BEHAVIORAL HEALTH INDIVIDUAL SERVICE LEVEL (ISL) ENCOUNTER REPORTING GUIDANCE

VERSION 1.1

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

This document is intended to serve as a primary source of guidance for counties to implement ISL encounter reporting. Counties and cities must use this guidance in conjunction with the ISL Code Library and the ISL Encounter Fields which together comprise the core technical resources for ISL reporting.

TABLE OF CONTENTS

Change Log 3

Introduction and Overview of ISL 4

In Scope for ISL Reporting 5

Out of Scope for ISL Reporting 6

ISL Encounter Fields and Validation Rules 7

ISL Encounter Fields 7

ISL Validation Rules 7

ISL Encounter Fields – Special Instructions 7

ISL Data quality measures 12

ISL Encounter Data Sharing and Authorization Guidance 13

Authorities Governing ISL Data Sharing 14

ISL Data Sharing Use Cases 17

ISL Code Library 21

Services with Existing Medi-Cal Service Codes 21

Services without Existing Medi-Cal Service Codes 21

ISL Code Library – Special Instructions 21

Appendix 28

Appendix A: Encounter Value Calculation Methodology 28

Appendix B: Void and Replacement Encounters Instructions 30

CHANGE LOG

Version	Date Published	Changes Made
1.0	June 15, 2026	• N/A (*original document*)
1.1	November 3, 2026	• Added ISL Encounter Data Sharing and Authorization Guidance, including information on data sharing authorities, consent considerations, and ISL data sharing use cases. • Added privacy guidance related to county submission of ISL encounter data. • Updated first-year ISL reporting deadline from September 30, 2027, to September 28, 2027. • Refined FSP and BHSS service coding and modifier guidance, including updates to applicable SMHS, DMC, DMC-ODS, and DHCS-defined ISL codes. • Added rounding guidance for expense-based ISL services. • Minor technical and formatting corrections. • Revised DHCS oversight of counties' ISL participation and fidelity to the County Performance Contract. • Added Program Name requirement language, including information on the implementation period of January 1, 2027 to July 1, 2027. • New Client Zip Code guidance. • Updated Client Date of Birth guidance, including the addition of a new unknown DOB value.

INTRODUCTION AND OVERVIEW OF ISL

Behavioral Health Individual Service Level (ISL) encounter reporting captures individual level behavioral health services provided directly to clients by city agencies (Berkeley and Tri City Mental Health) and county behavioral health systems (collectively referred to as "counties"), and county provider networks (collectively referred to as "providers"). These reporting requirements apply only to services that are not reimbursable through the Medi-Cal program. Medi-Cal covered services delivered to a Medi-Cal enrolled individual must continue to be billed through Short Doyle and CA-MMIS and are not reported as ISL encounters.

ISL encounters are a critical component of Behavioral Health Services Act (BHSA) reporting and are necessary to support DHCS' statutory responsibilities. DHCS will use ISL data to gain an understanding of service provision under the BHSA, generate performance measures, and support population health management, among other functions. ISL encounters support a consistent view of the behavioral health services counties deliver and the individuals they serve.

Pursuant to Welfare and Institutions Code (WIC) sections 5963.04(a)(2)(H) and (I), 5963.04(b), and 5897(d), effective January 1, 2027, counties are required to submit ISL encounters for all in-scope services delivered on and after January 1, 2027, to DHCS. At a minimum, counties must submit ISL encounters to DHCS annually, no later than 90 days after the close of the fiscal year (FY) in which services were rendered.

For the first year of ISL reporting, counties are required to report services delivered between January 1, 2027, and June 30, 2027, by at least 90 days after the close of the 2027 FY (2027 FY Close: June 30, 2027, ISL 1st Year Reporting Deadline: September 28, 2027). For all subsequent years, counties must report the full fiscal year of ISL encounters in accordance with the same 90-day post FY close timeline.

Beginning July 1, 2026, counties may begin submitting ISL encounters to DHCS for services delivered between July 1, 2026, and December 31, 2026. This period will be for testing and technical assistance (TA) purposes only. DHCS will not utilize data submitted during this six-month period for county performance measures or monitoring, and data submitted will solely be used for purposes of refining and strengthening ISL reporting. Counties that do not submit ISL encounters during this time period will not be required to submit those encounters retroactively.

Counties are strongly encouraged to begin reporting ISL encounters starting in July 2026 to support system testing and receive early TA; however, all counties will receive TA leading up to and following January 1, 2027.

All ISL encounters must be submitted accurately and aligned with ISL guidance and technical resources.

Counties must ensure that ISL data submitted to DHCS is shared in accordance with applicable state and federal privacy laws and regulations governing the information submitted. Counties should only submit ISL data to DHCS as permitted by those laws and regulations.

DHCS will oversee and monitor counties' participation and fidelity to ISL requirements through the County Performance Contract.

In Scope for ISL Reporting

Behavioral health services delivered to an individual that are not claimable to Medi-Cal are in scope for ISL encounter reporting. This includes:

- Behavioral health services represented in the Medi-Cal benefit package that are delivered to individuals who are not enrolled in Medi-Cal on the date of service delivery.[1]
- Behavioral health services represented in the Medi-Cal benefit package that are delivered in settings that are locked out of Medi-Cal claiming.
- Behavioral health services represented in the Medi-Cal benefit package and for which a Medi-Cal member has exhausted the benefit.
- Behavioral health services or expenses that are not represented in the Medi-Cal benefit package and are represented in the non-Medi-Cal ("DHCS-defined") ISL code set.

In some cases, a county may submit an ISL encounter, then later seek to resubmit that same encounter as a billable Medi-Cal claim (if for example a client was approved for retroactive Medi-Cal coverage that covers the date of service). In these scenarios, the county must submit a void ISL encounter to avoid duplicative utilization records. See instructions for voiding ISL encounters in "Appendix B: Voiding and Replacing Encounters."

Please see the full list of in scope BH ISL service codes in the ISL Code Library.

[1] Chapter 6, Section C.2.2 of the BHSA Policy Manual requires counties to ensure providers check for and support Medi-Cal enrollment for eligible individuals.

Out of Scope for ISL Reporting

Behavioral health services not in scope for ISL encounter reporting include:

- Services delivered to Medi-Cal-enrolled individuals that are claimed and funded through Medi-Cal.
- Outreach and engagement services in which there is no identifiable client or that do not result in an identifiable client.
- Outreach, engagement, education or prevention services or activities directed towards community- or organization-level audiences (e.g., schools, senior centers, faith-based organizations).
- Investments in workforce recruitment, education, or training.
- Professional licensing or certification testing fees for county or county-contracted staff.
- Investments or ongoing support for county behavioral health call centers or hotlines.
- Investments to purchase, construct, or renovate housing.
- Contributions to a county or municipal housing flex pool (however, services paid for using these contributions are in scope for ISL reporting).
- Investments in the county's behavioral health facilities (e.g., purchase of buildings/land, repairs, renovations) or match funds for the Behavioral Health Infrastructure Bond Act of 2023 Behavioral Health Continuum Infrastructure Program (BHCIP) awards.
- Investments in county technology systems or infrastructure (e.g., electronic health records, telemedicine platforms, data warehouses).
- Any other county-funded services or expenditures for which service level codes are not defined in the ISL Code Library.

ISL ENCOUNTER FIELDS AND VALIDATION RULES

ISL Encounter Fields

The ISL Encounter Fields are the data elements that counties are required to populate for each ISL encounter they submit. ISL encounters leverage a subset of American National Standards Institute (ANSI) X12 837 data elements that counties currently submit through Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) claims. DHCS intends to promote parity in the collection and reporting of individual-level behavioral health service and expenditure data, regardless of funding source.

ISL Validation Rules

The ISL validation rules describe the rules and logic used by DHCS to process encounters. It defines field dependencies, data element specifications, and data reference tables, and establishes the criteria used to conduct encounter processing.

Please see the ISL Validation Rules Catalog within the ISL application in the County Portal.

ISL Encounter Fields – Special Instructions

This section outlines special instructions for select ISL encounter fields that require additional guidance. Please see the complete list of ISL Encounter Fields for every field.

In this section, the *italicized text* indicates the definition of the encounter field being specified, and the » bulleted text are the special instructions for that associated encounter field.

Encounter ID

A county generated numeric-only identifier for each encounter.

» An encounter ID must contain numeric characters only.

» For an original encounter (i.e., not a void or replacement), the encounter ID must be unique. For void or replacement encounters, the encounter ID must match the original encounter being voided or replaced.

Encounter Submission Type

Encounter Submission Type specifies if the claim is original, replacement, or void.

» See "Appendix B: Void and Replacement Encounter Instructions" for detailed instructions on completing the Encounter Submission Type field.

Encounter Service Type

This field is not intended for county completion; however, residual elements of the field remain within the ISL module, and DHCS is flagging this for county awareness. Encounter Service Type identifies whether the service provided is Outpatient (O) (submitted on an 837P for Medi-Cal claims), Inpatient (I) (submitted on an 837I for Medi-Cal claims), or Expense (E). This field is used for back-end system validation and to support field dependencies. DHCS has developed a system update to automatically assign the appropriate Encounter Service Type for each encounter.

» For Medi-Cal services with a CPT/HCPCS code submitted through ISL, the Encounter Service Type is assigned based on the submitted Place of Service code.

» For services with a DHCS-defined ISL-code submitted through ISL, the Encounter Service Type is assigned based on the designation identified in the applicable sheet of the ISL Code Library.

Counties may choose to submit the Encounter Service Type field as NULL or assign a value (E, O, or I). The value submitted in this field will not have any impact on how submitted data is processed; Encounter Service Type will always be assigned according to the rules described above regardless of the value submitted by the county.

Client Social Security Number (SSN)

The client's social security number.

» If a county submits a "pseudo-SSN" (e.g., 999999999) in the Client SSN field, the submission must include a complete and valid value in either the Client Medi-Cal CIN field or the Client County Medical Record Number (MRN) field.

Client Date of Birth (DOB)

Date of birth of the client who received the service.

- If the client's date of birth is not available at the time of the encounter, counties may populate the client DOB field with 19000101 [YYYYMMDD] to indicate that the date of birth is unknown.

Client Insurance Status

The insurance(es) of the client who received the service, at the time of service (e.g. Medi-Cal, Medicare, Private/Commercial Insurance, Uninsured)

- If the client's insurance status is unknown at the time of the encounter, counties may submit UNKNOWN in the Client Insurance Status field.
- Counties may submit multiple Client Insurance Status values for a single client. When a client has more than one insurance value, counties must submit all applicable values in the Client Insurance Status field, separated by a comma (,) delimiter.
    - Example: Insurance 1, Insurance 2, Insurance 3

Client Race/Ethnicity

Client's race(s) or ethnic group(s).

- Counties must align race and ethnicity reporting with applicable standards published in the United States Core Data for Interoperability (USCDI). Please see the USCDI website for more details.
- Counties may submit multiple Race and/or Ethnicity values for a single client. When a client has more than one Race and/or Ethnicity value, counties must submit all applicable values in the Client Race/Ethnicity field, separated by a comma (,) delimiter.
- Example: Race 1, Ethnicity 1, Race 2, Race 3

Client Zip Code

Zip code associated with physical residence of client that received the service.

- Counties may submit client ZIP Codes in any of the following formats: 5-digit ZIP Code (#####), 9-digit ZIP+4 Code without a hyphen (#########), or 9-digit ZIP+4 Code with a hyphen (#####-####). All formats are accepted.
- If the client is experiencing homelessness or the client's ZIP Code is unknown, counties must enter the Zip Code of the billing provider.

Program Name

The county-assigned Program Name used across Short Doyle, CA-MMIS claims, and ISL encounters. Guidance on the use of Program Name in Short Doyle and CA-MMIS claims is forthcoming.

- If the same Program delivers Medi-Cal claimable services and ISL-reportable services, counties must report all services with the same Program Name consistently across Short Doyle, CA-MMIS, and ISL.
- County changes to a Program Name must occur in each system where that Program Name is used (ISL, Short Doyle, and CA-MMIS, as applicable), and all DHCS Program Name related materials must be updated to reflect this change.

Service Date

The date the client was delivered the service.

- For inpatient stays, the county may submit NULL in the Service Date field.

Admission Date and Discharge Date

Admission Date is the date the client was admitted to the facility. Discharge Date is the date the client was discharged from the facility.

- To align with the ISL reporting timelines, admission and discharge date should be after July 1, 2026. Dates prior will result in an encounter rejection.
- For inpatient stays where the client is admitted and discharged within the same fiscal year, counties must submit a single encounter with the Submission Type designated as Original and include both the Admission Date and Discharge Date.
- For inpatient stays that span fiscal years (client starts an inpatient stay in one fiscal year and ends an inpatient stay in the following fiscal year), counties must submit a separate Original encounter for each fiscal year, using a unique Encounter ID for each encounter. Counties must adhere to the reporting deadline and submit the stay for the fiscal year within 90 days after close of the fiscal year.
- The encounter submitted in the fiscal year in which the stay began must include the original Admission Date and a blank Discharge Date.

- The encounter submitted in the fiscal year in which the stay ended must include the original Admission Date and the final Discharge Date.
- For example, if a client is admitted on June 15, 2027, and discharged on July 15, 2027, the county must submit:
- By September 28, 2027 (90 days post end of the fiscal year): an Original encounter with a unique Encounter ID, an Admission Date of June 15, 2027, and no Discharge Date.
- By September 28, 2028 (90 days post end of the following fiscal year): a separate Original encounter with a different unique Encounter ID, the same Admission Date of June 15, 2027, and a Discharge Date of July 15, 2027.

Diagnosis Code

Principal diagnosis of the client.

- For ISL encounters with an Expense Service Type, if the client's diagnosis is unknown at the time of the encounter, counties may submit UNKNOWN in the Diagnosis Code field.
- Counties are strongly encouraged to prioritize timely diagnosis capture, including the use of appropriate ICD-10-CM Z-codes when clinically applicable.

Secondary Diagnosis Codes

Secondary diagnoses of the client.

- Counties may submit multiple secondary diagnosis code values for a single client. When a client has multiple secondary diagnosis codes, counties must submit all secondary diagnosis codes in the Secondary Diagnosis Code field, separated by a comma (,) delimiter.
    - Example: Dx2, Dx3, Dx4

Place of Service (POS) Code

Location where service was delivered.

- DHCS uses the reported Place of Service (POS) Code to assign an Encounter Service Type to each ISL encounter. The assigned Service Type determines the applicable encounter validation and reporting rules.
- A Place of Service Code is required for all ISL encounters submitted with a Medi-Cal service code.
- For ISL encounters submitted with a DHCS-defined ISL code, a Place of Service Code is not required because DHCS will automatically assign the appropriate Service Type based on the code submitted.
- Place of Service Code must align with Medi-Cal billing manual standards and must reflect the physical location where the service occurred (i.e., where the client was located at the time of service).

Encounter Value

Encounter Value may reflect either (1) the actual cost incurred where the ISL encounter represents an invoice-based payment or direct expense, or (2) a standardized proxy valuation established by the county to reasonably represent the value of the reported ISL service when an encounter level payment amount is not available.

- See "Appendix A: Encounter Value Calculation Methodology" for additional detail and required calculation frameworks for completing the Encounter Value field.

ISL DATA QUALITY MEASURES

DHCS is implementing ISL Data Quality Measures (DQMs) to support ongoing monitoring and improvement of the overall quality of ISL encounter data. ISL DQMs will be available to counties through the ISL Portal and will help DHCS and counties monitor reporting trends, identify and investigate potential data quality issues, and inform opportunities to strengthen ISL reporting over time, including through targeted technical assistance as appropriate.

Information regarding the ISL DQMs, including measure-specific methodologies, will be available to counties directly within the ISL Portal.

ISL ENCOUNTER DATA SHARING AND AUTHORIZATION GUIDANCE

Disclaimer

As the state's Medi-Cal agency, DHCS does not have the authority to interpret or enforce many of the federal and state privacy laws that are discussed and referenced throughout this document. As such, DHCS cannot provide legal advice to Medi-Cal Partners regarding when disclosures comply with applicable privacy laws. This document ***does not constitute legal advice*** *and is only intended to provide guidance that is illustrative in nature; Medi-Cal Partners should consult with their individual legal counsels before making any determinations regarding data sharing and required authorization.*

DHCS is the lead state agency responsible for the oversight and administration of the BHSA. DHCS holds local county programs accountable through regular compliance reviews, performance metrics, and funding approvals. As part of these continuing responsibilities, DHCS will require counties to submit ISL encounter data to DHCS, for non-Medi-Cal-claimable services, including but not limited to, services paid using BHSA funds, including Housing Intervention Services, Full Service Partnerships (FSPs), Behavioral Health Services and Supports (BHSS), and other county administered funding sources, as applicable.[2] In accordance with federal and state privacy laws, DHCS will use this data to:

- Construct Behavioral Health Transformation (BHT) Phase 2 measures for the purposes of assessing behavioral health, child welfare, criminal legal, housing, and other types of data relevant to BHT goals;
- Support DHCS' fiscal oversight and monitoring responsibilities under BHSA; and
- Facilitate outreach, care coordination, and population health management activities by redisclosing minimum necessary individually identifiable information in accordance with applicable laws to county Behavioral Health Plans (BHPs), Managed

[2] For more information about BHSA and services funded by BHSA, see: Behavioral Health Services Act | DHCS

Care Plans (MCPs), and their contracted providers that have an existing treatment and/or care coordination relationship with the client through Medi-Cal Connect.[3,4]

ISL encounters will contain personally identifiable information (PII),[5] including protected health information (PHI)[6] and, in some cases, substance use information protected by 42 C.F.R. Part 2 (referred to as "Part 2").[7] This section discusses the data sharing and client authorization considerations for the sharing of ISL encounters from contracted providers to the county, from the county to DHCS, and downstream redisclosures by DHCS back to counties, MCPs, and contracted providers to support outreach and care coordination. Such redisclosures by DHCS are made in accordance with federal and state privacy laws to support population health management and care coordination.

Authorities Governing ISL Data Sharing

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that regulates PHI, which consists of personally identifiable health information that is created or received by a HIPAA-covered entity or its business associate.[8] The HIPAA Privacy Rule *generally* permits disclosure of PHI for certain purposes, including for treatment, payment, or healthcare operations (TPO), including for audit and evaluation purposes,

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[3] For more information about the authority and use cases of redisclosed data via Medi-Cal Connect see: https://www.dhcs.ca.gov/medi-cal-connect/.

[4] For information about allowable redisclosures see Section 2.2 in the DHCS CalAIM Data Sharing Authorization Guidance, available here: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CalAIM-Data-Sharing-Authorization-Guidance-1.pdf

[5] **PII** is "any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual." See: m06-19.pdf

[6] **PHI** is a subset of PII that consists of personally identifiable health information that is created or received by a covered entity, as defined under HIPAA.

[7] 42 C.F.R. Part 2 (referred to as "Part 2") is a federal regulation that protects the confidentiality of some but not all types of SUD information. The regulation applies to SUD programs that hold themselves out as providing such services and that receive federal assistance. For more information regarding Part 2 and who qualifies as a Part 2 provider, see the Data Sharing Authorization Guidance.

[8] "Covered Entities and Business Associates," U.S. HHS.

without individual authorization.[9] HIPAA therefore allows healthcare providers to disclose PHI to counties, including behavioral health plans (BHPs), and MCPs for purposes of reimbursement without individual consent. Similarly, HIPAA allows healthcare providers, counties, and MCPs to share client identifying health information with DHCS for the purposes of audits and evaluations without individual consent.[10,11]

If a HIPAA-covered entity engages a business associate to help it carry out its healthcare activities and functions, the covered entity must have a written business associate agreement with the business associate. The contract establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the HIPAA requirements to protect the privacy and security of PHI.

If the contracted entity is not a HIPAA-covered entity (e.g., certain housing providers), they are not bound by the HIPAA Privacy Rule and therefore HIPAA does not restrict their ability to share client identifying information with a covered entity – including with county BHPs and DHCS. However, the receiving HIPAA-covered entity must handle those identifiers as PHI under HIPAA. There may be other state or federal privacy laws that restrict sharing this information, which should be considered prior to a disclosure. For example, housing organizations that participate in their Continuum of Care's (CoC's) Homelessness Information Management System (HMIS) and are sharing client information from HMIS with counties for payment and tracking of BHSA, Medi-Cal, or

[9] Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 C.F.R. pts. 160, 164 subpts. A & E (2026).

[10] 45 CFR §§ 164.501, 164,506(c)(4). In the case of disclosures for program evaluation purposes, HIPAA requires both the disclosing party and the recipient to have a relationship with the individual and the disclose PHI to pertain to that relationship. In the case of disclosures to DHCS, those requirements are met.

[11] Generally, individual service level (ISL) encounters can be part of the designated record set, but it depends on how the records are used and maintained. Under HIPAA, the designated record set includes:

- Medical records and billing records maintained by or for a covered entity
- Enrollment, payment, claims adjudication, and case management records
- Any other records used to make decisions about the individual.

Organizations should consult with their legal counsel and review the Office of Civil Rights guidance which outlines the specific uses for which govern if the ISL encounter is considered part of the designated record set and generally subject to access by the client. 45 C.F.R. § 164.501; What personal health information do individuals have a right under HIPAA to access from their health care providers and health plans? | HHS.gov

other funded services, should consult their CoC's privacy notice as that data may be subject to additional consent requirements.[12]

Part 2

Some ISL encounters will include Part 2 information, therefore Part 2 programs, counties, and DHCS will need to consider Part 2 rules and consent considerations to ensure appropriate disclosure and redisclosure of such information.[13]

Part 2 programs sometimes need to disclose Part 2 information to counties for payment purposes, which, under BHSA, counties will then seek to redisclose as ISL encounters to DHCS. Part 2 explicitly states that individual consent is required for a Part 2 program to disclose information to the county or MCP, including for payment purposes. However, redisclosure from the county to DHCS does not require individual consent assuming that redisclosure falls within the program evaluation exemption, which states that identifying information may be disclosed to federal, state, or local government agencies, and the contractors, subcontractors, and legal representatives of such agencies, in the course of conducting audits or evaluations mandated by statute or regulation, if those audits or evaluations cannot be carried out using deidentified information.[14]

However, in order for DHCS to redisclose Part 2 information through Medi-Cal Connect to counties, MCPs, and their contracted providers to support outreach and care coordination, individual consent authorizing such disclosure is required. A broad TPO consent would permit such a disclosure. If no such consent is on file, DHCS will not redisclose Part 2 protected information, but may still redisclose other non-Part 2 information where consent is not required under applicable law. DHCS recently released

[12] Continuum of Care's HMIS must have a Privacy Notice that meets HMIS privacy standards. Federal HUD rules do not require organizations that record, use or process data on homeless clients for an HMIS to obtain individual consent for collection, uses and disclosures of data that are described in the Privacy Notice. Housing organizations are only required to obtain consent for uses and disclosures of personal information that are not included in the Privacy Notice. For more information about data sharing authorization for housing organizations, see the DHCS Data Sharing Authorization Guidance: Medi-Cal Housing Support Services Toolkit.

[13] For more information on how to determine if an organization qualifies as a Part 2 Provider, please see the CalAIM Data Sharing Authorization Guidance, Section 2.2. Available here: https://www.dhcs.ca.gov/wp-content/uploads/2025/10/CalAIM-Data-Sharing-Authorization-Guidance-1.pdf.

[14] 42 C.F.R. 2.53

BHIN 26-013[15] requiring all BHPs and Drug Medi-Cal (DMC) Counties to use the Authorization to Share Confidential Member Information (ASCMI) Form[16] as the broad TPO consent form to authorize such disclosure.[17] Additionally, DHCS is launching a consent management portal (CMP) to serve as a centralized repository of ASCMI Forms for Care Partners to access to submit, query, and retrieve client consent preferences.

Behavioral Health Services Act

BHSA requires DHCS to "establish metrics, in consultation with counties, stakeholders, and the Behavioral Health Services Oversight and Accountability Commission to measure and evaluate the quality and efficacy" of behavioral health services and programs.[18] The law further requires DHCS to "establish minimum quality metrics to measure and evaluate the quality and efficacy of services and programs covered under Medi-Cal behavioral health delivery systems."[19]

Therefore, DHCS has authority to receive individual level data from counties, including Part 2 data, for purposes of calculating Phase 2 measures that utilize aggregated data from ISL encounters without additional consent from individuals under both HIPAA and Part 2, as such use falls within its statutorily mandated oversight and accountability role.

Please see the DHCS Data Sharing Authorization Guidance for additional information regarding federal and state data sharing and privacy laws and regulations.

ISL Data Sharing Use Cases

The table below summarizes and outlines legal authorities and in general whether consent is needed depending on the data being shared and who is disclosing the

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[15] For more information regarding Real Time Behavioral Health Data Sharing BHIN, see here: Behavioral-Health-Data-Sharing-BHIN-26-013.pdf. DHCS released a corresponding Real Time Behavioral Health Data Sharing APL outlining similar requirements for MCPs, see here: APL26-004.pdf

[16] More information about the ASCMI Initiative, including the ASCMI Form and consent management platform (CMP), can be found here: CalAIM ASCMI Initiative - DHCS - CA.gov

[17] DHCS recently launched a statewide Consent Management Platform (CMP), which is a DHCS-hosted, centralized system that supports the electronic collection, storage, maintenance, and retrieval of a Client's consent preferences. The CMP creates a standardized mechanism for managing client authorizations to share protected information and closes a key operational gap in the state's interoperability infrastructure by enabling lawful, real time data exchange while preserving individual privacy and choice.

[18] Cal. W&I Code §§ 5963.04(b), (d).

[19] Cal. W&I Code § 14197.71(b).

information. Organizations should consult with their own legal counsel to confirm whether consent is required for their own specific data sharing circumstances.

ISL Encounter Data Sharing Use Case	Consent Analysis
Sharing PHI from a HIPAA-Covered Entity to County: Submission of service and client record information from a county-contracted covered entity program to the county for purposes of payment for BHSA funded services.	• Submission of PHI to county is **allowed under HIPAA <u>without</u> individual consent** under the HIPAA payment exception.
Sharing SUD client information from a Part 2 Program to County: Submission of service and client record information from a county-contracted Part 2 program to the county for purposes of payment for BHSA funded services.	• Submission of Part 2 protected data to the county is **allowed <u>with</u> individual consent.**[20] • Part 2 programs that are **operated by the county** may share Part 2 protected data with the county **without individual consent,** assuming the recipient is part of that Part 2 program or has direct administrative control over such program.

[20] If the Part 2 data is being shared with the county for payment purposes, a more narrow consent specifically for payment administration is sufficient. Broader sharing of Part 2 data with the county for purposes beyond payment administration (e.g., care coordination, population health management), requires the individual to sign a broad Part 2 TPO consent via the ASCMI form.

ISL Encounter Data Sharing Use Case	Consent Analysis
Sharing from Non-Covered Entity to County: Submission of service and client record information from a county-contracted provider who is not a covered entity for the purposes of payment for BHSA funded services.	• As non-covered entities are not governed by HIPAA, HIPAA does not restrict their ability to share identifiable client information with the county without individual consent. However, the data must be treated as PHI once it is received by the county as a HIPAA-covered entity. • Note that other data sharing authorization laws may apply to the organization (e.g. Confidentiality of Medication Information Act in some instances), which could require individual consent to share specific identifiable information with the county.
Sharing ISL Encounter from the County to DHCS: County submission of ISL encounter data to DHCS via the county ISL portal.	• Submission of PHI to DHCS is **allowed <u>without</u> individual consent** under HIPAA since the disclosure is being made for a program evaluation purpose, which is a type of healthcare operation. • Submission of Part 2 protected data to DHCS is **allowed <u>without</u> individual consent** so long as that disclosure of Part 2 protected data falls within the program evaluation exemption.
Redisclosure of Identifiable Client Data from DHCS to Counties, MCPs, and their Contracted Providers: DHCS sharing minimum necessary identifiable client healthcare and SUD information originating from ISL encounters with counties, MCPs, and their	• Identifiable PHI may be **redisclosed <u>without</u> individual consent** under HIPAA if the disclosure is for treatment and/or care coordination purposes. • If the identifiable information redisclosed includes Part 2, there must

ISL Encounter Data Sharing Use Case	Consent Analysis
contracted providers that have an existing relationship with the client via Medi-Cal Connect.	be **a signed ASCMI Form (a broad TPO consent)**[21]

[21] For more information about the authority and use cases of redisclosed data via Medi-Cal Connect see: https://www.dhcs.ca.gov/medi-cal-connect/.

ISL CODE LIBRARY

Please see the full list of in scope ISL service codes in the ISL Code Library. Counties are required to follow all service coding instructions outlined in the ISL Code Library and the special instructions below.

Services with Existing Medi-Cal Service Codes

For ISL reported services that are identical to a covered Medi-Cal benefit but not claimed for Medi-Cal reimbursement, counties must submit the ISL encounter using the same procedure code and modifier combination that would be used for Medi-Cal billing.

Services without Existing Medi-Cal Service Codes

For services that do not have existing Medi-Cal service codes, counties must report these services via ISL encounters using DHCS-defined ISL service codes and modifiers. These codes are specifically designed to capture non-Medi-Cal funded behavioral health services that are not otherwise represented in standard medical coding schemas.

ISL Code Library – Special Instructions

This guidance is for ISL purposes and counties should refer to relevant DHCS policy manuals, governing notices, regulations, guides, etc. for the most up-to-date requirements and definitions for the specific BHSA components listed below.

Housing Services

The ISL Encounter Code Library includes codes that differentiate whether a service was provided in an interim or permanent setting. For example, there are two codes for Rental Subsidies, Recovery Residences, Housing Services Cost Supplement and Operating Subsidies, with one code designated for interim settings and one for permanent settings. Counties must ensure the submitted ISL code aligns with the type of setting in which the service was provided.

Additionally, the housing services code set includes codes for some, but not all, specific setting types. Where setting-specific codes exist (e.g., Hotel/Motel Vouchers, Recovery Residences), counties must use those codes. Where a specific setting code does not

exist, counties must use the appropriate general code based on: (1) whether the funding supports housing services provided to county clients residing in housing, a rental subsidy or an operating subsidy; and (2) whether the setting is an interim or permanent setting. These codes include:

- ISL206 Rental Subsidy: Interim Setting
- ISL207 Rental Subsidy: Permanent Setting
- ISL208 Housing Services Cost Supplement: Interim
- ISL209 Housing Services Cost Supplement: Permanent
- ISL221 Operating Subsidy: Interim Setting
- ISL222 Operating Subsidy: Permanent Setting

DHCS recognizes that counties may provide operating subsidies that are not directly tied to a single individual. Operating subsidy codes may be used when a county provides funding to a setting in which county clients reside, if a reasonable portion of the subsidy can be attributed to a specific individual. In these cases, the encounter should reflect the amount attributable to that individual (i.e., subsidy amount divided by number of county clients served).

Operating subsidy codes should not be used for counties covering the non-Medi-Cal coverable *"rent"* costs in an interim setting. For a Medi-Cal member receiving Transitional Rent in an interim setting, counties should use the code ISL206 Rental Subsidy: Interim Setting code to capture the non-Medi-Cal share of costs.

Day-Based Codes

- For all codes within the ISL Code Library with a unit of 'days,' except for DHCS-defined ISL codes classified as 'Inpatient' (and therefore use Admission and Discharge date), counties must submit a separate original encounter for each day of service. Each daily encounter must be assigned a unique Encounter ID.
- For interim and permanent settings, if a client moves to, or is placed in a new setting, the county must submit encounters for those days of stay. Similarly, if a client leaves a setting and returns at a later date, the county must submit separate encounters for each distinct day of the client's stay.
- For stays that span fiscal years, the county must submit encounters separately for the dates of service that occur within each fiscal year. Encounters associated with a given

fiscal year must be submitted in accordance with reporting requirements and no later than 90 days following the close of that fiscal year.

Full Service Partnership (FSP) Services

Codes for FSP services in the ISL Code Library align with the codes used for Medi-Cal billing. Where a Medi-Cal code exists for an FSP service, counties must use the same code used for Medi-Cal billing. FSP services without a Medi-Cal code are reported using DHCS-defined ISL codes. The tables below outline the service codes and modifiers counties must use when submitting ISL encounters for ACT, FACT, IPS, HFW, FSP ICM, Assertive Field-Based SUD, and other FSP services.

ACT, FACT and IPS

The service codes and modifiers for ACT, FACT and IPS vary based on whether a county has opted to cover the EBPs as bundled Medi-Cal services.

Counties that have opted to cover ACT, FACT and/or IPS as bundled Medi-Cal services must use the same bundled service codes for Medi-Cal claims and for ISL encounters, regardless of whether the individual is enrolled in Medi-Cal. Counties must submit separate ISL encounters using the bundled service code for each applicable date of service (not a single ISL encounter representing the full month of services).

Counties that have not opted to cover ACT, FACT and/or IPS as bundled Medi-Cal services must use individual "unbundled" SMHS service codes and an associated modifier for ISL encounters. "Unbundled" SMHS service codes and the associated modifier must be used regardless of whether the individual is enrolled in Medi-Cal.

All DHCS-defined ISL coded services that are delivered as part of ACT, FACT, or IPS must include the associated EBP modifier, regardless of the county's opt-in status.

Counties that have approved exemptions for ACT, FACT or IPS must not submit any ISL encounters for those EBPs.

The tables below list the specific service codes and modifiers for ACT, FACT, and IPS.

ACT	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H0040	n/a
County *did not opt in* to cover bundled Medi-Cal service	Appropriate SMHS codes	WJ
DHCS-defined ISL coded services delivered as part of ACT	Appropriate DHCS-defined ISL codes	WJ

FACT	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H0039	n/a
County *did not opt in* to cover bundled Medi-Cal service	Appropriate SMHS codes	WK
DHCS-defined ISL coded services delivered as part of FACT	Appropriate DHCS-defined ISL codes	WK

IPS	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H2023	n/a
County *did not opt in* to cover bundled Medi-Cal service	Appropriate SMHS, DMC, or DMC-ODS codes	WD
DHCS-defined ISL coded services delivered as part of IPS	Appropriate DHCS-defined ISL codes	WD

HFW, FSP ICM, Assertive Field-Based SUD, and Other FSP Services

The ISL service codes and modifiers for HFW, FSP ICM, Assertive Field-Based SUD, and other FSP services[22] are the same for all counties. The table below lists the specific service codes and modifiers for these FSP services.

HFW	Service Code(s)	Modifier
HFW monthly rate	H2022	n/a
HFW flex funds[23]	ISL406*	n/a

** Counties should use ISL406 for any goods and expenses delivered by a HFW provider that are not captured in the HFW monthly rate, including expenses such as food, clothing,*

[22] Includes all FSP services that are not captured as part of ACT, FACT, IPS, HFW, FSP ICM, and Assertive Field-Based SUD (e.g., primary SUD FSPs, other EBPs, or other recovery-oriented services).

[23] HFW flex funds are not part of the Medi-Cal benefit package. HFW flex funds must always be coded as an ISL encounter, regardless of whether an individual is enrolled in Medi-Cal.

travel, and employment expenses. Counties should not use ISL400-405 for services, goods, and expenses delivered as part of HFW.

Other individual services provided as part of the HFW service package should be reported using applicable individual service codes, not the HFW monthly rate code.

FSP	Service Code(s)	Modifier
FSP ICM	Appropriate SMHS or ISL codes	WI
Assertive Field-Based SUD	Appropriate SMHS, DMC, DMC-ODS, or ISL codes	WA
Other FSP Services	Appropriate SMHS, DMC, DMC-ODS or ISL codes	WF

Behavioral Health Services and Supports

Codes for BHSS early intervention services in the ISL Code Library align with the codes used for Medi-Cal billing. Where a Medi-Cal code exists for a BHSS early intervention service, counties must use the same code used for Medi-Cal billing. BHSS early intervention services without a Medi-Cal code are reported using DHCS-defined ISL codes. The tables below outline the service codes and modifiers counties must use when submitting ISL encounters for these services.

CSC for FEP

Counties that have opted to cover CSC for FEP as a bundled Medi-Cal service will use the same bundled service code for Medi-Cal claims and for ISL encounters, regardless of whether the individual is enrolled in Medi-Cal. Counties must submit separate ISL encounters using the bundled service code for each applicable date of service (not a single ISL encounter representing the full month of services).

Counties that have not opted to cover CSC for FEP as a bundled Medi-Cal service must use individual "unbundled" SMHS service codes and an associated modifier for ISL encounters. "Unbundled" SMHS service codes and the associated modifier must be used regardless of whether the individual is enrolled in Medi-Cal.

All DHCS-defined ISL-coded services delivered as part of CSC for FEP must include the associated CSC for FEP modifier, regardless of the county's opt-in status.

Other BHSS Early Intervention Services

The ISL service codes and modifiers for BHSS EBPs and community-defined evidence practices (CDEPs) and other BHSS early intervention services are the same for all counties.

CSC for FEP	Service Code(s)	Modifier
County *opted in* to cover bundled Medi-Cal service	H2040	n/a
County *did not opt in* to cover bundled Medi-Cal service	Appropriate SMHS codes	WC
DHCS-defined ISL-coded services delivered as part of CSC for FEP	Appropriate DHCS-defined ISL codes	WC

BHSS Early Intervention (EI) Service	Service Code(s)	Modifier
BHSS EI EBPs and CDEPs	Appropriate SMHS, DMC, DMC-ODS or DHCS-defined ISL codes	HX
Other BHSS EI Services (not EBPs or CDEPs)	Appropriate SMHS, DMC, DMC-ODS or DHCS-defined ISL codes	WB

APPENDIX

Appendix A: Encounter Value Calculation Methodology

This appendix provides the prescribed framework for completing the Encounter Value field. Encounter Value must represent the county's assigned dollar value for the specific ISL encounter, determined using a documented and consistently applied methodology. Depending on the encounter type, Encounter Value may be derived from an actual payment amount, a standardized proxy value, or another valuation methodology described in this appendix.

Calculation Approaches by ISL Unit Type/Expense Type

This guidance applies to ISL encounters representing services or expenditures funded by the county that are not reimbursed through Medi-Cal. In some cases, services reported to ISL may align with existing Medi-Cal service definitions and valuation methodologies but are not payable through Medi-Cal because the individual is not eligible for Medi-Cal or the individual has exhausted the Medi-Cal benefit. In such cases, existing Medi-Cal valuation methodologies must be used, as described below.

- **Time-Based ISL Services** (units = minutes). Use when the ISL code is reported in minutes.
- Units: Report the number of minutes to deliver the encounter.
- Encounter Value: Using outpatient Medi-Cal Practitioner Types, assign a per minute proxy value based on the role of the person who provided the service, then multiply that value by the reported minutes as follows:
    - Map the ISL renderer to a Medi-Cal practitioner type. To do this, identify the staff role of the person who rendered the ISL service and map it to the closest applicable Practitioner Type used in Medi-Cal billing standards for SMHS and DMC/DMCODS.
    - If the renderer’s classification is not typically mapped to a DHCS-claimable Practitioner Type (e.g., a Medical Office Assistant), select the closest comparable Practitioner Type for valuation purposes and apply it consistently. If no close match exists, an “Other Qualified Provider” Practitioner Type may be used as a standardized proxy.
    - Calculate Encounter Value using a per minute value. After selecting the Practitioner Type, use the county’s assigned Medi-Cal rate for that

Practitioner Type as the proxy, convert it to a per minute value using a consistent methodology, and multiply by the reported minutes (units).

- **Expense-Based ISL Services** (units = dollars). Use this option when the ISL code represents a direct cost, such as a purchased item or service.
- Units: Report units where 1 unit = $1 (i.e., the number of units equals the dollar value assigned to the expense-based ISL encounter).
- Encounter Value: Report the dollar value assigned by the county to the expense-based ISL encounter. The Encounter Value should reasonably reflect the value of the item or service provided to the individual and be determined using a documented and consistently applied methodology.
- Rounding: In instances where the county uses the actual payment amount associated with the encounter, counties may round dollar amounts to the nearest whole dollar when reporting both the Unit Quantity field and the Encounter Value field for expense-based ISL services. Counties must apply the rounding approach consistently across ISL reporting.

  For example:

  - If the expense is $24.49 or below, the county may report 24 units and an Encounter Value of $24.
  - If the expense is $24.50 or above, the county may report 25 units and an Encounter Value of $25.

- **Day-Based ISL Services** (units = days). Use when the ISL code is day-based (per diem).
- Units: Report the number of days represented by the encounter (units = 1 per day).
- Encounter Value: Apply an appropriate daily value to the reported days, based on one of the following methods arranged in order of priority:
- Contract-operated services (per diem / per client day): Identify the contracted daily rate applicable to the service and use that rate to value the encounter based on the reported day units.
- If the contracted housing program uses multiple daily rates that appropriately roll up to the same ISL code and the county's system of record cannot efficiently associate

multiple fee schedules with a single ISL procedure code, the county may use a reasonable, documented methodology to establish a representative daily value for ISL reporting purposes. This may include a weighted average of the rates paid to the contracted housing program, provided the methodology reasonably reflects the county's payment arrangement, and is applied consistently.

- County-operated services: Use a County-defined proxy per diem that reasonably represents the county's cost of delivering the day-based service (e.g., County cost methodology used for internal rate development or cost allocation), applied to the number of reported days; ensure this rate is applied consistently where applicable.
    - Contract-operated services with non–per diem payment arrangements (e.g., operating subsidies): If the county subsidizes provider operating costs and the provider is not paid on a per day, per client basis, the County must use a standardized allocation method to translate the payment arrangement into a daily value for ISL reporting purposes. This approach is applicable only when the ISL service code requires a per day value (i.e., day-based codes).

- **CPT/HCPCS-Coded Services** Reported in ISL (not reimbursed by Medi-Cal). A service or cost incurred must be reported in ISL when it is tied to an individual and is not reimbursed through Medi-Cal. For services that have an existing CPT or HCPCS code and would ordinarily be billed using Medi-Cal claiming standards, these standards must still be followed when the encounter is reportable in ISL. Therefore, the Encounter Value must be equal to the amount the county would have claimed to Medi-Cal.
- Units: Report units consistent with the applicable Medi-Cal service definition for the CPT or HCPCS coded service (e.g., units equal minutes, hours, days, etc.).
- Encounter Value: Use the applicable DHCS-established maximum rate associated with the HCPCS or CPT code, applied to the reported units.

Appendix B: Void and Replacement Encounters Instructions

This guidance describes the approach for counties' submission and DHCS' processing of void and replacement ISL encounters. First-time ISL encounter submissions that were

rejected by DHCS must be corrected and resubmitted as encounters with Encounter Submission Type as Original, since they were not accepted into the system.

Previously accepted ISL encounters may be updated with:

- Replacement: When correcting or updating an existing accepted ISL encounter while keeping it valid
- Void: When the ISL encounter should be cancelled and no longer considered valid

Replacement and Void actions are only applicable to previously accepted ISL encounters.

Once an encounter is voided, no further updates (including replacements) are allowed.

Void of an Accepted Encounter

Counties may need to void an accepted encounter for the following reasons:

- The encounter was submitted in error.
- The encounter should not have been reported.
- The encounter needs to be removed from reporting and downstream processing (for example, a client was approved for retroactive Medi-Cal coverage that covers the date of service).

To void an accepted ISL encounter, counties must:

- Submit an encounter identical to the original accepted encounter, with the same Encounter ID, except for the new encounter's Encounter Submission Type is Void.

Example:

Date	Encounter ID	Encounter Submission Type	Is Active
3/1	0091234	Original	Y

Date	Encounter ID	Encounter Submission Type	Is Active
3/26	0091234	Void	N

Counties cannot replace an ISL encounter once it has been voided. Counties also cannot void an ISL encounter that has been rejected.

For inpatient encounters, counties submitting an encounter with an Encounter Submission Type as Void and using an Encounter ID that was used in a previous inpatient encounter voids all previously accepted encounters associated with that Encounter ID value.

Counties cannot void only one day or one encounter within an inpatient encounter chain. For any corrections to encounters in an inpatient chain, counties should replace one day or one encounter, not void.

Replacement of an Accepted Encounter

Counties must replace an accepted encounter if an encounter field was submitted incorrectly or inaccurately, but the entire encounter does not need to be voided. An encounter with Encounter Submission Type as Replacement updates and corrects the existing accepted encounter and retains the encounter for reporting and downstream processing.

To replace an accepted ISL encounter, counties must:

- Submit an encounter identical to the original accepted encounter, using the same Encounter ID, except for the new encounter's Encounter Submission Type is Replacement and the encounter fields that required correction have been revised.

Example:

Date	Encounter ID	Encounter Submission Type	Is Active
3/26	0091234	Original	Y

Date	Encounter ID	Encounter Submission Type	Is Active
3/28	0091234	Replacement	Y