gov. Submission of replacement claims must not exceed 6 months from initial payment or 6 months from the date that 835 was sent (regardless if DRC is present) or claim will be denied.

CHAPTER SIX: FUNDING

CHAPTER 6: FUNDING

6.0 Introduction

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

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

6.1 Federal Share: FMAP Percentage and Aid Codes

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

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

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

6.2 State Share and Proposition 30

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

6.2.1. State Required Proposition 30 Services

The State will reimburse DMC-ODS counties 100% of the non-federal share to provide certain services to certain beneficiaries as described in this section of the billing manual.

6.2.1.1. Medi-Cal Optional Expansion Full Scope Beneficiaries

For Full Scope beneficiaries enrolled through the Medi-Cal Optional Expansion Program (ACA), the state will reimburse DMC-ODS counties one hundred percent of the non-federal share for all services (pregnancy and non-pregnancy) when services are provided in one of the following levels of care.

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

This means that DHCS will reimburse DMC-ODS counties one hundred percent of the approved amount for services provided in those levels of care when provided to a beneficiary with unsatisfactory immigration status enrolled through the ACA.

6.2.1.2. Non-Perinatal Full Scope Federally Eligible Beneficiaries
For Full Scope Non-federally eligible beneficiaries **not** enrolled through the Medi-Cal Optional Expansion Program, the state will reimburse counties the non-federal share for **non-pregnancy** services when services are provided in one of the following levels of care.

- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

6.2.1.3. State Only Medi-Cal Beneficiaries Added After September 30, 2012
The state will reimburse counties 100 percent of the non-federal share for certain services provided to state only medi-cal beneficiaries added after September 30, 2012. This subsection discusses each group of State-Only Medi-Cal beneficiaries added after September 30, 2012 and the specific services for which the state reimburses 100 percent of the non-federal share.

Senate Bill (SB) 75 – Medi-Cal for All Children
Children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements (SB 75, Chapter 8, Statutes of 2015). As a result, children under 19 years of age who do not have satisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which beneficiaries are eligible for the State-Only Medi-Cal Program as a result of SB 75 by the beneficiaries' aid code. The state will reimburse counties 100 percent for **non-pregnancy** services provided to beneficiaries enrolled in the State Only Medi-Cal Program pursuant to SB 75 beneficiaries. For SB 75 beneficiaries receiving pregnancy services, the state will reimburse counties the non-federal share portion. Services provided in the listed levels of care below are subject to these funding requirements.

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2

- Residential Treatment 3.5 , services submitted with modifier U3

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

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

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

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

6.2.2. Federally Required Proposition 30 Services
DHCS has not implemented any federally required Proposition 30 services for DMC-ODS counties.

6.2.3. One Hundred Percent County Funded
The county is responsible to finance 100% of the cost to provide services to beneficiaries in the following eligibility groups.

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 Medi-Cal Optional Expansion Program. The state will reimburse counties 100 percent of the cost when the service is a **non-pregnancy** service for Qualified Non-Citizens enrolled through the Medi-Cal Optional Expansion Program (ACA). For pregnancy related services, the state will reimburse counties the non-federal share for Qualified Non-Citizens enrolled through the Medi-Cal Optional Expansion program. Services provided in the listed levels of care below are subject to these funding reimbursement requirements.

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

For Qualified Non-Citizens that are **not** enrolled through the Med-Cal Optional Expansion Program, the state will reimburse counties the non-federal share for pregnancy services provided in the levels of care listed above. Qualified Non-Citizens are enrolled in specific aid codes that are listed in the Aid Code Master Chart.

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. Federal reimbursement is not available for non-pregnancy services provided to PRUCOL beneficiaries enrolled through the Medi-Cal Optional Expansion Program. The state will reimburse counties 100 percent of the cost when the service is a **non-pregnancy** services provided to PRUCUL beneficiaries enrolled through the Medi-Cal Optional Expansion Program (ACA). For pregnancy related services, the state will reimburse counties the non-federal share for PRUCOL beneficiaries enrolled through the Medi-Cal Optional Expansion program. Services provided in the listed levels of care below are subject to these funding reimbursement requirements.

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG
- Intensive Outpatient Treatment (IOT), services submitted with modifier U8
- Residential Treatment 3.1, services submitted with modifier U1
- Residential Treatment 3.3, services submitted with modifier U2
- Residential Treatment 3.5 , services submitted with modifier U3

For PRUCOL beneficiaries that are **not** enrolled through the Med-Cal Optional Expansion Program, the state will reimburse counties the non-federal share for pregnancy services provided in the levels of care listed above. PRUCOL beneficiaries are enrolled in specific aid codes that are listed in the Aid Code Master Chart.

Minor Consent Beneficiaries

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

CHAPTER SEVEN: ANCILLARY TABLES

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

Table 1 Disciplines

Rendering providers/practitioners may only provide services consistent with their education/licensure (scope of practice), length of experience and/or job description. The following table describes the abbreviations that are used in service tables 1-12. The column labeled Abbreviations gives the abbreviation used in service tables 1-12 and the column labeled Discipline states what the discipline is. A taxonomy code describing the provider delivering the service must be listed on all professional claims (837P claims) or the claim will be denied. The SD/MC claiming system will verify whether the service was provided appropriately based, in part, on whether the provider's taxonomy code is associated with the service provided. Providers allowed to perform each procedure are specified in service tables 1-12. Taxonomy codes associated with the providers below can be found in Appendix 1-Taxonomy Codes.

DMC ODS Counties	
Abbreviations	**Discipline**
LP	Licensed Physician
PA	Physician Assistant
Pharm	Registered Pharmacist
Psy	Psychologist (Licensed or Waivered)
LCSW	Licensed Clinical Social Worker
MFT	Licensed Marriage Family Therapist
LPCC	Licensed Professional Clinical Counselor
RN	Registered Nurse
NP	Nurse Practitioner
AOD	Certified/registered AOD Counselor
Peer	Certified Peer Support Specialist

Table 2 Place of Service Codes for Professional Claim

Many codes have specified place of service codes describing where they can be performed. As a result, allowable places of service must accompany appropriate CPT and HCPCS codes for SD/MC to process the claim. Below are the allowable places of service associated with codes listed in service tables 1-12. The column titled Place of Service Code lists the code associated with the name of the place of service. The column titled Place of Service Name lists the name of the place of service. The column titled Place of Service Description describes the place of service. Place of service codes must be used on 837 professional claims to specify where the service(s) were rendered or the claim will be denied. Allowable places of service for each code are listed in services tables 1-12. As the Centers for Medicare and Medicaid Services (CMS) develops and maintains place of service codes and descriptions, DHCS will not be changing or in any way altering them until they are modified by CMS. Please note that if a service is provided via telehealth (audio only or audio/video) place of service code 02 or 10 **must** be used.

Place of Service Code	Place of Service Name	Place of Service Description
01	Pharmacy	A facility where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home'	The location, other than in patients home, where health services and health related services are provided or received, through a telecommunication system
03	School	A facility whose primary purpose is education
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters)
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.

Place of Service Code	Place of Service Name	Place of Service Description
10	Telehealth Provided in Patient's Home	Health services and health related services are provided or received, through a telecommunication system in the patient's home.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).
15	Mobile Unit	A facility/unit that moves from place to place equipped to provide preventive screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short-term accommodation such as a hotel, campground, hostel, cruise ship or resort where the patient receives care and which is not identified by any other Place of Service code.
17	Walk-in Retail Health Clinic	A walk-in retail clinic, other than an office, urgent care facility, pharmacy, or independent clinic and not described by any other Place of Service code that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
18	Place of Employment-Worksite	A location, not described by any other Place of Service code, owned and operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual.
19	Off Campus—Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

Place of Service Code	Place of Service Name	Place of Service Description
22	On-Campus Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance—Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Code	Place of Service Name	Place of Service Description
52	Psychiatric Facility—Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center (CMHC)	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility, which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or a distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location, which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT).
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia or influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

Place of Service Code	Place of Service Name	Place of Service Description
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically underserved area, that provides ambulatory primary medical care under the direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Table 3 Modifiers.

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

Medicare's definitions of the modifiers often differ from California-specific definitions. For example, in Medicare modifier GT is specific to a Medicare telehealth demonstration project in Alaska and Hawaii whereas modifier SC means medically necessary. Due to the considerable discrepancy between how DHCS uses HCPCS modifiers and Medicare uses HCPCS modifiers, HCPCS modifiers are only used with CPT codes when a service cannot be billed to Medicare or when CMS requires the use of a specific HCPCS modifier (e.g., modifier XE).

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

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

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
27	**Multiple Outpatient Hospital Evaluation and Management (E/M) Encounters on the Same Date**: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level of outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The lockout codes that can be overridden have ** next to them in service tables 1-12. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.
59	**Distinct Procedural Service**: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an evaluation and management service.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. This modifier may be used by a licensed, intern/resident or otherwise qualified healthcare professional employed by the county and/or contracted provider. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	This modifier will be used with CPT codes that are part of an over-ridable lockout combination

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
93	**Audio only telehealth services**	Use when service is provided via telephone	This modifier will be used with CPT codes
95	**Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunication System:** Synchronous telemedicine is defined as a **real-time** interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.	Use this modifier when a health care professional is providing services and benefits via telehealth. If using this modifier, indicate that the service was provided in Place of Service 02 or 10.	This modifier will be used with CPT codes that can be provided in a telehealth place of service.
GC	This service has been performed in part by a resident under the direction of a teaching physician.	Use this modifier when a physician resident performed the service. The supervising physician's NPI would be reported with modifier GC after the service to indicate that a resident performed the service. If an intern who is not a resident performed the service, use modifier HL. Interns and residents are licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician as stated on page 23 of BHIN 21-075 and page 6m of State Plan Amendment 21-0058	
GQ	Via asynchronous telecommunication system	For outpatient services: Use this modifier with procedure code 99368 when non-physicians rendered a clinical consultation. Must be submitted with place of service 02 or 10. This benefit in only available in DMC – ODS Counties.	
GT	Via interactive audio and video telecommunication systems	Use this modifier on day or 24-hour claims when the service was provided via telehealth. Also use this modifier with Code	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		H2011 (Crisis Intervention, per 15 minutes) when service is provided via telehealth.	
HA	Child/adolescent program	Use this modifier with 24-hour services when the beneficiary is less than 21 years old on the service date.	
HD	(Pregnant/ Parenting women's program)	All claims must have an HD modifier when service is provided to a woman who is pregnant/postpartum.	
HF	Identifies when Contingency Management Services was provided as part of a Substance Use Disorder Program	Under this modifier to bill for contingency Management Services, Code H0050 (Alcohol and/or Drug Services, brief intervention, 15 minutes)	
HG	Opioid treatment program (OTP).	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder. All Claims must have HG (and a UA) modifier when service is provided in NTP Setting	
HL	Intern	Use this modifier when registrants and interns who are working in clinical settings under the supervision to obtain licensure performed the service. The supervising clinician's NPI would be reported with modifier HL after the service to indicate that an intern performed the service. If a resident performed the service, use modifier GC. Interns and residents are licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician as stated on page 23 of BHIN 21-075 and page 6m of State Plan Amendment 21-0058.	
HW	The State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30	Use this modifier to identify services that the county provided as a result of a **state** mandate that are subject to Proposition 30. Currently use this modifier with code H2011 (Crisis Intervention Services, per 15 minutes.	
SC	Valid for codes when the service was provided via telephone or audio-only systems.	Use this modifier when a health care professional is providing services and benefits via telephone or audio-only and that service is described by a HCPCS code. If using this modifier,	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		indicate that the service was provided in Place of Service 02 or 10.	
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	
XP	Separate practitioner, a service that is distinct because it was performed by a separate practitioner.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.	Use this modifier, as appropriate, to override those lockout codes that can be overridden with a modifier. The codes that can be overridden have * or ** next to them. These modifiers need to be used even if the over-ridable lockout combinations were provided by that same provider to the	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service codes cannot be billed together, whichever code is processed second will be denied.	
U1	ASAM 3.1 Residential (RES)	Clinically Managed Low - Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	
U2	ASAM 3.3 Residential (RES)	Clinically Managed Population - Specific High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	
U3	ASAM 3.5 Residential (RES)	Clinically Managed High Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	
U4	Ambulatory withdrawal management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision. Does not represent a "level of care". It represents a certain service within one of the levels of care.	
U5	Ambulatory withdrawal management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation. Does not represent a "level of care". It represents a certain service within one of the levels of care.	
U6	Recovery Services	Recovery services that can be provided in all settings (ODF, IOT, PH, OTP/NTP, RES 3.1 & 3.3, 3.5, 3.2 WM).Does not	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		represent a “level of care”. It represents classification of service for within one of the levels of care.	
U7	Outpatient Services (ODF)	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	
U8	Intensive Outpatient Services (IOT)	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	
U9	Residential Withdraw Management , 3.2	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	
UA	ASAM OTP/NTP	All claims must include an UA (and an HG) modifier when service is provided in NTP setting.	
UB	Partial Hospitalization	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	

CHAPTER EIGHT: SERVICE TABLES

The service tables below describe the procedure codes associated with each service type: Assessment, Crisis Intervention, Medication Services, Family therapy, Care Coordination, Discharge Services, Group Counseling, Individual Counseling, Recovery Services, and Treatment Planning, and Peer Support Services. There is also a table for a group of codes called Supplemental. Supplemental codes are codes that must be used with another code. As stated above (and except for Care Coordination Services, Recovery Services, Peer Support Services, and MAT Services), outpatient services 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 - ODS Counties:

- H0019|U1: 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.
- H0019|U2: 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.
- H0019|U3: 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.
- H0012|U9: Alcohol and/or drug services: (residential addiction program outpatient). Subacute detoxification.

All the service tables contain the following columns:

1. Service: This column provides a brief description of the procedure. Most descriptions are self-explanatory but there are a few items that should be noted.
    - New vs. established patient: Some evaluation and management (E/M) codes (CPT codes 99202-99499) are described as being services for a new or for an established patient. In the context of E/M codes, 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. 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. When advanced practice nurses and physician assistants work with physicians/psychiatrists in the same practice, they are considered as working in the exact same specialty and subspecialty as the physician/psychiatrist whether or not they are working "under" the psychiatrist's/physician's license. Furthermore, if the patient receives care in county-operated facilities and/or from county-employed providers, then the patient is an existing patient so long as they continue to receive care in that provider from in county-operated facilities and/or county-employed providers. As CPT E/M codes are separated by whether or not the patient is new or established, please make sure to bill the appropriate code.
    - Qualified health care professional: In the context of E/M codes, qualified healthcare professional: In the context of E/M codes, "qualified healthcare professional" usually means a physician assistant or advanced practice nurse. There are exceptions to this rule. For example, the services described by CPT code 99368 (medical team conference) can be rendered by most provider types. In general, however, a Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist can render E/M services. Please also note that the service

descriptions provided are brief descriptions. For a full description of the services, please consult the CPT book. The CPT books are copyrighted by the American Medical Association (AMA) and are commercially available for purchase. AMA publishes CPT errata and technical corrections throughout the year on the AMA website dedicated to that purpose.

- Time: Each code is associated with a length of time 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. However, one unit of time is attained when the mid-point is passed. For example, one unit of CPT code 96170, Health Behavioral Intervention first 30 minutes, may be claimed when 16 minutes of intervention have elapsed. Sixteen minutes is more than mid-way between zero and thirty minutes. Level of medical decision is not explicitly considered as part of code selection as it is assumed that the more complex situations require more time.

2. Code (Required): This lists the procedure code.

3. SD/MC Allowable Disciplines (Required): 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 alphanumeric characters of the relevant taxonomies is located in Appendix 1-Taxonomy Codes. Counties are responsible for ensuring that providers deliver services within their scope of practice. If an intern or resident performs a service, the service code should have modifier HL or GC after it and the taxonomy and NPI of the supervising clinician/physician should be on the claim. A service code that uses an HL or GC modifier should not be submitted to Medicare first; they should be submitted to SD/MC directly.

4. Allowable Place of Service (Required): CPT codes must be reported in allowable places of service. This column lists the number of the place(s) of service where the different procedures are allowed. Refer to Table 2-Place of Service Codes for Professional Claim for a description of the Place of Service codes. If a claim does not list a place of service, it will be denied. As stated in Telehealth section above, if a service is provided via telehealth, the place of service **must** be either 02 or 10. In addition, no service code may be claimed for place of service 09.

5. Lockout Codes: Some codes cannot be billed together and others can only be billed together in extraordinary circumstances. Codes that cannot be billed with the procedure listed in column Code are listed in the Lockout Codes column. If a code is not included in the service tables' column titled Lockout Codes then it can be used with the code in the Code column. However, 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 if the code is not an evaluation and management code or prolonged service code G2212 if the code is an evaluation and management code.

   If a CPT code has an * or ** after it, it can be listed with the procedure under extraordinary circumstances. If a CPT code has * after it, it can be used with modifier 59, XE, XP, or XU, as appropriate. If a code has ** after it, it can be used with modifiers 27, 59, XE, XP, or XU as appropriate. The modifier must follow the code in the Lockout Codes column. Please refer to Table 3-Modifiers for a description of the

modifiers and when to use them. Note: Most of the codes listed in the Lockout Codes column may be overridden under appropriate circumstances. If considering claiming for two codes that cannot normally be billed together, review both codes to see whether there is any instance in which one of the service codes appear in the Code and Lockout Codes columns carrying a * or **. Also, note that all outpatient services (except for Care Coordination and Recovery Services codes) are locked out against inpatient and 24-hour services except for the date of admission.

6. Dependent on Codes: Some codes can only be billed after certain other codes are billed. If there are codes listed in the Dependent on Codes column, those codes must be billed before the procedure in question. The dependent codes must be billed on the same claim as the primary code(s). If the column states "None", then the codes can be billed alone. Only one 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.
7. Exempt from Medicare COB?: This column specifies whether a procedure, if rendered to a Medi-Medi beneficiary, claims must first be submitted to Medicare before being submitted to SD/MC if an eligible licensed provider (Physician, Physician Assistant, Nurse Practitioner, Clinical Social Worker, or Clinical Psychologist) renders it and the service does not carry an HL or GC modifier. If there is a No in the Column then the procedure must be submitted to Medicare first. If there is a yes in the column then it does not need to be submitted to Medicare first. If a licensed professional listed above did not provide a procedure, the service should not be submitted to Medicare, as Medicare will reject the claim.
8. Maximum Units that Can be Billed: All codes will be billed in units. Most CPT codes that are listed in the manual have a time or time range associated with them. When a code did not have a time or time range associated with it, DHCS assigned a time of 15 minutes to that code. This column lists the maximum number of units that the procedure can be billed in a 24-hour period. Please note, that no procedure must be billed the maximum number of times it can be billed. A unit of service is attained when a mid-point is passed. For example, CPT code 96130 (Psychological Testing Evaluation, first 60 minutes) can be claimed when 31 minutes of direct service have been provided. Thirty-one minutes is more than mid-way between zero and 60 minutes. Please note, procedures should be billed at the number of units that correspond to the number of minutes of direct service provided to the patient. Procedure codes can only be claimed in whole units; fractional units will be denied.
9. Allowable Modifiers: This column lists the modifiers that are allowed with this procedure. 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 or code. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. There are some instances (such as lack of an over-riding modifier) when lack of a modifier will cause a service code to be denied. Please note that HCPCS (alpha) modifiers can be used with CPT and HCPCS codes but CPT (numeric) modifiers can only be used with CPT codes. However, Medicare's definitions of the modifiers often differ from California-specific definitions. For example, in Medicare modifier GT can be used without additional restrictions as part of a federal telehealth demonstration project in Alaska and Hawaii whereas modifier SC means the service or supply is medically necessary. Due to the considerable discrepancy between how DHCS uses HCPCS modifiers and Medicare uses the same HCPCS modifiers, HCPCS modifiers are only used with CPT codes when a service cannot be billed to Medicare, when CMS requires the use of a specific HCPCS modifier (e.g., modifier XE.

Service Table 1 Assessment Codes

Consists of activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 03, 05 - 08, 10-26, 31-34, 41-42, 49-58, 60-62, 49, 65, 71-72, 81, 99	Cannot be billed with: 90791,90792, 90849, 96170-96171*, 99202-99205**, 99212-99215**, 99217**, 99234-99236**, 99304-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**,	None	No	1	DMC – ODS: HD, HG, UA, U1, U2, U3, U7, U8, UB, HL, GC, 59, XE, XP, XU
Psychiatric Diagnostic Evaluation, 15 Minutes	90791	DMC – ODS: • LP • PA • Psy • LCSW • MFT • NP	DMC – ODS: 01-08, 10-26, 31-34, 41-42, 49-58, 60-62, 65, 71-72, 81, 99	Cannot be billed with: 90792, 90882*, 90885*,90887*, 90889*, 96160, 96170, 96171,	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, , 59, 93, 95

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• LPCC		99202-99205**, 99212-99215**, 99217**, 99234-99236**, -99304-99310**, 99324-99328**, 99334-99337**, 99339-99340**, 99341-99345**, 99347-99350**, 99367-99368**, 99408-99409**, 99441-99443**, 99451**, 99495-99496** G0396*,G0397*, G2011*				
Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	DMC – ODS: • LP • PA • NP	DMC – ODS: All Except 09.	Cannot be billed with: 90791, 90865,90882*, 90885*,90887*, 90889*, 96160, 96170, 96171, 99202-99205**, 99212-99215** 99217**, 99234-99236**, 99304-99310**,	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, , 59, 93, 95

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99324-99328**, 99495-99496* 99334-99337**, 99339-99340**, 99341-99345**, 99347-99350**, 99367-99368**, 99408-99409** 99441-99443**, 99451** G0396*,G0397*, G2011*,				
Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885	DMC – ODS: • LP • PA • Psy • LCSW • MFT • NP • LPCC	DMC – ODS: All except 02,09, and 10	Cannot be billed with: 90791,90792, , 96170, 96171*,	None	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, XE, XP, XU
Psychological Testing Evaluation, First Hour	96130	DMC – ODS: • LP • PA • Psy	DMC – ODS: All except 09	Cannot be billed with: 99202-99205, 99212-99215, 99217,	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• NP		99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350,				
Psychological Testing Evaluation, Each Additional Hour	96131	DMC – ODS: • LP • PA • Psy • NP	DMC – ODS: All except 09	Cannot be billed with: N/A	Must use code 96130 before coding 96131.	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 93, 95, XE, XP, XU
Telephone Assessment and Management Service, 5-10 Minutes	98966	DMC – ODS: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 98967,98968, 99495, 99496	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, 59, 93, XE, XP, XU
Telephone Assessment and Management Service, 11-20 Minutes	98967	DMC – ODS: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 98966,98968, 99495, 99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, 59, 93, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Telephone Assessment and Management Service, 21-30 Minutes	98968	DMC – ODS: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 98966,98967, 99495, 99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, 59, 93, XE, XP, XU
Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849, 90865, 96130*, 99212-99215** 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of a New patient, 30-44 Minutes	99203	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849,90865, 96130*, 99212-99215** 99234-99236,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC,, 27, 59, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99304-99306, 99408-99409**, G0396*,G0397*, G2011*				
Office or Other Outpatient Visit of a New Patient, 45-59 Minutes	99204	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849,90865, 96130*, 99212-99215** 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of a New Patient, 60-74 Minutes	99205	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849,90865, 96130*, 99212-99215** 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established	99212	DMC – ODS: • LP • PA	DMC – ODS: 01, 02, 03-08,	Cannot be billed with: 90791-90792, 90849,	None	No	1	DMC – ODS:

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Patient, 10-19 Minutes		• NP	10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	90865, 96130* 99202-99205, 99213-99215, 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*				HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849, 90865,96130* 99202-99205, 99212** 99214-99215, 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849, 90865,96130* 99202-99205, 99212-99213*, 99215, 99234-99236, 99304-99306, 99408-99409**,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				G0396*,G0397*, G2011*				
Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215	DMC – ODS: • LP • PA • NP	DMC – ODS: 01, 02, 03-08, 10-20, 22-26, 31-34, 41-42, 49-50, 52-55, 57-58, 60, 62, 65,71-72, 81, 99	Cannot be billed with: 90791-90792, 90849, 90865,96130* 99202-99205, 99212- 99214**, 99234-99236, 99304-99306, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 35-44 Minutes	99234	DMC- ODS: • LP • PA • NP	DMC – ODS: 05 – 08, 19, 21-23, 26, 51, 61 .	Cannot be billed with: 90791 -90792, 90849,90865, 96130*, 99202-99205**, 99212-99215**, 99217**, 99235-99236, 99307-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U9, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 45-53 minutes	99235	DMC – ODS: • LP • PA • NP	DMC – ODS: 05-08, 19, 21-23, 26, 51, 61	Cannot be billed with: 90791 -90792, 90849,90865, 96130*, 99202-99205**, 99212-99215**, 99217**, 99234,** 99236, 99307-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U9, UB, HL, GC, 27, 59, XE, XP, XU
Observation or Inpatient Hospital Care, Including Admission and Discharge on the Same Date, 54-60 Minutes	99236	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 - 08, 19, 21-23, 26, 51, 61	Cannot be billed with: 90791 -90792, 90849,90865, 96130*, 99202-99205**, 99212-99215**, 99217**, 99234,** 99235**, 99307-99310**, 99324-99328**, 99334-99337**,	None	No	1	DMC – ODS: HD, U9, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99341-99345**, 99347-99350**, 99408-99409**, 99451, G0396*, G0397*, G2011*,				
Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16-29 Minutes	99304	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 – 08, 26, 31, 32	Cannot be billed with: 90791-90792 90849,90865, 96130* 99202-99205** 99212-99215** 99305-99306 99307-99310** 99324-99328** 99334-99337** 99341-99345** 99347-99350** 99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU
Initial Nursing Facility Care per Day, for the	99305	DMC – ODS: • LP	DMC – ODS: 05 – 08, 26, 31, 32	Cannot be billed with: 9079	None	No	1	DMC – ODS:

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes		• PA • NP		90849,90865, 96130* 99202-99205** 99212-99215** 99304**,99306, 99307-99310** 99324-99328** 99334-99337** 99341-99345** 99347-99350** 99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,				HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU
Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40-60 Minutes	99306	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 – 08, 26, 31, 32	Cannot be billed with: 90791-90792, 90849,90865, 96130* 99202-99205** 99212-99215** 99304**,99305, 99307-99310** 99324-99328** 99334-99337** 99341-99345** 99347-99350**	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,				
Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 - 08, 26, 31, 32	Cannot be billed with: 90791-90792, 90849,90865, 96130*, 99234-99236, 99304- 99306, 99308-99310, 99324-99328, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU
Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor	99308	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 - 08, 26, 31 32	Cannot be billed with: 90791-90792, 90849,90865, 96130* 99234-99236, 99304-99306, 99307**, 99309-99310, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Complication, 13-19 Minutes								
Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 - 08, 26, 31 32	Cannot be billed with: 90791-90792, 90849,90865, 96130* 99234-99236, 99304-99306, 99307-99308**, 99310, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU
Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310	DMC – ODS: • LP • PA • NP	DMC – ODS: 05 – 08, 26, 31 32	Cannot be billed with: 90791-90792, 90849,90865, 96130* 99234-99236, 99304-99306, 99307-99309**, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Domiciliary or Rest Home Visit of a New Patient, 15-25 Minutes	99324	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849,90865, 96130*, 99234-99236, 99304-99306, 99325-99328, 99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of a New Patient, 26-35 Minutes	99325	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,33-34, 54-56	Cannot be billed with: 90791,90792, 90849,90865, 96130*, 99234-99236, 99304-99306, 99324** 99326-99328, 99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of a	99326	DMC – ODS:	DMC – ODS:	Cannot be billed with:	None	No	1	DMC – ODS:

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
New Patient, 36-50 Minutes		• LP • PA • NP	04, 05 - 08, 12-16, 26 ,33-34, 54-56	90791,90792, 90849, 90865, 96130*, 99234-99236, 99304-99306, 99324-99325**, 99327-99328 99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,				HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of a New Patient, 51-65 Minutes	99327	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54,	Cannot be billed with: 90791,90792, 90849,90865,96130* ,99234-99236, 99304-99306, 99324-99326**, 99328,99451, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of a New Patient, 66-80 Minutes	99328	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849,90865, 96130*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99234-99236, 99304-99306, 99324-99327**, 99408-99409**, 99451, G0396*, G0397*, G2011*,				
Domiciliary or Rest Home Visit of an Established Patient, 10-20 Minutes	99334	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99335-99337, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of an Established Patient, 21-35 Minutes	99335	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99334**, 99336-99337, 99408-99409**,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99451, G0396*, G0397*, G2011*,				
Domiciliary or Rest Home Visit of an Established Patient, 36-50 Minutes	99336	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 - 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99334-99335**, 99337, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Domiciliary or Rest Home Visit of an Established Patient, 51-70 Minutes	99337	DMC – ODS: • LP • PA • NP	DMC – ODS: 04, 05 – 08, 12-16, 26 ,31-34, 54-56	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99334-99336**, 99337, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Home Visit of a New Patient, 15-25 Minutes	99341	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849,90865, 96130*, 99234-99236, 99304-99306, 99342—99345, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Home Visit of a New Patient, 26-35 Minutes	99342	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849,90865, 96130*, 99234-99236, 99304-99306, 99341**, 99343—99345, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Home Visit of a New Patient, 36-50 Minutes	99343	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849,90865, 96130*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99234-99236, 99304-99306, 99341-99342**, 99344—99345, 99408-99409**, 99451, G0396*, G0397*, G2011*,				
Home Visit of a New Patient, 51-65 Minutes	99344	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99341-99343**, 99345, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Home Visit of a New Patient, 66-80 Minutes	99345	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99341-99344**, 99408-99409**,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99451, G0396*, G0397*, G2011*,				
Home Visit of an Established Patient, 10-20 Minutes	99347	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99348-99350, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Home Visit of an Established Patient, 21-35 Minutes	99348	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99347**, 99349-99350, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Home Visit of an Established Patient, 36-50 Minutes	99349	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99347-99348**, 99350, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Home Visit of an Established Patient, 51-70 Minutes	99350	DMC – ODS: • LP • PA • NP	DMC – ODS: 04 - 08, 12-16, 31-34	Cannot be billed with: 90791,90792, 90849, 90865,96130*, 99234-99236, 99304-99306, 99347-99349**, 99408-99409**, 99451, G0396*, G0397*, G2011*,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Telephone Evaluation and Management Service, 5-10 Minutes	99441	DMC – ODS: • LP • PA • NP	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 90791,90792, 99442,99443, 99495, 99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, , 27,59, 93, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Telephone Evaluation and Management Service, 11-20 Minutes	99442	DMC – ODS: • LP • PA • NP	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 90791,90792, 99441,99443, 99495, 99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, , 27,59, 93, XE, XP, XU
Telephone Evaluation and Management Service, 21-30 Minutes	99443	DMC – ODS: • LP • PA • NP	DMC – ODS: 02, 05 - 08, 10	Cannot be billed with: 90791,90792, 99441,99442, 99495, 99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, , 27,59, 93, XE, XP, XU
Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC ODS: All except 09	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Alcohol and/or drug screening. Laboratory analysis	H0003	DMC - ODS: • LP • PA • Psy	DMC – ODS: All except 02,09, and 10	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• RN • NP • Pharma						
Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048	DMC - ODS: • LP • PA • RN • NP • Pharma	DMC – ODS: All except 02, 09. 10	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC
Alcohol and/or drug screening	H0049	DMC - ODS: • LP • Pharma • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Alcohol and/or substance (other than tobacco)	G2011	DMC - ODS: • LP	DMC – ODS: All except 09 and 21.	Cannot be billed with: 90791-90792,	None	No	1	DMC – ODS:

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).		• Pharma • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD		90849, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99408-99409, G0396-G0397,				HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC, 59, XE, XP, XU
Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396	DMC - ODS: • LP • Pharma • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09 and 21.	Cannot be billed with: 90791-90792, 90849, 96170, 96171*, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99408-99409, G0397, G2011	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC, 59, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397	DMC - ODS: • LP • Pharma • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	All except 09 and 21.	Cannot be billed with: 90791-90792, 90849, 96170, 96171, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99408-99409, G0396, G2011	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC, 59, XE, XP, XU

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
**Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.
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Service Table 2 SUD Crisis Intervention Codes

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

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Alcohol and/or drug services; crisis intervention (outpatient),	H0007	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP	DMC – ODS: All except 02, 09, and 10.	None,	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC
Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • Peers • AOD	DMC – ODS: 15	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, GT, HW, SC

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.

** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 3 Medication Services Codes

Medication Services includes 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.

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note:** MAT services codes H0033 and H0034 codes are NOT lockout against residential and inpatient services.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212	DMC – ODS: • LP • PA • NP	DMC – ODS: All except 09	None	90791, 90792, 90865, 90882, 90885, 90887, 90889, 96131, 99215,99217, 99236, 99310,99328, 99337,99340, 99345,99350, 99368,99409,	No	95	HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC,
Oral Medication Administration, Direct Observation, 15 Minutes	H0033	DMC – ODS: • LP • PA • Pharma • NP • RN	DMC ODS: All except 09	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, UB, GC
Medication Training and Support, per 15 Minutes	H0034	DMC – ODS: • LP • PA • Pharma • NP	DMC ODS: All except 09	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9,

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** MAT services codes H0033 and H0034 codes are NOT lockout against residential and inpatient services.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• RN						UB, HL, GC, UB, GC

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 4 Treatment Planning Codes

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

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09.	None	None	Yes	96	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Community-Based Wrap-Around Services, per 15 Minutes	H2021	DMC – ODS: • LP • PA • Pharma • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09.	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Psychoeducational Service, per 15 minutes	H2027	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09.	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 5 Individual Counseling Codes

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

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Behavioral health counseling and therapy, 15 minutes.	H0004	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09, 21, 23, and 51.	None	None	H0004 not exempt from Medicare when provided with modifiers UA: HG for NTP/MAT dosing.	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408	DMC - ODS: • LP • PA • NP	DMC – ODS: All except 09, 81.	Cannot be billed with: 90791-90792, 90849, 96170-96171*, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345,	None	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, UB, HL, GC, 27, 59, 93, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
				99347-99350, 99409, 99451, G0396, G0397, G2011,				
Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409	DMC - ODS: • LP • PA • NP	DMC – ODS: All except 09, 81.	Cannot be billed with: 90791-90792, 90849, 96170-96171*, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99408, 99451, G0396, G0397, G2011,	None	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, UB, HL, GC, 27, 59, 93, 95, XE, XP, XU
Alcohol and/or substance abuse services, family/couple counseling	T1006	DMC - ODS: • LP • Psy • PA • LCSW • MFT • RN	DMC – ODS: All except 09, 41, and 42.	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• NP • LPCC • AOD						
Alcohol and/or Drug Services, brief intervention, 15 minutes (Code must be used to submit claims for Contingency Management Services)	H0050	DMC - ODS: • LP • Psy • PA • LCSW • MFT • RN • NP • LPCC • AOD • Peers	DMC – ODS: All Except 09	None	None	Yes	96	DMC – ODS: HD, UA, HG, U7, U8, UB, HF

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 6 Group Counseling Codes

Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. Units for group counseling should be calculated using the following formula:

Number of minutes for the group counseling session/15 minute increments = Total Units to submit using code H0005
For example: 120 minutes/15 minutes = 8 Units which is equivalent to 8 units of code H0005*
*DHCS will adjust the rate to 1/6th. Counties should submit claims separately for each beneficiary receiving group counseling

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 01, 09, 21, 41, 42, 51, 61, 81.	None	None	H0005 not exempt from Medicare when provided with modifiers UA: HG for NTP/MAT dosing.	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded services.

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Service Table 7 Care Coordination Codes

Care Coordination consists of activities to provide coordination of SUD care, mental health care, and primary care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings.

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** Care Coordination codes are NOT lockout against residential and inpatient services.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies,	90882	DMC - ODS: • LP • PA • Psy • LCSW • MFT	DMC – ODS: All except 02, 09, and 10.	Cannot be billed with: 90791-90792, 96170-96171,	None	Yes	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, , XE, XP, XU

employers, or institutions.		• RN • NP • LPCC • AOD						
Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – ODS: All except 02, 09, 10.	Cannot be billed with: 90791-90792, , 96170-96171,	None	No	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, XE, XP, XU,
Administration of patient-focused health risk assessment instrument.	96160	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – ODS: All except 09.	Cannot be billed with: 90791-90792, 96170-96171,	None	No	1	DMC – ODS: HD, U1, U7, U8, UB, HL, GC, 93, 95
Individual physician supervisory of a patient (patient not present) in home, 15 – 29 minutes	99339	DMC - ODS: • LP • PA • NP	DMC – ODS: All except 01-03, 09 -11, 17-26, 41, 42, 49, 50, 52, 53, 57, 58, 60, 61, 62, 65, 71, 72, 81, 99.	Cannot be billed with: 90791-90792, 99495-99496,	None	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU

Individual physician supervisory of a patient (patient not present) in home. Each additional 30 minutes	99340	DMC - ODS: • LP • PA • NP	DMC – ODS: All except 01-03, 09 -11, 17-26, 41, 42, 49, 50, 52, 53, 57, 58, 60, 61, 62, 65, 71, 72, 81, 99.	Cannot be billed with: 90791-90792, 99495-99496,	99339	No	1	DMC – ODS: HD, U7, U8, UB, HL, GC, 27, 59, XE, XP, XU
Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367	DMC – ODS: • LP	DMC ODS: All except 09	Cannot be billed with: 90791-90792, 99495-99496,	None	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 27, 59, 93, 95, XE, XP, XU
Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non-Physician. Patient and/or Family Not Present. 30 Minutes or More	99368	DMC – ODS: • PA • Pharma • Psy • LCSW • MFT • RN • NP • LPCC	DMC ODS: All except 09 DMC State Plan: Not a covered benefit	Cannot be billed with: 90791-90792, 99495-99496,	None	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GQ, 27, 59, 93, 95, XE, XP, XU
Inter-Professional Telephone/Internet/	99451	DMC – ODS: • LP	DMC – ODS:	Cannot be billed with: 90791-90792,	None	No	1	DMC – ODS:

Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes			Only 02 and 10	99217, 99334-99236, 99304-99310, 99324-99328, 99334-99337 99341-99345 99347-99350 99408-99409,				HD, U7, U8, U9, UB, HL, GC, 27, 59, 95, XE, XP, XU
Prenatal Care, at risk assessment.	H1000	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All Except 09	None	None	Yes	96	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC
Targeted Case Management, Each 15 Minutes	T1017	DMC - ODS: • LP • PA • Pharma • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All Except 09	None	None	Yes	96	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.

** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

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Service Table 8 Recovery Services Codes

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries.

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note**: Recovery Services codes are NOT lockout against residential and inpatient services.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Alcohol and/or drug services: (hospital inpatient) Subacute detoxification	H0008	DMC - ODS: • LP • PA • NP • Pharma	DMC – ODS: Only 05 - 08, 21, 26, 52, 61,	None	None	Yes	96	DMC – ODS: HD, UA, HG, U6, U9, HL, GC, SC
Alcohol and/or drug services: (hospital inpatient) Acute detoxification	H0009	DMC - ODS: • LP • PA • NP • Pharma	DMC – ODS: Only 05 - 08, 21, 26, 52, 61,	None	None	Yes	96	DMC – ODS: HD, UA, HG, U6, U9, HL, GC, SC
Comprehensive community support services, per 15 minutes	H2015	DMC - ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – ODS: All except 09.	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U6, U7, U8, U9, UB, HL, GC, SC

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note**: Recovery Services codes are NOT lockout against residential and inpatient services.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• AOD						
Psychosocial Rehabilitation, per 15 Minutes	H2017	DMC - ODS: • LP • PA • Psy • Pharma • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09.	None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U6, U7, U8, U9, UB, HL, GC, SC
Alcohol and/or other drug treatment program, Per Hour	H2035	DMC - ODS: • LP • PA • Psy • Pharma • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09, 21, 31, 32, 51, 61,	None	None	Yes	23	DMC – ODS: HD, UA, HG, U1, U2, U3, U6, U7, U8, U9, UB, HL, GC , SC

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.

** Except with modifiers 27, 59, XE, XP, XU. Modifiers have to be on the target or excluded service.

Service Table 9 Supplemental Services Codes

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

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Interactive Complexity	90785	DMC – ODS: • LP • PA • Psy • Pharma • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09	Cannot be billed with: 96170-96171,	90791-90792, 99202-99205, 99212-99215, 99217, 99234 – 99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350,	No	1 per allowed procedure per provider per beneficiary.	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 93, 95
Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887	DMC – ODS: • LP • PA • Pharma • Psy • LCSW • MFT	DMC – ODS: All except 09	Cannot be billed with: 90791-90792, 96170, 96171*	90849, 90865,90882 90889, 96130, 96160, 99202-99205, 99212-99215, 99217,	Yes	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• NP • LPCC			99234-99236, 99304-99310, 99324-99328, 99334-99337, 99339-99340, 99341-99345, 99347-99350, 99367-99368, 99408-99409, 99495-99496,			
Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – ODS: All except 09	Cannot be billed with: 90785, 90791-90792, 90849*, 90865, 90882*, 90885*, 90887*, 90889*, 96160, 99408-99409, G0396-G0397*,	90791-90792, 90865, 96130-96131, 98966-98968, 99202-99205, 99212-99215, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99441-99443, G0396-G0397, G2011, H0001,	Yes	1	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – ODS: All except 09	Cannot be billed with: 90785, 90791-90792, 90849, 90865, 90882*, 90885, 90887, 90889*, 96160, 99408-99409, G0396-G0397*,	96170	Yes	47	DMC – ODS: HD, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95, XE, XP, XU
Sign Language or Oral Interpretive Services, 15 Minutes	T1013	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09	None	90791-90792, 90849,90865, 90885,90887, 96130, 96131,96160, 96170, 96171, 98966-98968, 99202-99205, 99212-99215, 99217, 99234-99236, 99304-99310, 99324-99328, 99334-99337, 99339-99340, 99341-99345, 99347-99350, 99354-99357,	Yes	Variable	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
					99367-99368, 99408-99409, 99441-99443, 99495-99496, G0396-G0397, G2011, G2212, H0001,H0003, H0004, H0005, H0007, H0008, H0009, H0019, H0020, H0033, H0034, H0050, H1000, H2014, H2015, H2017, H2021, H2027, H2035, S0201, S5000, S5001, T1006, T1007, T1017,			

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 10 Discharge Services Codes

Discharge services includes 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.

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Observation Care Discharge Day Management, 15 Minutes	99217	DMC – ODS: • LP • PA • NP	DMC - ODS: 05-08, 19, 22, 23, 26, 31, 32, 54	Cannot be billed with: 90791-90792, 90849,90865, 96130*, 99234-99236, 99408-99409**, 99451, G0396-G0397*, G2011*,	None	No	1	DMC – ODS: HD, UA, HG, GC, 27, 59, XE, XP, XU
Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495	DMC – ODS: • LP • PA • NP	DMC – ODS: All except 09, 21, 31, 51, 54, 55, 56, 61	Cannot be billed with: 90791-90792, 98966-98968*, 99339-99340**, 99441-99443*, 99496,	None	No	1	DMC – ODS HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, , 27, 59, 95, XE, XP, XU
Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	DMC – ODS: • LP • PA • NP	DMC – ODS: All except 09, 21, 31, 51, 54, 55, 56, 61	Cannot be billed with: 90791-90792, 98966-98968*, 99339-99340** 99441-99443*, 99495,	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, , 27, 59, 95, XE, XP, XU

Alcohol and/or substance abuse services, treatment plan development and/or modification**.**	T1007	DMC – ODS: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – ODS: All except 09.	None	None	Yes	96	**DMC ODS:** HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, SC

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 11 Family Therapy Codes

Family Therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

Service	**Code**	**SD/MC Allowable Disciplines**	**Allowable Place of Service**	**Lockout Codes** **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	**Dependent on Codes**	**Exempt from Medicare COB?**	**Maximum Units that Can be Billed**	**Allowable Modifiers**
Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846	DMC –ODS: • LP • PA • Psy • LCSW • MFT	DMC-ODS: All except 09	Cannot be billed with: 90791, 90792, 96170, 96171, 99408, 99409,	None	No	1	DMC-ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC,

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• NP • LPCC		90847*, 90849*, 90865*, 99202-99205***, 99212-99215**, 99217**, 99234-99236**, 99304-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**, G0396-G0397*, G2011*,				59, 93, 95, XE, XP, XU
Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847	DMC –ODS: • LP • PA • Psy • LCSW • MFT • NP • LPCC	DMC-ODS: All except 09	90791, 90792, 96170, 96171, 99408, 99409, 90846*, 90849*, 90865*, 99202-99205***, 99212-99215**, 99217**, 99234-99236**, 99304-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**, G0396-G0397*, G2011*,	None	No	1	DMC-ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 93, 95, XE, XP, XU

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission or discharge.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Multiple-Family Group Psychotherapy, 15 Minutes	90849	DMC – ODS: • LP • PA • Psy • LCSW • MFT • NP • LPCC	DMC – ODS: All except 09	Cannot be billed with: 90791, 90792, 96170, 96171, 99408, 99409, 90846*, 90847*, 90865*, 99202-99205**, 99212-99215**, 99217**, 99234-99236**, 99304-99310**, 99324-99328**, 99334-99337**, 99341-99345**, 99347-99350**, G0396-G0397*, G2011*,	None	No	1	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, HL, GC, 59, 95, XE, XP, XU ,

*Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.

** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 12 Peer Support Specialist Services Codes

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

Service	Code	SD/MC Allowable Disciplines	Allowable Place of Service	Lockout Codes **Note:** Peer Support Services codes are NOT lockout against residential or inpatient services.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Behavioral Health Prevention Education service, delivery of service with target population to affect knowledge, attitude, and/or behavior.	H0025	DMC – ODS: • Peer Support Specialists	DMC – ODS: All except 09	Cannot be billed with: None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, SC
Self-help/peer services, per 15 minutes	H0038	DMC – ODS: • Peer Support Specialists	DMC – ODS: All except 09	Cannot be billed with: None	None	Yes	96	DMC – ODS: HD, UA, HG, U1, U2, U3, U7, U8, U9, UB, SC

Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.
** Except with modifiers 27, 59, XE, XP, and XU. Modifiers have to be on the target or excluded service.

Service Table 13 Existing 24-Hour and Day Services

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

Partial Hospitalization (ASAM Level 2.5)
Services feature twenty or more hours of clinically intensive programming per week. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified patient needs which require daily management but that can be appropriately addressed in a structured outpatient setting. Services consist of intake, individual and/or group counseling, patient

education, family therapy, medication services, crisis intervention, treatment planning, and discharge services. This service is claimed as a single unit per day. Procedure S0201 represents this service and it is available in Drug Medi-Cal – ODS counties only.

Withdrawal Management (ASAM Levels 1, 2, and 3.2)
Services includes intake, observation, medication services, and discharge services. Providers must have a residential license and be certified to provide residential detoxification for ASAM 3.2 Residential Withdrawal Management. Providers must have an AOD Detox Certification to provide ASAM 1 or 2 Withdrawal Management. Service code H0012 in table below represents Withdrawal Management 3.2. Service code H0014 with modifier U4 represents Withdrawal Management 1 and H0014 with modifier U5 represents withdrawal Management 2.

Narcotic Treatment Program (NTP) Services:
Services includes intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone. Service code H0020 in table below represents these services and it is considered a day service. Other medications, under the Opioid NTP program, which includes Buprenorphine, Naloxone and Disulfiram are billed using codes S5000 and S5001 using a National Drug Code (NDC). One unit per day is allowed for dosing.
If a service (other than the actual dosing of medications) was provided via telehealth, use Modifier GT: (Valid for codes when the service was provided via synchronous, interactive audio and telecommunication systems).
For the services below, the HA (Child/adolescent program) modifier must be included if the beneficiary was less than 21 years old on the date of service.

		DMC – ODS	
Category	**Procedure Code & Modifier**	**Description**	**Exempt from Medicare COB?**
Existing 24-Hour Service	H0019: U1	Behavioral Health; Long Term Residential	Yes
Existing 24-Hour Service	H0019: U2	Behavioral Health; Long Term Residential	Yes
Existing 24-Hour Service	H0019: U3	Behavioral Health; Long Term Residential	Yes
Existing 24-Hour Service	H0012: U9	Alcohol and/or drug services: (residential addiction program outpatient). Subacute detoxification	Yes
Existing Day Service	H0014: U7: U4	Alcohol and/or drug services; ambulatory detoxification	Yes
Existing Day Service	H0014: U7: U5	Alcohol and/or drug services; ambulatory detoxification	Yes
Existing Day Service	H0014: U8: U4	Alcohol and/or drug services; ambulatory detoxification	Yes

		DMC – ODS	
Category	**Procedure Code & Modifier**	**Description**	**Exempt from Medicare COB?**
Existing Day Service	H0014: U8: U5	Alcohol and/or drug services; ambulatory detoxification	Yes
Existing Day Service	H0014: UB: U4	Alcohol and/or drug services; ambulatory detoxification	Yes
Existing Day Service	H0014: UB: U5	Alcohol and/or drug services; ambulatory detoxification	Yes
Existing Da Service	H0020: UA: HG	Alcohol and/or drug services; methadone	No
Existing Day Service	S0201: UB	Partial Hospitalization	Yes
Existing Day Service	S5000: UA: HG	Prescription Drug: Generic	No
Existing Day Service	S5001: UA: HG	Prescription Drug: Brand Name	No

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 service tables 1-12 for the rules governing outpatient service codes. Even though SD/MC only verifies the first four alphanumeric characters, the provider is obligated to provide the entire taxonomy code on the 837P claim. For beneficiaries who are also eligible for Mental Health Services, please see the Mental Health Billing Manual to reference taxonomy codes under the Mental Health Services program.

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

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Alcohol and Other Drug Counselors (AOD Counselors)	146D
	146L
	146M
	146N
	171M
	374K
	2258
	2260
	4053
Licensed Professional Clinical Counselor (LPCC)	1012
	102X
	103K
	1714
	222Q
	106E
	225C
	2256
Marriage and Family Therapist (MFT)	1012
	102X
	103K

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	106E
	106H
	1714
	222Q
	225C
	2256
Nurse Practitioner (NP)	363L
Pharmacist (Pharma)	1835
Physician Assistant (PA)	363A
Licensed Physician (LP)	202C
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	2082
	2083
	2084
	2085
	2086
	2088
	208C
	208D
	208G
	208M
	202D
	208U
	208V
	2098
Peer Support Specialist	175T
Psychologist (Psy)	102L
	103G
	103T
Registered Nurse (RN)	3675
	374K
	163W
Licensed Clinical Social Worker (LCSW)	102X
	103K
	1041
	1714
	106E
	225C
	222Q

Appendix 2: Definitions

Claim: A request for payment that a provider submits to the MHP 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. MHPs and counties submit claim files.

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

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

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

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

Intern: A licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician as stated on page 23 of BHIN 21-075 and page 6m of State Plan Amendment 21-0058.

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 services tables 1-12.

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. DHCS classifies these individuals as licensed-eligible practitioners registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician as stated on page 23 of BHIN 21-075 and page 6m of State Plan Amendment 21-0058.

Service Line: A line on the claim describing one service and containing one procedure code. A service line can contain multiple units of one procedure code but it cannot contain more than one procedure code.
Services Provided by Interns/Residents: To indicate that the service was provided by an intern use modifier HL after the service code. Indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. To indicate that the service was provided by a resident use modifier GC after the service code. On the claim, indicate that the supervising professional is the billing provider. Services that have modifiers HL or GC after them, even if they are otherwise eligible for Medicare COB, should be sent directly to Medi-Cal.
Target Code: In an over-ridable combination, this is the code that must use the over-riding modifier.
Waivered Professional: A professional from another state whose license is recognized by California. Waivered professionals can bill under their own license and do not need to use an HL or a GC modifier.

Appendix 3: DMC ODS Procedure Codes

Appendix 3 below lists the procedure codes included as benefits for DMC – ODS counties. Column 1 includes the procedure code; column two includes descriptions for each procedure.

Procedure Code	Code Description
90785	Interactive Complexity
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90846	Family Psychotherapy (Without the Patient Present), 26-50 minutes
90847	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes
90849	Multiple-family group psychotherapy
90865	Narcosynthesis for Psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarital (Amital) interview.
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data
90889	Preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.

96130	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
96131	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision-making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour.
96160	Administration of patient-focused health risk assessment instrument.
96170	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes
96171	Health behavior intervention, family (without the patient present), face-to-face. Each additional 16 - 30 minutes.
98966	Non-Face-to-Face Non-physician Services. Telephone Services. Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian. 5-10 minutes of medical discussion.
98967	Non-Face-to-Face Non-physician Services. Telephone Services. Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian. 11-20 minutes of medical discussion.
98968	Non-Face-to-Face Non-physician Services. Telephone Services. Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian. 21-30 minutes of medical discussion.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or explanation and straightforward medical decision-making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or explanation and low level of medical decision-making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or explanation and moderate level of medical decision-making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or explanation and high level of medical decision-making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or explanation and straightforward medical decision-making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or explanation and low level of medical decision-making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or explanation and moderate level of medical decision-making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or explanation and high level of medical decision-making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99217	Observation Care Discharge Services, Services are used to report evaluation and management services provided to patients designated/admitted as “observation status” in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital. Observation care discharge day management. This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital.
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires the following three components: • A detailed or comprehensive history • A detailed or comprehensive examination • Medical decision-making that is straightforward or of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient’s hospital floor or unit. 35-44 Minutes.
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires the following three components: • A comprehensive history • A comprehensive examination • Medical decision-making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient’s hospital floor or unit. 45-53 Minutes.

99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires the following three components: • A comprehensive history • A comprehensive examination • Medical decision-making of high complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit. 54-60 Minutes
99304	Initial Nursing Facility Care per day, for the evaluation and management of a patient which requires three of the three components: • Detailed or comprehensive history • Detailed or comprehensive examination • Medical decision-making that is straightforward or of low complexity Counseling and/or coordination of care with other physicians, other qualified health professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit. 16-29 minutes
99305	Initial Nursing Facility Care per day, for the evaluation and management of a patient which requires three of the following three components: • Detailed or comprehensive history • Detailed or comprehensive examination • Medical decision-making that is moderate complexity Counseling and/or coordination of care with other physicians, other qualified health professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit. 30-39 minutes.
99306	Initial Nursing Facility Care per day, for the evaluation and management of a patient which requires three of following the three components: • Comprehensive history • Comprehensive examination • Medical decision-making of high complexity Counseling and/or coordination of care with other physicians, other qualified health professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

	Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit. 40-60 minutes
99307	Subsequent Nursing Facility Care, per day, for the evaluation and management of a patient, which requires at least 2 of the following 3 components • A problem focused interval history • A problem focused examination • Straightforward medical decision-making Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit. 1-12 minutes
99308	Subsequent Nursing Facility Care, per day, for the evaluation and management of a patient, which requires at least 2 of the following 3 components • An expanded problem focused interval history • An expanded problem focused examination • Medical decision-making of low complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit. 13-19 minutes
99309	Subsequent Nursing Facility Care, per day, for the evaluation and management of a patient, which requires at least 2 of the following 3 components: • A detailed interval history • A detailed examination • Medical decision-making of moderate complexity Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit. 20-25 minutes
99310	Subsequent Nursing Facility Care, per day, for the evaluation and management of a patient, which requires at least 2 of the following 3 components: • A detailed interval history • A detailed examination • Medical decision-making of moderate complexity

	Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit. 30-40 minutes
99324	Domiciliary or rest home visit for the evaluation and management of a new patient. 15-25 Minutes
99325	Domiciliary or rest home visit for the evaluation and management of a new patient, Low complexity. 26-35 Minutes
99326	Domiciliary or rest home visit for the evaluation and management of a new patient, Moderate Complexity. 36-50 Minutes
99327	Domiciliary or rest home visit for the evaluation and management of a new patient, Moderate Complexity. 51-65 Minutes
99328	Domiciliary or rest home visit for the evaluation and management of a new patient, High Complexity. 66-80 Minutes
99334	Domiciliary or rest home visit for the evaluation and management of an established patient. 10-20 Minutes
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, Low Complexity. 21-35 Minutes
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, Moderate Complexity. 36-50 Minutes
99337	Domiciliary or rest home visit for the evaluation and management of an established patient, Moderate to High Complexity. 51-70 Minutes
99339	Individual physician supervisory of a patient (patient not present) in home, domiciliary or rest home, requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. 15-29 Minutes.
99340	Individual physician supervisory of a patient (patient not present) in home, domiciliary or rest home, requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Each additional 30 minutes.
99341	Home visit for the evaluation and management of a new patient: Requires 3 components: a problem focused history; a problem focused examination; and a straightforward medical decision-making. 15-25 Minutes
99342	Home visit for the evaluation and management of a new patient: Requires 3 components: an expanded problem focused history; an expanded problem focused examination; and a medical decision-making of low complexity. 26-35 Minutes
99343	Home visit for the evaluation and management of a new patient: Requires 3 components: a detailed history; a detailed examination; and a medical decision-making of moderate complexity. 36-50 Minutes
99344	Home visit for the evaluation and management of a new patient: Requires 3 components: a comprehensive history; a comprehensive examination; and a medical decision-making of moderate complexity. 51-65 Minutes
99345	Home visit for the evaluation and management of a new patient: Requires 3 components: a comprehensive history; a comprehensive examination; and a medical decision-making of high complexity. Significant new problem requiring immediate physician attention. 66-80 Minutes

99347	Home visit for the evaluation and management of an established patient: Requires at least 2 of these 3 components: a problem focused interval history; a problem focused examination; and a straightforward medical decision-making. 10-20 Minutes.
99348	Home visit for the evaluation and management of an established patient: Requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; and a medical decision-making of low complexity. 21-35 Minutes.
99349	Home visit for the evaluation and management of an established patient: Requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; and a medical decision-making of moderate complexity. 36-50 Minutes
99350	Home visit for the evaluation and management of an established patient: Requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive examination; and a medical decision-making of moderate to high complexity. 51-70 Minutes
99367	Medical Team Conference; with interdisciplinary team of health care professionals, patient and/or family not present, 30 or more; participation by physician.
99368	Medical Team Conference; with interdisciplinary team of health care professionals, patient and/or family not present, 30 or more, participation by nonphysician qualified health care professional
99408	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT ,DAST), and brief intervention (SBI) services. 15-30 minutes.
99409	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT ,DAST), and brief intervention (SBI) services. Greater than 30 minutes.
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 5-10 minutes of medical discussion.
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 11-20 minutes of medical discussion.
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report E/M services provided to an established patient, parent, or guardian. 21-30 minutes of medical discussion.
99451	Inter-professional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional. 5-15 minutes
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision-making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision-making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge

G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment. 5-14 Minutes
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to office or other outpatient evaluation and management services) (15 min)
H0001	Alcohol and/or drug assessment.
H0003	Alcohol and/or drug screening. Laboratory analysis of specimens for presence of alcohol and/or drugs.
H0004	Behavioral health counseling and therapy, 15 minutes.
H0005	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.
H0007	Alcohol and/or drug services; crisis intervention (outpatient),
H0008	Alcohol and/or drug services: (hospital inpatient) Subacute detoxification
H0009	Alcohol and/or drug services: (hospital inpatient) Acute detoxification
H0012	Alcohol and/or drug services: (residential addiction program outpatient). Subacute detoxification
H0014	Alcohol and/or drug services; ambulatory detoxification
H0019	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.
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0048	Alcohol and/or other drug testing. Collection and handling only, specimens other than blood.
H0049	Alcohol and/or drug screening
H0050	Alcohol and/or Drug Services, brief intervention, 15 minutes
H1000	Prenatal Care, at risk assessment.
H2014	Skills training and development, per 15 minutes.
H2015	Comprehensive community support services, per 15 minutes
H2017	Psychosocial rehabilitation services, 15 Minutes.
H2021	Community-based wrap-around services, per 15 minutes

H2027	Psychoeducational Service, per 15 minutes
H2035	Alcohol and/or other drug treatment program, Per Hour
S0201	Partial Hospitalization Services; less than 24 hours, per diem.
S5000	Prescription Drug: Generic
S5001	Prescription Drug: Brand Name
T1006	Alcohol and/or substance abuse services, family/couple counseling
T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification.
T1013	Sign Language or Oral Interpretative Services.
T1017	Targeted Case Management