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

This chapter includes:

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

1.1 About This Billing Manual

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

1.1.1 Objectives

The primary objectives of this Billing Manual are to:

- Provide explanations, procedures and requirements for claiming
- Provide claiming system overviews and process descriptions
- Provide 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 - State Plan services including but not limited to:

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

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

1.3 Authority

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

1.3.1 Social Security Act

Federal Social Security Act Title XIX, Grants to States for Medical Assistance Programs, 42 USC § 1396-1396v, Subchapter XIX, Chapter 7 (1965), provides the basis for the development of each State's Medicaid plan.

1.3.2 Social Security Act Title XXI, 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 DHCS Information Notices

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

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

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

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

1.3.9 Companion Guide for the 835 Healthcare Claim Payment/Advice

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

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

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

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

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

This is the technical report document for the ANSI ASC X12N 837 Health Care Claims (837) transaction for professional claims and/or encounters. This document provides a definitive statement of what

trading partners must be able to support in this version of the 837. For more information about the 837P Implementation Guide, please refer to the X12 website.

1.3.13 ASC X12N/005010X221 Health Care Claim Payment/Advice (835) Implementation Guide
The purpose of this implementation guide is to provide standardized data requirements and content for all users of ANSI ASC X12.835, Health Care Claim Payment/ Advice (835). This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. For more information about the 835 Healthcare Claim Payment/Advice, please refer to the X12 website.

1.3.14 Claim Adjustment Reason Codes-Remittance Advice Remarks (CARC-RARC)
This is more detailed information about the meaning of the denial codes received.

1.4 Medi-Cal Claims Customer Service Office (MedCCC)

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

What counties can expect when contacting MedCCC:

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

To ensure the accuracy of the inquiry and responses, MedCCC requests that counties email inquiries to MedCCC@dhcs.ca.gov. 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 - State Plan trading partners (e.g., counties, Contracted Providers, and authorized Vendors) to access information securely over the Internet. DHCS will continue to allow trading partners to have two Approvers per system. Each county's behavioral health director appoints Approvers.

All system approver certification forms are available on the DHCS 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-SD/MC-ADP (Substance Use Disorder). The Designated Approvers will also be able to send their own staff invites to the Portal as users.

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

2.2 Provider Numbers and NPIs

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

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

Federal regulations require that individual healthcare providers and organizations obtain NPIs. DHCS maintains a 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 - State Plan services, providers must first be DMC certified by DHCS PED. Certification is unique to a particular facility location and specifies the DMC services that can be provided at that location. Certification also distinguishes between services

that can be provided within the regular (non-perinatal) DMC program, and those that may be provided within the perinatal DMC program for substance use disorder services for pregnant and postpartum women. For more specific certification information, contact PED by email, DHCRecert@dhcs.ca.gov, or visit the DHCS Provider Enrollment 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. 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.
- External auditors can review verification of beneficiary Medi-Cal eligibility after the claimed month of service.
- Medi-Cal eligibility may require that a beneficiary's Share of Cost (SOC) be met before Medi-Cal will pay for any services.
- Clients who are eligible for Supplemental Security Income (SSI) are Medi-Cal eligible.
- Medi-Cal eligibility may be established retroactively through legislation, court hearings, and/or decisions.
- HIPAA 270/271 transactions are available from DHCS to verify beneficiary Medi-Cal eligibility.
- Counties and/or providers should verify beneficiary Medi-Cal eligibility prior to submitting claims for reimbursement.

3.1.2 Eligibility Review

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

3.1.3 Monthly MEDS Extract File (MMEF)

The Monthly MEDS Extract File (MMEF) contains, among other data, all Aid Codes for which beneficiaries who are the county's responsibility are eligible at the date/time the file was created. The MMEF contains information for the current month and previous 15 months. A new MMEF is available at the end of each month and applies to the following month's eligibility. MMEF data is not used to determine eligibility during adjudication. The adjudication process queries the Medi-Cal Eligibility Data System (MEDS) for eligibility data at the time the claim is being adjudicated.

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

3.1.4 MEDS and MEDSLITE

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

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

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

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)[2], Mental Health Programs, and/or EPSDT[3] programs.

[2] Drug Medi-Cal Overview

[3] 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 - State Plan services and it includes:

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

4.1 DMC - State Plan Covered Services

Substance use disorder (SUD) treatment services are provided in accordance with the Code of Federal Regulations (CFR) 440.130(d) to restore the beneficiary to their best possible functional level. All SUD treatment services must be recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice. SUD treatment services are based on medical necessity.
The following services, per State Plan Amendment 20-0006, are reimbursable under the DMC – State Plan Program. Claims for reimbursement of DMC-SPA services may be submitted to the SD/MC claiming system via the Portal.

4.1.1 Assessment:

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

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

4.1.2 Group Counseling:

"Group Counseling" means a contact with multiple beneficiaries at the same time. Group counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes at least 2 and no more than 12 participants.

4.1.3 Individual Counseling:

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

4.1.4 Medical Psychotherapy:

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

4.1.5 Medication Services:

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

4.1.6 Medication for Addiction Treatment (also known as Medication Assisted Treatment (MAT)) for Opioid Use Disorders (OUD):

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

4.1.7 Mobile Crisis Services: State Plan Amendment 22-0043

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

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

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

4.1.8 Patient Education:

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

4.1.9 Peer Support Services:

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

Peer support services include the following service components:

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

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

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

4.1.10 SUD Crisis Intervention Services:
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.

4.2 DMC – State Plan Levels of Care

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

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- Patient Education (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1-A)
- SUD Crisis Intervention Services (as defined above)

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

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- Patient Education (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-A of the State Plan)
- SUD Crisis Intervention Services (as defined above)

4.2.3 Outpatient Treatment Services (also known as Outpatient Drug Free (ODF) :
Outpatient Services include the following components:

- Assessment (as defined above)
- Individual Counseling (as defined above)
- Group Counseling (as defined above)
- Patient Education (as defined above)
- Medication Services (as defined above)
- MAT for OUD (as defined in Supplement 3 to Attachment 3.1-A of the State Plan)

- Crisis Intervention Services (as defined above)

4.2.4 Perinatal Residential Services:

Perinatal Residential Substance Use Disorder Treatment includes assessment, individual and group counseling services, parenting education, body specimen screens, medication services, MAT for OUD services, and crisis intervention services provided by staff that are lawfully authorized to provide these services within their scope of practice or licensure. Perinatal residential services must be provided in a residential facility licensed by DHCS. Services are reimbursable only when provided in a facility with treatment capacity of sixteen beds or less. The cost of room and board is not reimbursable under the Medi-Cal program. Facilities shall store and safeguard all residents' medications, and facility staff members may assist with resident's self-administration of medication.

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

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

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

CHAPTER FIVE: CLAIMS PROCESSING

5.0 Introduction

Drug Medi-Cal codes are billed using Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) Level II, and Revenue codes[4]. 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 standard 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 Claims

The SD/MC claiming system adjudicates all claims that pass the SNIP edits and are accepted. Adjudication involves application of all business requirements described in this chapter of the billing

manual. Claims or service lines that meet all the business requirements are approved and claims or services lines that do not meet a business requirement are denied.

5.2.1 Zero Dollar Claims

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

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

5.2.5 Beneficiary Date of Birth

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

5.2.6 Beneficiary Gender

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

5.2.7 Beneficiary Date of Death

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

5.2.8 Dates of Services Within a Claim

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

5.2.9 Claims for Residential Stays that Cross One or More Months

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

5.2.10 Service Lines and Date Ranges

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

5.2.11 Date of Service and Date of Submission

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

5.2.12 Duplicate Services

<u>24-Hour Services</u>

24-hour service procedure codes are listed in service table 11 and duplicates are not allowed. 24-hour services are considered duplicate if all of the following data elements associated with two service lines are the same:

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

<u>Outpatient Services</u>

Outpatient services are listed in service tables 1-10. Except for 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 procedure code is considered a duplicate if all of the following data elements are the same:

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

Duplicate services are not allowed.

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

5.2.13 Claiming for Interpretation, Health Behavior Intervention and Interactive Complexity

Sign language or oral interpretation (T1013) , Interactive Complexity (90785), and health behavior intervention (codes 96170 and 96171) occur along with another service, such as counseling. These codes

must be submitted on the same claim as the primary service. AOD counselors (and other DMC eligible providers) can also submit claims for interpretation (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 interactive complexity (90785) is allowed with any service. Either 90785 or T1013 can be billed in any given encounter; 90785 and T1013 cannot be billed together.

Claims for interpretation, health behavior intervention and interactive complexity may not exceed the claims for the primary service. If a county submits more units of T1013 than are allowed by the sum of all the primary services provided, the interpretation services service line will be denied.

5.2.14 Claim Timeliness – Original Claims

The timeline for initial submission of DMC-State Plan claims is critical. Original claims must be submitted within 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.

5.2.15 Service Facility Location

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

5.2.16 Service Facility Validation

SD/MC verifies that the service facility identified on the claim was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided. As discussed in Section 2.3, DHCS records in the Provider Application and Validation for Enrollment 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.

5.2.17 Rendering Provider Taxonomy Code

Outpatient services are listed in service tables 1-10 SD/MC will deny service lines for outpatient services that do not contain the rendering provider's taxonomy code unless the service is mobile crisis.

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 1-10 identify SD/MC Allowable Disciplines for each procedure code. Appendix 1 lists each discipline that is eligible to provide one or more substance use disorder treatment services and the first four characters of the taxonomy codes that identify each discipline. SD/MC will deny all service lines for outpatient services where the first four characters of the rendering provider's taxonomy code does not identify a SD/MC Allowable Discipline for the procedure code on the service line.

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 unless the service is mobile crisis. 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 – State Plan Counties:

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

Services will be denied if a procedure modifier defining level of care has not been submitted or if the submitted outpatient procedure code is not allowable with the submitted modifier(s). See Service Tables 1-10 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.

5.2.19 Multiple Levels of Care on Same Day

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

5.2.20 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 1-10. SD/MC will deny all claims for outpatient services that do not include a place of service code. Service Tables 1-10 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 1-10 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 in history.

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

5.2.25 Maximum Units – Outpatient Services

Column 8, labeled "Maximum Units that Can be Billed", in Service Tables 1-10 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 1-10. Only the time it takes to provide direct services associated with that code can be counted toward a unit of service**.** Except for Medication Addiction Treatment (MAT) services, all units of service must be whole numbers or the service line wil be denied.

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

5.2.26 Fractional Units – MAT Services

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. If billing for MAT services without the cost of medication, do not include an NDC code. 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 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.

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 1-10, 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 is not covered by Medicare. 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 Medicare eligible service to a Medicare beneficiary:

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

NTP services and Medicare Part B beneficiaries:

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

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

1. Claims for Treatment Planning
2. 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.
3. Claims for Mobile Crisis services
4. Claims for Peer Support services
5. 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 Institutions for Mental Disease (IMDs)

Services provided to beneficiaries in an Institution for Mental Disease (IMD) are not eligible for federal Medicaid reimbursement. An IMD is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services (42 CFR 435.1010). The exceptions to this rule are if the beneficiary is 65 years or older or under 22 years old receiving services in an inpatient psychiatric facility. DHCS posts a list of facilities that are classified as an IMD to the following webpage.

5.2.30 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[5]. SD/MC will also deny a claim for a service when NCCI prohibits that service from being provided to a beneficiary on the same day as a service approved in history unless certain conditions are met.

Service tables 1-10 identify the outpatient services combinations for procedure codes that cannot be billed for the same beneficiary on the same day. Column 2, 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 2 when provided to the same beneficiary on the same day. The combination of the Code in Column 2 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.

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

Target codes are identified in Column 5 of Service Tables 1-10 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.

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, Disulfran, 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.
- Methadone cannot be billed in the same calendar month as Buprenorphine: Long-Acting Injection or Naltrexone: Long-Acting Injection-Vivitrol.
    - Only Disulfiram, Naloxone, and Acamorosate are allowed to be billed in same calendar month as Buprenorphine: Long-Acting Injection-Vivitrol.
    - 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.

5.2.31 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 are not covered benefits in the DMC –State Plan program. Counties should use aid codes related to "pregnancy/emergency services" for pregnancy services only.

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

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

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

5.2.33 Covered Diagnosis

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

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

5.3.0 Replacing Approved and Denied Claims

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

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, litigation, there was a delay in certifying the provider, there was a third party processing delay, there was a delay in eligibility determination, special circumstances that cause a billing delay such as a court decision or fair hearing, determination by DHCS that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control by contacting MedCCC at MedCCC@dhcs.ca.gov. Submission of replacement claims must not exceed 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

6.0 Introduction

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

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

6.1 Federal Share: FMAP Percentage and Aid Codes

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

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

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

The federal share for non-pregnancy services provided to a beneficiary enrolled in the State Only Medi-Cal program is 0 percent. The federal government does not reimburse states for the cost of 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 State Plan 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 State Plan counties one hundred percent of the non-federal share for all services (pregnancy and non-pregnancy).

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

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

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

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

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

Young Adult Expansion

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

Older Adult Expansion

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

6.2.2. Federally Required Proposition 30 Services

DHCS will reimburse state plan counties 50 percent of the non-federal share for Drug-Medical services provided as a result of Proposition 30. Currently, Medication Addiction Treatment (MAT) falls under this requirement. Counties must include modifier HV when submitting MAT services claims.

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

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.

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 PRUCOL 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.

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 1-10. The column labeled Abbreviations gives the abbreviation used in service tables 1-10 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 1-10. Taxonomy codes associated with the providers below can be found in Appendix 1-Taxonomy Codes.

DMC State Plan 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 1-10. 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 1-9. As the Centers for Medicare and Medicaid Services (CMS) develops and maintains place of service codes and descriptions, DHCS will not be changing or in any way altering them until they are modified by CMS. Please note that if a service is provided via telehealth (audio only or audio/video) place of service code 02 or 10 **must** be used unless the service is mobile crisis.

Place of Service Code	Place of Service Name	Place of Service Description
01	Pharmacy	A facility where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Telehealth Provided Other than in Patient's Home'	The location, 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.

Place of Service Code	Place of Service Name	Place of Service Description
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.
10	Telehealth Provided in Patient's Home	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.

Place of Service Code	Place of Service Name	Place of Service Description
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On-Campus Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
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.

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

Place of Service Code	Place of Service Name	Place of Service Description
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetic services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically underserved area, that provides ambulatory primary medical care under the direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

Table 3 Modifiers.

Modifiers provide a way to report or indicate that a service or procedure that has been performed has been modified by some specific circumstance but not changed in its definition. Modifiers will not impact how much a service is reimbursed but may impact how a service should be billed and/or who pays for the service. For example, a service code with an HL/GC modifier (service provided by an intern or resident) should be billed directly to SD/MC; a service billed with an HV modifier indicates that the county provided the service as a result of a state mandate and that the state will pay the non-federal share of that service pursuant to Proposition 30. If a modifier is used to override a lockout (for example modifier XP can be used to indicate that two CPT codes that could not otherwise be billed together can be billed together in this case) the modifier must be used with the "target" code or the code that would otherwise not be able to be billed with the primary service. Please note that HCPCS (alpha) modifiers can be used with CPT and HCPCS codes but CPT (numeric) modifiers can only be used with CPT codes.

The column labeled Modifier provides the modifier number or 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).	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 1-10. This modifier needs to be used even if the over-ridable lockout combinations were provided by that same provider to the same beneficiary in different settings because when SD/MC is determining whether two services cannot be billed together (i.e., are "locked out"), it compares the service code billed only to previously *approved* service codes on the submitted claim and in the beneficiary's history. If two service	This modifier will only be used with CPT codes that are part of an over-ridable lockout combination.

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

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

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
		have HG (and a UA) modifier when service is provided in NTP Setting	
HL	Intern	Use this modifier when the service was performed by a registrants and interns who are working in clinical settings under supervision to obtain licensure. If the pre-licensed professional has an NPI, they may report their own NPI. If they do not, the supervising clinician's NPI would be reported with modifier HL after the service to indicate that the service was performed by a pre-licensed professional. If the service was performed by a resident, use modifier GC.	Services provided by individuals who are currently registered with the applicable Board.
HV	Funded by state addictions agency. The State covers 50% of the nonfederal share, as the service was determined to be covered under Proposition 30.	State Plan counties should use this modifier to identify services that the county provided as a result of a **federal** mandate that are subject to Proposition 30.Currently, Medication Addiction Treatment (MAT) falls under this requirement. Counties must include modifier HV when submitting MAT services claims. Methadone provided in NTP settings does not fall under this funding requirement.	H0033 with an NDC code
HW	The State covers 100 percent of the nonfederal share, as the service was determined to be covered under Proposition 30	Use this modifier to identify services that the county provided as a result of a **state** mandate that are subject to Proposition 30. Currently use this modifier with code H2011 with place of service 15(Mobile Crisis)	H2011 with place of service 15 (mobile crisis)
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, indicate that the service was provided in Place of Service 02 or 10 unless billing for mobile crisis.	This modifier only applies to HCPCS codes.
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	

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.	
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 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.	

Modifier	Definition	When to Use	Codes/Code Types this Modifier applies to
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.	
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	
UA	ASAM OTP/NTP	All claims must include an UA (and an HG) modifier when service is provided in NTP setting.	

CHAPTER EIGHT: SERVICE TABLES

The service tables below describe the procedure codes associated with each service type: Assessment, SUD Crisis Intervention, Medication Services, Mobile Crisis Services, Treatment Planning, Individual Counseling, Group Counseling, Discharge, 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, the codes in service tables 1-10 are not allowable when billed on the same date of service as the following 24-hour services except on the dates of admission or discharge:

DMC - State Plan Counties:

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

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.
    a. New vs. established patients: Some evaluation and management (E/M) codes are described as being services for a new or an established patient, and should be billed accordingly. For these codes:
        i. A new patient means an individual who has not received any professional services from the physician/qualified healthcare professional; or another physician/qualified healthcare professional of the exact same specialty, and subspecialty who belongs to the same group practice within the past three years.
        ii. An established patient is an individual who has received professional services from the physician/qualified healthcare professional or another physician/ qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
        iii. Refer to the CPT Manual E/M Services Guidelines for additional information on new and established patients.

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

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

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. If the pre-licensed professional has their own NPI, they may report their own NPI as the rendering professional. A service code that uses an HL or GC modifier should not be submitted to Medicare first; it should be submitted to SDMC 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 unless the service is mobile crisis. 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 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 does not have a dedicated add-on code or is an evaluation and management code, use prolonged service code G2212 as the add-on 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 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 dual eligible beneficiary, 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. With the exception of MAT services (procedure codes S5000, S5001, and H0033 when submitted with an NDC), procedure codes can only be claimed in whole units; fractional units will be denied. When selecting a CPT code, providers should follow the CPT Manual for instructions on how to bill each code using time. DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in either before or after a patient visit.

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.

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.	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 – State Plan: • LP • PA • NP	DMC State Plan: 05, 06, 07, 08, 49, 72	Cannot be billed with: 90791,90792, , 90880, 96170-96171*, 99202-99205**, 99212-99215**, 99217**,	None	No	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, HL, GC, 59, XE, XP, XU
Psychiatric Diagnostic Evaluation, 15 Minutes	90791	DMC – State Plan: • LP • PA • Psy • LCSW • MFT • NP • LPCC	DMC State Plan: 02, 10, 05, 06, 07, 08, 49, 72	Cannot be billed with: 90792, 90885*,90887*, 96170, 96171, 99202-99205**, 99212-99215**, 99217**, -99408-99409**, 99441-99443**, 99495-99496** G0396*,G0397*, G2011*,	None	No	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02,05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791, 90865, 90885*,90887*, 96170, 96171, 99202-99205**, 99212-99215** 99217**, 99408-99409** 99441-99443**, G0396*,G0397*, G2011*,	None	No	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, HL, GC, 59, 93, 95
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 – State Plan: • LP • PA • Psy • LCSW • MFT • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791,90792, , 96170, 96171*,	None	Yes	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, HL, GC, 59, XE, XP, XU
Psychological Testing Evaluation, First Hour	96130	DMC – State Plan: • LP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 99202-99205, 99212-99215,	None	No	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• PA • Psy • NP		99217,				
Psychological Testing Evaluation, Each Additional Hour	96131	DMC – State Plan: • LP • PA • Psy • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: N/A	Must use code 96130 before coding 96131.	No	1	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, HL, GC, 59, 93, 95, XE, XP, XU
Telephone Assessment and Management Service, 5-10 Minutes	98966	DMC – State Plan: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – State Plan: 02, 05 - 08, 10	Cannot be billed with: 98967,98968, 99495, 99496	None	No	1	DMC – State Plan: HD, U7, U8, HL, 59, 93, XE, XP, XU
Telephone Assessment and Management Service, 11-20 Minutes	98967	DMC – State Plan: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – State Plan: 02, 05 – 08, 10	Cannot be billed with: 98966,98968, 99495, 99496,	None	No	1	DMC – State Plan: HD, U7, U8, 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.	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 – State Plan: • PA • Psy • LCSW • MFT • NP • LPCC	DMC – State Plan: 02, 05 - 08, 10	Cannot be billed with: 98966,98967, 99495, 99496,	None	No	1	DMC – State Plan: HD, U7, U8, HL, 59, 93 , XE, XP, XU
Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08,10, 49, 72	Cannot be billed with: 90791-90792, 90865, 96130*, 99212-99215** 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of a New patient, 30-44 Minutes	99203	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, 90865, 96130*, 99212-99215** 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Office or Other Outpatient Visit of a New Patient, 45-59 Minutes	99204	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, ,90865, 96130*, 99212-99215** 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of a New Patient, 60-74 Minutes	99205	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, ,90865, 96130*, 99212-99215** 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, , 90865, 96130* 99202-99205, 99213-99215, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of	99213	DMC – State Plan:	DMC – State Plan:	Cannot be billed with:	None	No	1	DMC – State Plan:

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
an Established Patient, 20-29 Minutes		• LP • PA • NP	02, 05, 06, 07, 08, 10, 49, 72	90791-90792, 90865,96130* 99202-99205, 99212** 99214-99215, 99408-99409**, G0396*,G0397*, G2011*				HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, , 90865,96130* 99202-99205, 99212-99213*, 99215, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, , 90865,96130* 99202-99205, 99212- 99214**, 99408-99409**, G0396*,G0397*, G2011*	None	No	1	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Telephone Evaluation and	99441	DMC – State Plan:	DMC – State Plan: 02, 05 - 08, 10	Cannot be billed with:	None	No	1	DMC State Plan:

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Management Service, 5-10 Minutes		• LP • PA • NP		90791,90792, 99442,99443, 99495, 99496,				HD, U7, U8, HL, GC, 27, 59, 93, XE, XP, XU
Telephone Evaluation and Management Service, 11-20 Minutes	99442	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05 - 08, 10	Cannot be billed with: 90791,90792, 99441,99443, 99495, 99496,	None	No	1	DMC State Plan: HD, U7, U8, HL, GC, 27, 59, 93 , XE, XP, XU
Telephone Evaluation and Management Service, 21-30 Minutes	99443	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05 – 08, 10	Cannot be billed with: 90791,90792, 99441,99442, 99495, 99496,	None	No	1	DMC State Plan: HD, U7, U8, 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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Alcohol and/or drug screening. Laboratory analysis	H0003	DMC - State Plan: • LP • PA • Psy • RN • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC,
Alcohol and/or other drug testing.	H0048	DMC - State Plan: • LP • PA • RN • NP	DMC – State Plan: 05, 06, 07, 08, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC
Alcohol and/or drug screening	H0049	DMC - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC
Alcohol and/or substance (other than tobacco) abuse structured	G2011	DMC State Plan: • LP • PA	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	Cannot be billed with: 90791-90792, 99202-99205,	None	No	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
assessment 5 -14 Min. (Note: use codes G2011, G0396, and G0397 to determine the ASAM Criteria).		• Psy • LCSW • MFT • RN • NP • LPCC • AOD		99212-99215, 99217, 99408-99409, G0396-G0397,				
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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	Cannot be billed with: 90791-90792, 96170, 96171*, 99202-99205, 99212-99215, 99217, 99408-99409, G0397, G2011	None	No	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC, 59, XE, XP, XU
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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	Cannot be billed with: 90791-90792, 96170, 96171, 99202-99205, 99212-99215, 99217, 99408-99409, G0396, G2011	None	No	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• AOD						

*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 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.	**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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 05, 06, 07, 08, 49, 72.	None,	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC

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:** All **outpatient** services are locked out against inpatient and 24-hour services except for the date of admission.	**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 – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	None	90791, 90792, 90865, 90885, 90887, 96131, 99215, 99217, 99236, 99310, 99328, 99368, 99409	No	95	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC
Oral Medication Administration, Direct Observation, 15 Minutes. Note: Use this code with a National Drug Code (NDC) to submit MAT services claims rendered by Non-NTP providers.	H0033	DMC – State Plan: • LP • PA • Pharma • NP • RN	DMC State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, GC, HV
Medication Training and Support, per 15 Minutes	H0034	DMC – State Plan: • LP • PA • Pharma • NP • RN	DMC State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, GC

Service Table 4 Mobile Crisis Codes

Mobile crisis services cannot be billed with 24-hour services except for the day of admission and the day of discharge.

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Mobile crisis	H2011	DMC - State Plan: N/A	DMC – State Plan: 15	None	None	Yes	96	DMC – State Plan: HD, HG, UA, U1, U2, U3, U7, U8, GT, HW, SC

Service Table 5 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.	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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, SC
Comprehensive community support services, per 15 minutes	H2015	DMC - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG U1, U2, U3, U7, U8, HL, GC, SC
Community-Based Wrap-Around Services, per 15 Minutes	H2021	DMC - State Plan: • LP • PA • Psy	DMC – State Plan:	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3,

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• LCSW • MFT • RN • NP • LPCC • AOD	02, 05, 06, 07, 08, 10, 49, 72.					U7, U8, HL, GC, SC
Psychoeducational Service, per 15 minutes	H2027	DMC - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC

Service Table 6 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Behavioral health counseling and therapy, 15 minutes.	H0004	DMC - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	None	None	H0004 not exempt from Medicare when provided with modifiers UA: HG for NTP/MAT dosing.	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, 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 - State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	Cannot be billed with: 90791-90792, 96170-96171*, 99202-99205, 99212-99215, 99217, 99409, G0396, G0397, G2011,	None	Yes	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI)	99409	DMC - State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72.	Cannot be billed with: 90791-90792, 96170-96171*, 99202-99205,	None	Yes	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, 27, 59,

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
services. Greater than 30 minutes.				99212-99215, 99217, 99408, G0396, G0397, G2011,				93, 95, XE, XP, XU
Alcohol and/or substance abuse services, family/couple counseling	T1006	DMC - State Plan: • LP • Psy • PA • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC

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

Service Table 7 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 by 4.5. 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.	**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 - State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	None	None	H0005 not exempt from Medicare when provided with modifiers UA: HG for NTP/MAT dosing.	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, SC

Service Table 8 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Interactive Complexity	90785	DMC – State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC • AOD	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 96170-96171,	90791-90792, 99202-9925, 99212-9215, 99217	No	1 per allowed procedure per provider per beneficiary.	DMC State Plan: HD, HG, UA, U1, U2, U3, U7, U8, 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 – State Plan: • LP • PA • Psy • LCSW • MFT • NP • LPCC	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, 96170, 96171*	90865, 96130, 99202-99205, 99212-99215, 99217, 99408-99409, 99495-99496	Yes	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, 59, 93, 95, XE, XP, XU
Health behavior intervention, family	96170	DMC – State Plan: • LP	DMC – State Plan:	Cannot be billed with:	90791-90792, 90865,	Yes	1	DMC – State Plan:

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
(without the patient present), face-to-face. 16-30 minutes		• PA • Psy • LCSW • MFT • RN • NP • LPCC	02, 05, 06, 07, 08, 10, 49, 72	90785, 90791-90792, 90865, 90885*, 90887*, 99408-99409, G0396-G0397*,	96130-96131, 98966-98968, 99202-99205, 99212-99215, 99441-99443, G0396-G0397, G2011, H0001,			HD, U1, U2, U3, U7, U8, HL, GC, 59, 93, 95, XE, XP, XU
Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171	DMC – State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90785, 90791-90792, 90865, 90885, 90887, 99408-99409, G0396-G0397*,	96170	Yes	47	DMC – State Plan: HD, U1, U2, U3, U7, U8, HL, GC, 59, 93, 95, XE, XP, XU
Sign Language or Oral Interpretive Services, 15 Minutes	T1013	DMC – State Plan: • LP • PA • Psy • LCSW • MFT • RN • NP • LPCC	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	None	90791-90792, 90865, 90885,90887, 96130, 96131, 96170, 96171, 98966-98968, 99202-99205, 99212-99215, 99217,	Yes	Variable	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
		• AOD			99408-99409, 99441-99443, 99495-99496, G0396-G0397, G2011, G2212, H0001, H0003, H0004, H0005, H0007, H0019, H0020, H0033, H0034, H2014, H2015, H2021, H2027, S5000, S5001, T1006, T1007			

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

Service Table 9 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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
Observation Care Discharge Day Management, 15 Minutes	99217	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 05, 06, 07, 08, 49, 72	Cannot be billed with: 90791-90792, 90865, 96130*, 99408-99409**, G0396-G0397*, G2011*,	None	No	1	DMC – State Plan: HD, UA, HG, GC, 27, 59, XE, XP, XU
Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days	99495	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, 98966-98968*, 99441-99443*, 99495,	None	No	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496	DMC – State Plan: • LP • PA • NP	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: 90791-90792, 98966-98968*, 99441-99443*, 99495,	None	No	1	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, HL, GC, 27, 59, 95, XE, XP, XU
Alcohol and/or substance abuse services, treatment	T1007	State Plan: • LP • PA	DMC – State Plan:	None	None	Yes	96	State Plan: HD, UA, HG, U1, U2, U3,

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.	Dependent on Codes	Exempt from Medicare COB?	Maximum Units that Can be Billed	Allowable Modifiers
plan development and/or modification.		• Psy • LCSW • MFT • RN • NP • LPCC • AOD	02, 05, 06, 07, 08, 10, 49, 72					U7, U8, HI, 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 10 Peer Support Specialist Services

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

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.	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 – State Plan: • Peer Support Specialists	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, SC
Self-help/peer services, per 15 minutes	H0038	DMC – State Plan: • Peer Support Specialists	DMC – State Plan: 02, 05, 06, 07, 08, 10, 49, 72	Cannot be billed with: None	None	Yes	96	DMC – State Plan: HD, UA, HG, U1, U2, U3, U7, U8, SC

Service Table 11 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 perinatal beneficiaries in facilities with no bed capacity limit. Service code H0018 and H0019 in table below represent this benefit.

Narcotic Treatment Program (NTP) Services:

Narcotic treatment program services 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). Please use modifiers HG and HV for procedures S5000 and S5001 to indicate when a Medication Assistance Treatment services was provided. One unit per day is allowed for dosing.

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

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

DMC – State Plan			
Category	Procedure Code & Modifier	Description	Exempt from Medicare COB?
Existing 24-Hour Service	H0018	Behavioral Health: Short-term residential	Yes
Existing 24-Hour Service	H0019	Behavioral Health; Long Term Residential	Yes
Existing Day Service	H0020: HG	Alcohol and/or drug services; Methadone	No
Existing Day Service	S5000: HG	Prescription Drug: Generic (Naltrexone)	Yes
Existing Day Service	S5001: HG	Prescription Drug: Brand Name (Naltrexone)	Yes
Existing Day Service	S5000: HG: HV	Prescription Drug: Generic (MAT Services)	No
Existing Day Service	S5001: HG: HV	Prescription Drug: Brand Name (MAT Services)	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
Marriage and Family Therapist (MFT) or Licensed Professional Clinical Counselor (LPCC)	1012
	101Y
	102X
	103K
	106H
	1714
	222Q
	225C
	2256

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Nurse Practitioner (NP)	363L
Pharmacist (Pharma)	1835
Physician Assistant (PA)	363A
Licensed Physician (LP)	202C
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081
	2082
	2083
	2084
	2085
	2086
	2088

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

Appendix 2: Definitions

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

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

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

Dependent Procedure: These are 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.

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

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

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

Intern: A licensed-eligible practitioner registered with the appropriate board working under the supervision of a licensed clinician.

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 1-10.

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

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

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

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 Procedure Codes

Appendix 3 below lists the procedure codes included as benefits for DMC - State Plan counties. Column 1 includes the procedure code and 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
90865	Narcosynthesis for Psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarital (Amital) interview.
90880	Hypnotherapy
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
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.
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.
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.
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),
H0018	Behavioral Health: Short-term residential (non-hospital residential treatment program), without room and board
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)
H0025	Behavioral health prevention education services, 15 minutes
H0033	Oral medication administration, direct observation

H0034	Medication training and support, per 15 minutes
H0038	Self-help/peer services, 15 minutes
H0048	Alcohol and/or other drug testing. Collection and handling only, specimens other than blood.
H0049	Alcohol and/or drug screening
H2011	Mobile crisis
H2014	Skills training and development, per 15 minutes.
H2015	Comprehensive community support services, per 15 minutes
H2021	Community-based wrap-around services, per 15 minutes
H2027	Psychoeducational Service, per 15 minutes
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.

Appendix 4- Monthly Medi-Cal Eligibility File (MMEF) Data Elements

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

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

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

Appendix 5- MEDSLITE Data Elements

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

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

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

62. Date suspension ended
63. Release date
64. Date of specific aid code inquiry
65. County of responsibility's specific aid code inquiry
66. Date of eligibility inquiry
67. Date of inquiry of when eligibility started