SPECIALTY MENTAL HEALTH SERVICES BILLING MANUAL

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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CHAPTER ONE - INTRODUCTION

1.0 Introduction

The Short Doyle/Medi-Cal (SD/MC) claims processing system allows California's County Mental Health Plans (MHP) to submit electronic claims for reimbursement of covered Specialty Mental Health Services (SMHS) provided to Medi-Cal-eligible beneficiaries. The Department of Health Care Services, Local Governmental Financing Division (DHCS LGFD) oversees the SD/MC claims processing system. This manual provides guidance on how to ensure that a claim and the service lines in that claim are not denied by the SD/MC claims processing system. CalAIM Behavioral Health Payment Reform Frequently Asked Questions contain clarifications and corrections related to claiming policy. To stay current on corrections to the billing manual, please check this site periodically. This manual does not include clinical guidance on when specific services/procedure codes or modifiers are appropriate or on the documentation that must accompany the service codes claimed. This chapter includes:

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

1.1 About This Manual

This Mental Health Medi-Cal Billing Manual is a publication of DHCS. DHCS administers the Specialty Mental Health Services Medi-Cal program (administered by the former Department of Mental Health through 6/30/2012). This Billing Manual provides trading partners with a reference document that describes the processes and rules relative to SD/MC claims for SMHS. Trading partners include Mental Health Plans (MHP), Billing Vendors of MHPs and others.

1.1.1 Objectives

The primary objectives of this Billing Manual are to:

- Provide explanations, procedures and requirements for claiming
- Provide claiming system overviews and process descriptions
- Provide links and/or information related to:
    - State and Federal laws and regulations
    - Letters and Information Notices
    - Reference documents such as:

- SD/MC User Manual
- Companion Guides
- Companion Guide Appendix

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

1.1.2 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 Medi-Cal specialty mental health services including but not limited to:

- Determination of Aid Code[1]
- Maintenance of eligibility information technology systems (e.g., Medi-Cal Eligibility Determination System [MEDS])
- Adjudication of SD/MC Mental Health claims
- Processing of claims for Federal Financial Participation (FFP) payments

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

- Submission of expenditure claims to the Centers for Medicare & Medicaid Services (CMS) to obtain FFP

For Medi-Cal specialty mental health services provided to a member by a certified provider, the cost of these services is paid by a combination of State, County and Federal funds.

The FFP sharing ratio (the percentage of costs reimbursed by the Federal government) is determined on an annual basis and is known as the Federal Medical Assistance Percentage (FMAP).

County expenditures represent a combination of State realignment funds, Mental Health Services Act (MHSA) funds, local county funds and other sources such as grants. Counties submit claims to the State which pays the full claim.

1.3 Authority

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

1.3.1 Social Security Act, Title XIX

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

1.3.2 Social Security Act, Title XXI

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

1.3.3 Health Insurance Portability and Accountability Act of 1996

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

1.3.4 Code of Federal Regulations

Title 42 of the Code of Federal Regulations (42 CFR) Chapter IV Subchapter C Parts 430-456 – Medical Assistance Programs, provides regulatory guidance for the Medicaid Program. Title 45 CFR Part 160 and Subparts A and E of Part 164 provide regulatory guidance for the HIPAA Privacy Rule.

1.3.5 Welfare and Institutions Code

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

1.3.6 Additional Resources:

- California Code of Regulations & DHCS Information Notices

Most applicable California regulations are in Title 9, Chapter 11. In accordance with Welfare and Institutions Code 14184.102(d), DHCS may implement the California Advancing and Innovating Medi-Cal (CalAIM) by means of all-county letters, plan letters, provider bulletins, information notices or similar instructions. As information notices that pertain to payment reform are issued or changes to the billing system are made, this manual, which is an attachment to an information notice, will be updated.

- Companion Guide for the 837 Professional and Institutional Health Claims

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

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

- 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.

- 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.

- 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.

- 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.

- Mental Health Claim Adjustment Reason Codes-Remittance Advice Remark Codes (CARC-RARC)

This is more detailed information about the meaning of the denial codes received.

1.4 Medi-Cal Claims Customer Service (MEDCCC) Office

MEDCCC was created to provide MHPs a single point of contact to assist them with SD/MC claiming process questions and issues. MEDCCC provides MHPs direct access to the State when they have questions regarding claim payment, need technical assistance with claim processing, have questions 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 MHPs when a potential issue with a claim process or business rule has been identified. MEDCCC assists MHPs with streamlining the claim process, resulting in improved processes and understanding of requirements at both the MHP and State levels.

What MHPs Can Expect When Contacting MEDCCC:

An email response acknowledging receipt of the MHP's issue or concern within 48 hours of receipt.

- An email response acknowledging receipt of the MHP's issue or concern within 48 business hours.
- The most current information on MHP's 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 MHPs submit their inquiries via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC . If you do not yet have access, please reach out to your designated county manager to request access.

CHAPTER TWO – GETTING STARTED

2.0 Introduction

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

- Enrolling in the DHCS Application Portal
- Legal Entity, Provider Numbers and National Provider Identifiers (NPI)
- Provider Enrollment and Medi-Cal Certification
- Online Provider System
- Companion Guide and Appendix

2.1 DHCS Application Portal

The DHCS Application Portal (Portal) is a collection of web applications that allow Mental Health Services trading partners (e.g., MHPs, 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. Approvers are appointed by each MHP director.

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 Approver 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-DMH or SD/MC-ADP as appropriate. The 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 Enrollment and Medi-Cal Certification

For a provider to be able to submit claims for providing SMHS to beneficiaries of an MHP, they must be Medi-Cal certified by the State and enrolled in Medi-Cal through the Provider Information Management System (PIMS). MHPs shall have completed, and submitted to DHCS, one Medi-Cal Certification and Transmittal form (Transmittal) for each provider utilized by the MHP. The Transmittal form can be found on either: 1)

DHCS website or 2) by e-mailing DMHCertification@dhcs.ca.gov. The purpose of the Transmittal is to "transmit" provider information necessary to adjudicate claims submitted to the Portal.

2.3 Companion Guide and Appendix

DHCS publishes a Companion Guide and a Companion Guide Appendix for each HIPAA-compliant transaction type used by SD/MC (e.g., 835, 837). The Companion Guide details how to format HIPAA-compliant 837 forms and what information the MHP can expect to receive on an 835 form. The Companion 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

Specialty mental health clients must be enrolled in Medi-Cal for the MHP to be reimbursed through the SD/MC claiming 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 enrolling individuals in the Medi-Cal program. The determination of member eligibility and the collection of member eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding member eligibility criteria may be obtained through the DHCS Medi-Cal Eligibility Division website.

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

- Medi-Cal eligibility is established on a monthly basis.
- Medi-Cal eligibility may require that a member's Share of Cost be met before Medi-Cal will pay for any services.
- Medi-Cal eligibility may be established retroactively through legislation, court hearings and/or decisions.
- HIPAA 270/271 transactions are available from DHCS to verify member Medi-Cal eligibility.
- MHPs should verify member Medi-Cal eligibility for the month of service prior to submitting claims for reimbursement.

3.1.2 Medi-Cal Eligibility Review

Once Medi-Cal eligibility is established, member eligibility information may be reviewed by authorized MHP staff. With few exceptions, the source of this eligibility verification information will be the DHCS Point of Service system.

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 the previous 15 months. A new MMEF is available at the end of each month and applies to the following month's eligibility. MMEF data is not used to determine eligibility during adjudication. The adjudication process queries the Medi-Cal Eligibility Data System (MEDS) for eligibility data at the time the claim is being adjudicated.

For additional information about the kind of data elements available in MMEF, refer to Appendix 3.

MEDS and MEDSLITE

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

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

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

County of Responsibility and County of Residence

MEDS, and/or MEDSLITE, has a field labeled County of Responsibility. The County of Responsibility field indicates the county that is responsible for covering the member's SMHS, SUD treatment services, except as described below in the policy section. In general, the county indicated in the MEDS, and/or MEDSLITE, County of Residence field will be the same as the county indicated in the MEDS, and/or MEDSLITE, County of Responsibility field. See BHIN 24-008

For additional information about the data elements available in MEDSLITE, refer to Appendix 4.

3.2 Aid Codes

During the Medi-Cal application and enrollment process, Aid Codes are assigned to Medi-Cal eligible clients to indicate the program(s) under which the client qualifies for services.

The DHCS Short Doyle Medi-Cal Aid Codes Chart (which includes both Mental Health and Drug Medi-Cal) is posted on the MEDCCC Library. The Aid Codes Chart provides useful information about the following:

- FFP
- Aid codes
- Type of benefits
- Share of cost
- Aid code descriptions
- Indication of reimbursement through the DHCS Fiscal Intermediary, Drug Medi-Cal Program (DMC), Mental Health Plans, and/or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) [2] programs.

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

CHAPTER FOUR – COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered Specialty Mental Health Services and provider certification.

- Covered Services
- Provider Certification

4.1 Covered Services

The Specialty Mental Health Services listed below are Medi-Cal covered services. Claims for reimbursement of specialty mental health services may be submitted to the SD/MC claiming system via the Portal.

4.1.1 Rehabilitative Mental Health Services: State Plan Amendment (SPA) 24-0042

Rehabilitative Mental Health Services provided through a specialty mental health delivery system available to Medicaid (Medi-Cal) beneficiaries who meet State criteria for access to the specialty mental health services delivery system. Rehabilitative Mental Health Services are provided in accordance with the 42 Code of Federal Regulations (CFR) Part 440.130(d). Rehabilitative Mental Health Services are recommended by a physician or other licensed mental health professional within the scope of their practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a member's functional level. Rehabilitative Mental Health Services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention. Rehabilitative Mental Health Services include services to enable a child to achieve age-appropriate growth and development. It is not necessary that a child actually achieved the developmental level in the past. Rehabilitative Mental health Services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency. Rehabilitative Mental Health Services may address co-occurring substance use disorders as clinically appropriate, and within the treating practitioner's scope of practice for beneficiaries who access these services to address their mental health conditions.

- **Assessment**: A service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary

and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards.

- **Employment and Education Support Services**: Support recovery by assisting members in managing their mental health conditions in vocational and educational settings. Services support members to function in the community and help reduce the risk of psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, substance use and homelessness.

  Employment and Education Support Services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member.

  Employment and Education Support Services include one or more of the following service components:

  - Employment Support Services that support a member with managing their mental health condition and addressing challenges as they work to restore, maintain and/or sustain employment.
  - Education Support Services that support a member with managing their mental health condition and addressing challenges that occur in educational settings.

- **Treatment Planning**: A service activity to develop or update a member's course of treatment, documentation of the recommended course of treatment, and monitoring of a member's progress.

- **Therapy:** Service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal, or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery, and resiliency to assist a member in acquiring greater personal, interpersonal, and community functioning or to modify feelings, thought processes, conditions, attitudes, or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or a group of beneficiaries, and may

include family therapy directed at improving the member's functioning and at which the member is present.

- **Psychosocial Rehabilitation**: A recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting beneficiaries to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression, such as art, recreation, dance, or music, as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning, including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources and/or medication education. Psychoeducation assists members in recognizing the symptoms of their mental health condition to prevent, manage, or reduce such symptoms. Psychosocial Rehabilitation, including psychoeducation, may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member. Psychosocial rehabilitation may be provided to a member or a group of beneficiaries.

Refer to the Service Table for the rules governing the procedure codes associated with these services.

4.1.2 Specialty Mental Health Services for Children and Youth: Mental Health Contract Template

Specialty Mental Health Services for Children and Youth include the following:

- **Functional Family Therapy (FFT)**: FFT is designed for youth from early to late adolescence (between the ages of 11-18) who are at-risk or have moderate to severe behavior or emotional challenges, such as conduct disorder, violent acting-out, substance use, and delinquency.

  FFT is a multisystemic intervention designed for at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that requires the engagement of youth/family members' social system (e.g., family, teachers, healthcare providers). The

program provides caregiver and youth interventions that focus on reducing adolescent behavioral problems, conduct disorder, substance use and recidivism, and improving parenting behavior.

The program is on average 12 to 14 one-hour sessions (though this may range from 8 to 30, depending on the severity of the case) spread over a three-month period. FFT is phased with steps that build upon each other. The five phases consist of: 1) Engagement; 2) Motivation; 3) Relational Assessment; 4) Behavior Change; and 5) Generalization.

- **Intensive Care Coordination (ICC)**: ICC is a targeted case management service that facilitates assessment of care planning for, and coordination of services to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria to access SMHS. ICC service components include: assessing, service planning and implementation, monitoring and adapting, and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family, and involved child-serving systems. The CFT is comprised of-as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, clergy, and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:
    - Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven, and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;
    - Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;
    - Supports the parent/caregiver in meeting their child's needs;
    - Helps establish the CFT and provides ongoing support; and

- Organizes and matches care across providers and child serving systems to allow the child to be served in the community[3]

» **Intensive Home-Based Services (IHBS)**: IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community, and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities include, but are not limited to assessment, treatment plan, therapy and collateral. IHBS is provided to beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

» **Multisystemic Therapy (MST)**: MST is an intensive family- and community-based treatment that uses therapy sessions to reduce challenging behaviors, criminogenic behavior, substance use, and juvenile justice involvement. For parents/caregivers, the goal is to learn skills to independently address difficulties in raising children and adolescents as well as skills to cope with other family, peer, and neighborhood problems. MST emphasizes cultural responsiveness and the centering of home and community settings, as well as partnership with law enforcement and the juvenile justice system.

  The treatment intensity varies based on youth and family needs (e.g., brief check-ins, 2-hour sessions, ranging from daily to weekly) over the course of 3-5 months.

» **Parent-Child Interaction Therapy (PCIT)**: PCIT is a specialized behavior management intervention for children (aged 2-7 years) who exhibit challenging behaviors, such as aggression or defiance, and it involves their caregivers.

  PCIT is conducted through coaching sessions wherein a caregiver wearing a headset interacts with their child in a playroom while the PCIT therapist observes through a one-way mirror from an observation room. The PCIT therapist provides in-the-moment coaching to caregivers via the wireless headset to teach caregivers strategies that will promote positive behaviors and to develop skills to

[3] See Exhibit E – Attachment 2, Section J of the Mental Health Contract Template.

manage a child's behavior. PCIT focuses on decreasing child behavior challenges (e.g., aggression, noncompliance, tantrums), and increasing positive parent behaviors (e.g., therapeutic play, effective commands), and improving the caregiver-child relationship through structured interactions.

- PCIT typically consists of weekly, hour-long sessions over 14 weeks, conducted in the presence of both caregiver and child. PCIT is implemented in two phases: (1) Child-Directed (CDI); (2) Parent-Directed Interaction (PDI). This is an individualized service that cannot be provided as a group service. **Therapeutic Behavioral Services (TBS):** Intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.
- **Therapeutic Foster Care (TFC) Services:** This model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services (SMHS) activities. In accordance with Attachment 4.19-B of the State Plan, the services provided in a therapeutic foster home include plan development, rehabilitation, and crisis intervention. TFC services are available to children up to Age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. TFC is intended for children who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes, and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

4.1.3 Hospital Inpatient: CCR Title 9, § 1820.205

Hospital inpatient services are provided in an acute psychiatric hospital or the distinct acute psychiatric portion of a general hospital licensed to provide psychiatric services by the California Department of Public Health. Hospital inpatient services must be medically necessary for the diagnosis or treatment of a mental health disorder requiring

an inpatient level of care. Except for Short-Doyle Medi-Cal (SD/MC) hospitals[4], inpatient services are not billed through the SD/MC system but are billed through the Fiscal Intermediary. As of July 1, 2023, SD/MC and Fee-for-Service Medi-Cal (FFS/MC) hospitals are reimbursed a bundled rate for routine and ancillary services.

4.1.4 Psychiatric Inpatient Hospital Professional Services: CCR Title 9, §1810.237.1

Psychiatric Inpatient Hospital Professional Services means specialty mental health services provided to a member by a licensed mental health professional with hospital admitting privileges while the member is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services such as services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services.

4.1.5 Hospital-Based Ancillary Services: SPA 23-0015 and SPA 09-004

Hospital-based ancillary services mean services other than routine hospital services and psychiatric inpatient hospital professional services that are received by a member admitted to a psychiatric hospital.

4.1.6 Routine Hospital Services: SPA 23-0015 and SPA 09-004

Routine Hospital Services means bed, board and all medical, nursing, and support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

4.1.7 Hospital Inpatient Administrative Day Services: CCR Title 9, § 1810.202

During a hospital stay, the MHP shall authorize payment for administrative day services if the following criteria are met: (1) member no longer needs inpatient care, but has previously met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services, (2) there is no appropriate, non-acute treatment facility within a reasonable geographic area and (3) the hospital demonstrates attempts to

[4] Hospitals that are Short Doyle/Medi-Cal hospitals are listed on Attachment 4.19-A, page 40.5 of State Plan Amendment 09-004. State Plan 09-004 also outlines the different methodologies for the rates paid to SD/MC and FFS/MC hospitals.

transfer to a lower level of care by documenting contacts with a minimum of five appropriate, non-acute treatment facilities per week.

4.1.8 Psychiatric Health Facility Services: SPA 22-0023

Psychiatric Health Facility services are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by the Department of Health Care Services. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychological Rehabilitation
- Crisis intervention

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

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

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

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

4.1.10 IPS Supported Employment: BHIN 25-009

The IPS model of Supported Employment is a community-based intervention that supports members living with significant behavioral health needs to find and maintain competitive employment. Participation in IPS Supported Employment supports improved employment outcomes as well as improved self-esteem, independence, sense of belonging, and overall health and well-being. According to the EBP Policy Guide, some members residing in an inpatient or residential treatment setting may benefit from IPS, however, IPS may not be delivered in a inpatient or residential setting. Community-based IPS teams may deliver IPS to members residing in inpatient and residential treatment settings during their treatment stay. However, the IPS Supported Employment team must meet with the member in a community-based location. See BHIN 22-016.

4.1.11 Assertive Community Treatment (ACT): SPA 24-0042

Assertive Community Treatment (ACT) is an Evidence-Based Practice (EBP) for members with complex and significant mental health needs. ACT supports recovery through an assertive, person-centered approach that assists members to cope with the symptoms of their mental health condition and acquire skills necessary to function and be integrated in the community.

ACT is a community-based, multidisciplinary team-based service. ACT may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member.

This service includes one or more of the following service components:

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Therapy
- Treatment Planning

DHCS has published a policy guide providing a more complete description of the benefit.

4.1.12 Forensic Assertive Community Treatment (FACT): SPA 24-0042

Forensic Assertive Community Treatment (FACT) is ACT for members who are justice-involved.

DHCS has published a policy guide providing a more complete description of the benefit.

4.1.13 Coordinated Specialty Care (CSC): SPA 24-0042

Coordinated Specialty Care is an EBP for members experiencing a first episode of psychosis. CSC addresses the symptoms of psychosis to reduce the risk of psychiatric hospitalization, emergency room visits, residential treatment, involvement with the criminal justice system, substance use, and homelessness. CSC is a person-centered EBP that helps members cope with the symptoms of their mental health condition and to function and remain integrated in the community.

CSC is a community-based, multidisciplinary team-based EBP. CSC may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment needs of the member.

This EBP includes one or more of the following service components:

- Assessment
- Crisis Intervention

- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment Planning

DHCS has published policy guide that provides a more complete description of the benefit.

4.1.14 Clubhouse Services: SPA 24-0042

Clubhouse Services are an EBP and are intentional, strengths-focused community-based service to support recovery from a mental health condition. Clubhouse Services use a social practice model, in which members voluntarily participate in clubhouse activities and duties alongside providers trained in the model.

This EBP includes one or more of the following service components:

- Employment and Education Support Services
- Medication Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Treatment Planning

DHCS has published policy guide that provides a more complete description of the benefit.

4.1.15 Children's Crisis Residential Programs: SPA 22-023

Children's Crisis Residential Programs (CCRP) provide children with Medi-Cal services, primarily crisis residential treatment services. CCRPs serve children experiencing mental health crises as an alternative to psychiatric hospitalization. CCRPs are a type of community care facility, and are, by definition, non-medical facilities.

4.1.16 Crisis Residential Treatment Services: SPA 22-0023

Crisis Residential Treatment Services (CRTS) are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days.

Crisis residential treatment services must have a clearly established site for services, although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of service.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation
- Crisis Intervention

4.1.17 Adult Residential Treatment Services: SPA 22-0023

Adult residential treatment services are recovery focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential program.

The service is available 24 hours a day, seven days a week and structured day and structured day and evening services are available all seven days.

Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a staff person of the facility on the day of service.

The service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.18 Crisis Stabilization: SPA 22-0023

Crisis stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a member to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the member or others, or substantially increase the risk of the member becoming gravely disabled.

Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital-based outpatient program (services in a hospital-based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Medical backup services must be available either on site or by written contract or agreement with general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

All beneficiaries receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the member's needs will be made, to the extent resources are available.

This service includes one or more of the following service components:

- Assessment
- Therapy
- Crisis Intervention
- Medication Support Services
- Referral and Linkages

4.1.19 Day Treatment Intensive: SPA 22-0023

Day Treatment Intensive is a structured, multi-disciplinary program which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the member in living within a community setting. Services are available for at least three hours each day. Day treatment intensive is a program that lasts less than 24 hours each

day. Day treatment intensive may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.20 Day Rehabilitation: SPA 22-0023

Day Rehabilitation is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the member.

Day rehabilitation services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

This service includes one or more of the following service components:

- Assessment
- Treatment Planning
- Therapy
- Psychosocial Rehabilitation

4.1.21 Targeted Case Management (TCM): CCR Title 9, § 1810.249

Targeted case management is a service that assists a member to access needed medical, educational, social, prevocational, vocational, rehabilitative or other community services. The service activities may include but are not limited to communication, coordination,

and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the member's progress; placement services and plan management. TCM services may be face-to-face or by telephone/telehealth with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

4.1.22 Mental Health Services: Professional Inpatient (IP) Visit

Mental Health Services: Professional IP visit services are the same as mental health services, except they are provided in a Fee-for-Service inpatient setting by professional staff. Claims for Mental Health Services: Professional Inpatient (IP) Visit should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.23 Medication Support Services: SPA 24-0042

Medication Support Services include prescribing, administering, dispensing and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of behavioral health conditions. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may include prescription, dispensing, monitoring, or administration of medication related to substance use disorder services for members with a co-occurring mental health condition and substance use disorder. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Medication support services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

This service includes one or more of the following service components:

- Evaluation of the need for medication
- Evaluation of clinical effectiveness and side effects
- Medication education including instruction in the use, risks and benefits of and alternatives for medication
- Treatment Planning

Limitations: The maximum number of hours claimable for medication support services in a 24-hour period is 4 hours.

Members may receive additional services in other levels of care if additional medication management is needed. This service is not duplicative of the drug counseling requirements described in 42 CFR 456.705.

Refer to the Service Table for the rules governing the codes associated with this service.

4.1.24 Medication Support: Professional IP Visit

Medication Support: Professional IP Visit services are the same as Medication Support, except they are provided in a Fee-for-Service IP setting by professional staff. Claims for Medication Support: Professional IP Visit should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.25 Crisis Intervention: State Plan Amendment: SPA 22-0023

Crisis intervention is an unplanned, expedited service, to or on behalf of a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. Crisis intervention may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Crisis intervention may be provided face-to-face, by telephone or by telehealth and may be provided in a clinic setting or anywhere in the community.

This service includes one or more of the following service components:

- Assessment
- Therapy
- Referral and Linkages

4.1.26 Crisis Intervention: Professional IP Visit

Crisis intervention: Professional IP visit services are the same services as crisis intervention except that the services are provided in a Fee-For-Service or SD/MC IP setting by professional staff. Claims for Mental Health Services: Professional Inpatient (IP) Visit should be submitted in the same manner as fee-for-service Medi-Cal claims for individual and group providers, as discussed in Section 5.10.0.

4.1.27 Peer Support Services: State Plan Amendment 22-0023

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 member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of 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 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 member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the member, family members or significant support persons.

4.1.28 Referral and Linkages: State Plan Amendment: 22-0023

Referral and Linkages are services and supports to connect a member with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support.

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

Community-based mobile crisis intervention 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 member requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile crisis services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restore the member to the highest possible functional level. 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 member a behavioral health crisis. Locations may include, but are not limited to the member's home, school or workplace, on the street, or where a member 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.

To claim for Mobile Crisis services, use Healthcare Common Procedure Coding System (HCPCS) code H2011 **with** Place of Service (POS) 15. Please note that *only* HCPCS H2011 with POS 15 means mobile crisis services as defined here.

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

4.1.30 Justice-Involved Reentry Initiative Behavioral Health Information Notice (BHIN) 23-059

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

These services are available to eligible members 90 days prior to their release. The Policy Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative states that "as part of behavioral health links, county behavioral health agencies will be required, within 14 days prior to release (if known) and in coordination with the pre- and/or post-release care manager, to ensure processes are in place for a professional-to-professional clinical handoff between the correctional behavioral health provider, a county behavioral health agency provider, and the member (as appropriate)."

All other pre-release services that could be delivered by county-based or county contracted providers, including clinical consultation, care management, and MAT should be billed by the behavioral health provider and not by the agency to CA-MMIS as either in-reach or embedded services.

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

4.2 Provider Certification

To receive payment for SMHS, the submitted service facility NPI must be certified to render the billed services on the date of service. Provider certification is performed by Medi-Cal's Provider Enrollment Division. Please refer to Provider System Documentation and Specialty Mental Health Services (SMHS) Provider Enrollment Frequently Asked Questions.

Certification of SMHS services is validated using Mode of Service and Service Function Codes. Any site certified to perform any Mode 15 service can provide any of the services listed in the Service Table.

24-Hour services are identified by Mode of Service '05,' along with the following Service Functions codes:

- 10-18: Acute Psychiatric Inpatient Hospital Services
- 19: Administrative Day Services
- 20-29: Psychiatric Health Facility
- 40-49: Crisis Residential Treatment (Children and Adults)
- 65-69: Adult Residential
- 95: Therapeutic Foster Care

Day services are identified by Mode of Service '10,' along with the following Service Function codes:

- 20-24: Crisis Stabilization – Emergency Room
- 25-29: Crisis Stabilization – Urgent Care
- 81-89: Day Treatment Intensive
- 91-99: Day Rehabilitation

CHAPTER FIVE – CLAIMS PROCESSING

5.0 Introduction

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

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

5.1 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 file. 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 Approving and Denying Claims

The SD/MC claiming system adjudicates all claim files 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 service 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 claims in which all services lines are submitted for $0.

5.2.2 Member 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 member. 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.

5.3.0 Member Eligibility

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

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

5.3.1 Member Date of Birth

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

5.3.2 Member Gender

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

5.3.3 Member Date of Death

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

5.4.0 Dates of Services Within a Claim

For any single claim, all dates of service must be within the same calendar month, except for claims for psychiatric inpatient hospital services. The discharge date on the claim for psychiatric inpatient hospital services may occur on the first day of the following month. For example, a claim for an individual who was admitted to the hospital on October 28

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

5.4.1 Claims for Inpatient Stays that Cross One or More Months

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

5.5.0 Duplicate Services

Inpatient, 24-Hour, and Day Services

Inpatient, 24-Hour, and day services are listed in service table 10. A claim for an inpatient, 24-Hour, or day service is considered a duplicate if all the following data elements are the same for another already approved service:

- The member's Client Index Number (CIN)
- The County submitting the claim
- The facility location's NPI
- Date of services
- Procedure Code
- Units of service
- The billed amount

Except for Crisis Stabilization, billed with S9484:HE:TG, all duplicate inpatient, 24-hour, and day services will be denied. Crisis Stabilization billed with S9484:HE:TG may duplicate a previously approved claim for Crisis Stabilization once without additional modifiers and Crisis Stabilization may be duplicated more than once with an appropriate over-riding modifier (i.e., 59, 76, or 77). Refer to Table 3 – Modifiers for a description of these modifiers.

Outpatient Services

Outpatient services are listed in the Service Table. Duplicate services are not allowed with the exception of Sign Language or Oral Interpretive Services (T1013) Interactive Complexity (90785), Peer Support Services, group services (H0025), mobile crisis (H2011, Place of service 15), T2021 (therapy substitute code), T2024 (assessment substitute code), T1017 and T1017:HK combination, any code that has the HQ modifier indicating that the service was delivered as a group service, and a BH-CONNECT monthly code. A claim for an outpatient service is considered a duplicate if all the following data elements are the same as another service line within a claim that was approved in history:

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

If a provider renders two services to the same member on the same day in two or more separate encounters, all encounters must be claimed as one service to ensure the additional encounters are not denied as duplicate services. For example, if a provider renders psychotherapy for crisis to a member for 30 minutes in the morning and provides psychotherapy for crisis to the same member for 30 minutes in the afternoon, the claim would be submitted for 60 minutes for psychotherapy for crisis (90839). Please use the place of service code where most of the service was provided.

5.6.0 Co-Practitioners

If multiple practitioners render services to the same member at the same time, each provider must claim the distinct service each practitioner rendered as a separate claim on a separate service line. Please see MHSUDS Information Notice 18-002 and BHIN 20-060R for more information about submitting claims to SD/MC for services rendered by multiple practitioners rendered to the same member at the same time.

5.7.0 Claiming for Interpretation and Interactive Complexity

Sign language or oral interpretation and Interactive Complexity occur along with another service, such as therapy. Sign language or oral interpretation and interactive complexity must be submitted on the same claim as the primary service. For example, if a clinician used an oral interpreter to provide therapy, the claim will include a service line for the therapy and a service line for the oral interpretation.

Refer to the Service Table for additional details. A claim for interpretation should be submitted when the provider and the patient cannot communicate in the same language, and the provider uses an on-site interpreter and/or individual trained in medical interpretation to provide medical interpretation.

Interpretation may not be claimed during an inpatient or residential stay as the cost of interpretation is included in the per diem rate. Interpretation also cannot be claimed for automated/digital translation or relay services. Interactive complexity (90785) and interpretation (T1013) should not be claimed together.

Counties should not claim for interpretation when claiming for mobile crisis services as the rate for mobile crisis incorporates interpretation.

Claims for interpretation may not exceed the claims for the primary service. One unit of sign language or oral interpretation is equal to 15 minutes. If a county submits more units of T1013 than are allowed by the sum of all the primary services provided, the interpretation services service line will be cut back to the time of the primary service. For example, if the MHP submits a claim that includes psychotherapy for 60 minutes and 5 units of sign language or oral interpretation, SD/MC will approve 4 units of sign language or oral interpretation services and deny one unit.

A claim for interpretation should include the taxonomy code and NPI of the individual who provided the primary service or the rendering provider.

Only one unit of interactive complexity is allowed with any service it can modify. Interactive complexity may be claimed when at least one of the following is present:

- The need to manage maladaptive communication (related to, eg, high anxiety, high reactivity, repeated questions, or disagreements) among participants that complicates delivery of care.
- Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan.
- Evidence or disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other participants.
- Use of play equipment or other physical devices to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who has developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive

communication skills to understand the physician or other qualified health care professional if he/she were to use typical language communication.

5.8.0 Claim Timeliness – Original Claims

The timeline for initial submission of a Specialty Mental Health Medi-Cal claim is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section 14705 and 42 CFR Section 447.45(d)). An original claim submitted after 12 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied. Please see section 5.38.0 for more information about requesting a DRC. Please refer to Appendix 5 for a list of DRCs.

5.9.0 Service Facility Location Address

The submitted service facility address must be a physical address. If a service facility address is submitted as a P.O. Box, Lock Box or Lock Bin, the associated service will be denied. This limitation only applies to the service facility address.

5.10.0 Professional Claims/Fee-for-Service Medi-Cal (FFS/MC) Individual and Group Providers

Counties may contract with individual and group providers who are licensed and enrolled to provide mental health services under the Fee-for-Service Medi-Cal program. Counties may also submit claims for professional services provided in a hospital. Psychiatric inpatient hospital professional services are defined in Title 9, California Code of Regulations (CCR), Section 1810.237.1. When a service is rendered by a FFS/MC individual or group provider, the claim must include "FFS" in the Claim Note Segment and the first three digits of the rendering provider's taxonomy code must be 101, 103, 104, 106, 163, 193, 207, 208, 363, or 364. SD/MC will deny the service line if the Claim Note Segment contains "FFS" and the first three digits of the rendering provider's taxonomy code do not start with 101, 103, 104, 106, 163, 193, 207, 208, 363, or 364. The SD/MC claiming system does not conduct the Service Facility Validation described in Section 5.11.0 on claims formatted as described above when adjudicating a claim.

5.11.0 Professional Claims in an Inpatient Setting: CCR Title 9, §1810.237.1

MHPs may reimburse professional services provided in **both** SD/MC and FFS/MC hospitals and submit claims for federal reimbursement to the SD/MC claiming system using the 837P.

The county's claim for professional services must include "FFS" in the Claim Note Segment and the first three digits in the rendering provider's taxonomy code must be 207, 208, 363, or 364. The SD/MC claiming system does not validate that individual providers are enrolled in Medi-Cal when adjudicating a claim with "FFS" in the Claim Note Segment.

5.12.0 Service Facility Validation

Except for claims submitted by: 1) FFS/MC individual and group providers, 2) BH-CONNECT organizational providers, and 2) Mobile Crisis organizational providers, SD/MC verifies that the service facility (i.e., organizational provider) was enrolled in PIMS and certified to render the Medi-Cal specialty mental health service claimed on the day the service was provided. As discussed in Section 4.2, DHCS records in the Provider Information Management System (PIMS) each organizational provider's NPI number and the specialty mental health services the organizational provider is certified to render. SD/MC will deny a service line if the organizational provider, as determined by the service facility NPI number on the claim, is not certified to provide the service billed, as determined by the procedure code on the service line.

Any facility that is enrolled in PIMS and certified to provide any Medi-Cal specialty mental health services may claim for BH-CONNECT Evidence-Based Practices (EBP) and Mobile Crisis services. Please note that before a county can claim for IMD services they must satisfy the requirements specified in BHIN 25-011. Further information on appropriate certification for IMD providers will be forthcoming.

5.13.0 Psychiatric Inpatient Hospital Services – Revenue Codes

All claims for psychiatric inpatient hospital services (acute psychiatric inpatient hospital and administrative day services) must include a valid revenue code. SD/MC will deny all service lines for psychiatric inpatient hospital services that do not have a valid revenue code.

5.14.0 Date of Admission and Date of Discharge

All claims for psychiatric inpatient hospital services and 24-hour services must include the member's date of admission. As discussed in section 5.4.1, claims for 24-hour services do not require a discharge date. SD/MC will deny all service lines for psychiatric inpatient hospital services and 24-hour services that do not include an admission date.

5.15.0 Administrative Day Services – Date of Admission

Administrative day services cannot be claimed on the day of admission to the hospital. SD/MC will deny all service lines for administrative day services that occurred on the member's date of admission to the hospital.

5.16.0 Rendering Provider Taxonomy Code

Outpatient services are listed in the Service Table. SD/MC will deny service lines for outpatient services that do not contain the rendering provider's taxonomy code unless the service is mobile crisis (H2011 Place of Service 15), transportation mileage (A0140) or transportation staff time (T2007). If the claim is for a day, 24-hour or mobile crisis service codes H2011 with POS 15, A0140, or T2007, SD/MC will ignore the rendering provider taxonomy code.

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

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

SD/MC will deny all service lines for outpatient services where the first four characters of the rendering provider's taxonomy code do not identify a SD/MC Allowable Discipline for the procedure code on the service line. Consistent with Implementation Guide Sections 1.10.1 and 1.10.4, the provider's NPI and taxonomy codes do not have to match.

Rendering provider information should not be reported with 24-hour, day, and mobile crisis services.

5.17.0 Clinical Trainees and Community Health Workers (CHW)

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

code with the first four characters 3902 and claim for the psychiatric diagnostic evaluation, using the procedure code: modifier combination 90791:AJ.

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

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

The supervisor's name and NPI must be reported at the claim level (loop 2310D) or at the service line level (loop 2420D). The rendering provider's name and NPI must be reported at the claim level (loop 2310B) or at the service line level (loop 2420A). Specific details on how to report provider NPIs on 837P claims are documented in the ASCX12 5010 Implementation Guide available for purchase at https://wpc-edi.com/. Claims for services provided by Clinical Trainees and CHWs that do not report a supervisor's NPI will be denied. For clinical trainees, "supervisor" refers to the licensed clinician who co-signed the progress note and thereby assumed responsibility for the care the Clinical Trainee provided to the member. For the CHW, "supervisor" refers to a licensed or non-licensed rendering provider who co-signed the progress note and thereby assumed responsibility for the care the CHW provided to the member. The supervisor's NPI needs to be on the claim. SDMC will validate the supervisor's NPI against data in the National Plan & Provider Enumeration System (NPPES). Claims for services rendered by Clinical

Trainees or CHWs that do not contain a valid supervisor's NPI will be denied with adjustment group, reason code, and remarks code CO/208/N297.

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

5.18.0 Telehealth Modifiers and Place of Service Codes:

When 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.

5.19.0 Day Treatment Intensive and Day Rehabilitation Services – Minimum Hours

Day treatment intensive and day rehabilitation must be provided for at least three hours before being eligible for reimbursement. One unit of service is equal to one hour of service. A day treatment intensive and day rehabilitation are paid a half-day rate when the beneficiary participates for at least three hours and less than four hours. Day treatment intensive and day rehabilitation services are paid a full-day rate when the beneficiary participates in the program for at least four hours. SD/MC will deny service lines for day treatment intensive and day rehabilitation services with less than three units of service.

Pursuant to Title 9, CCR, 1840.360(a), day treatment intensive and day rehabilitation are not reimbursable with crisis residential, inpatient, PHF and psychiatric nursing facility except for day of admission.

5.20.0 Place of Service Codes

SD/MC will deny all claims for outpatient services that do not include a place of service code. The Service Table lists all the outpatient procedure codes and the place of service codes that may be billed with each procedure code. SD/MC will deny service lines that contain place of service code that may not be billed with the procedure code on the service line.

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

Therapeutic Foster Care includes a bundle of services provided to a member placed in a therapeutic foster home. Claims for therapeutic foster care must include a place of

service code and the place of service code must be one of the following: 03 (School), 11 (Office), 12 (Home), or 16 (Temporary Lodging). SD/MC will deny a service line for Therapeutic Foster Care if the place of service code is not one of the four listed above.

If the member is in a Justice-Involved aid code and a non-Justice Involved aid code is also present, and one of the following service codes is listed as having taken place in place of service 09 (Jail), SDMC will select the justice-involved aid code.

The codes the county can claim for members with Justice-Involved aid codes in place of service 09 (Jail) are as follows: 90885, 90887, 96127, 96161, 99366, 99367, H0032, H2000, T1001, T1013, T1017, T2024, 99368, 99484, H0031, 99441, 99442, 99443.

Codes the county can claim in place of service 09, 02, or 10 (telehealth) if the member is in a justice-involved aid code are: 98966, 98967, 98968, and 99451.

Note that CMS added Place of Service Code 27, effective October 1, 2023, to capture services that are provided in a non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

5.21.0 Dependent Codes

The Service Table lists all outpatient procedure codes. The procedure codes listed in Column A labeled "Code" are considered primary procedure codes. The procedure codes listed in Column O labeled "Dependent on Codes" identifies procedure codes that must be billed before the primary procedure can be billed. If the county needs to submit a dependent code, the dependent code must be on the same claim as the primary code.

5.22.0 100 Percent County Funded Services

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.

5.23.0 Units of Service – Outpatient Services

All claims for outpatient services must use units of service. Column R, labeled "Maximum Units that Can be Billed per Member Per Day" in the Service Table identifies the maximum units of service that may be included on a service line for each outpatient

procedure. SD/MC will deny a service line that is not billed in units or reports units that exceed the unit maximum as displayed in the "Maximum Units that Can Be Billed per Member per Day" Column. Time, as defined in Appendix 2-Definitions, associated with that code can be counted toward a unit of service. All units of service must be whole numbers, or the service line will be denied.

5.24.0 How to Select Codes Based on Time

Column D of the Service Table, "Minimum Time Needed to Claim 1 Unit" states the minimum time of direct patient care associated with one unit of the code in column C and Column E "Time When Add-On Code or next Code in Series Can be Claimed" states at what point an add-on code should be claimed when the time is continuous. Column F "Can This Code be Extended?" states when the code can be extended and if HCPCS Code T2021 or T2024 should be usedin its stead at a specified time. Please note that the Payment Reform Frequently Asked Questions document discusses the substitution rules at length.

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

Most Codes

Most codes (with exceptions noted below) should be selected based on the midpoint rule meaning that a unit associated with a code is attained when the midpoint is passed. For example, if one unit of a code is one hour, one unit of that code is attained when 31 minutes of direct patient care have been provided. A disruption in the service does not create a new, initial service. For example, if a patient receives 30 minutes of therapy in the morning and 20 minutes of therapy in the afternoon, the provider will claim one unit of 90834 (Psychotherapy, 45 minutes with patient) because 38-52 minutes of psychotherapy had been provided. There are, however, exceptions to the midpoint rule.

Codes with Defined Time Ranges

Some codes, such as Evaluation and Management (E&M) codes have defined time ranges and are not subject to the midpoint rule. The MHP can claim one unit of that code when a healthcare professional delivered the lower bound of the service indicated

in the range. For example, when selecting a unit of an E&M code (CPT codes 99202-99499), the time defined for the service is used for selecting the appropriate code. This means that the code can be claimed once the lower bound of the time indicated on the code has been reached. Therefore, if billing for 99202 (office or other outpatient visit, 15-29 minutes) a provider can bill for one unit of that code when they saw the patient for 15 minutes.

Drug Administration CPT (**not HCPCS**) Codes

If a drug administration code has a time range associated with it, one unit of a drug administration CPT code can be reported when the minimum number of minutes for that code has been attained. For example, 96365 (intravenous infusion 1-60 minutes) can be reported when 1 minute of service has been attained. If the infusion takes more than 90 minutes and less than 120 minutes, report 96366.

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

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

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
90791	Psychiatric diagnostic evaluation	60 mins	At 31 minutes of service
90792	Psychiatric diagnostic evaluation with medical services	60 mins	At 31 minutes of service
90845	Psychoanalysis	45 mins	At 23 minutes of service
90849	Multiple-family group psychotherapy	84 mins	At 43 minutes of service
90853	Group psychotherapy (other than of a multiple-family group)	50 mins	At 26 minutes of service

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)	90 mins	At 46 minutes of service
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	60 mins	At 31 minutes of service
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session	10 mins	At 6 minutes of service
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	45 mins	At 23 minutes of service
90870	Electroconvulsive therapy (includes necessary monitoring)	20 mins	At 11 minutes of service
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	50 mins	At 26 minutes of service
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a	60 mins	At 31 minutes of service

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
	qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report		
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	15 mins	At 8 minutes of service
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	15 mins	At 8 minutes of service
96161	Administration of caregiver-focused health risk assessment instrument for the benefit of the patient, with scoring and documentation, per standardized instrument	15 mins	At 8 minutes of service
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	15 mins	At 3 minutes of service
96371	Subcutaneous infusion for therapy or prophylaxis; additional pump set-up with establishment of new subcutaneous infusion site(s)	15 mins	At 8 minutes of service

Code	Definition	Medicare/LGFD Assigned Time as of July 1, 2024	When Can You Bill for One Unit of Service?
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	15 mins	At 1 minute of service
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial	15 mins	At 1 minute of service
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug	15 mins	At 3 minutes of service
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug	15 mins	At 3 minutes of service
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	15 mins	At 1 minute of service

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

Group Services

Group services are indicated by appending modifier HQ or by the definition of the service. SD/MC will adjust the rate for group services by 4.5. Counties should submit claims for each member receiving group services and SD/MC will adjust the rate for each claim by 4.5. For example, if the county's rate for therapy rendered by a specific provider type for 84 minutes is $99 and that county claims 90849 (Multiple-family group psychotherapy, 84 minutes) rendered by that same provider type, the rate for each member in that group will be $22 (or $99/4.5) for unit of service. Please refer to the Service Table to see which codes are defined as group services and which codes take the HQ modifier. For example, Parent-Child Interactive Therapy is an individualized service that cannot be provided as a group service. Therefore, if modifiers HQ and 22 are used together, claims will deny.

5.25.0 Caregiver Services

Caregiver services can be provided as part of many different service categories. Therefore, codes describing caregiver services 97550, 97551, 97552, 96202, 96203, G0541, G0542, G0543, G0539, and G0540 *must* be claimed with *one* modifier mapping the caregiver service to the type of service that was rendered. If a caregiver code is claimed without a modifier mapping the code to a service type, the claim will be denied.

Modifiers that must be used with caregiver codes in SMHS are listed below.

No.	Service Category	Modifier	Modifier Definition
1	Assessment	CG	Policy criteria applied
2	Medication Support Services	RD	Drug provided to beneficiary but not administered "incident to"
3	Psychosocial Rehabilitation	HH	Integrated mental health/substance abuse program
4	Referral and Linkages	HT	Multi-disciplinary team
5	Therapy	HS	Family/couple without client present
6	Treatment Planning	HI	Integrated mental health and intellectual disability/developmental disabilities program
7	Crisis Intervention	ET	Emergency services

5.26.0 BH-CONNECT Evidence-Based Practices (EBP)

Certain BH-CONNECT Evidence-Based Practices (EBP) are bundled services that must be claimed monthly. These services are: Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Multisystemic Therapy (MST), IPS Supported Employment (IPS SEP) and Coordinated Specialty Care (CSC). MHPs may submit one claim per calendar month for each EBP encounter. Bundled services are billed as a single unit per defined bundle, such as per encounter. For ACT/FACT, providers may document time to show that the required activities occurred, and the service meets the minimum requirements for a contact, but "time" is not used to calculate units of service. As a result, midpoint or "8-minute" rules do not apply unless Medi-Cal guidance specifically states otherwise. The service is claimed as one bundled unit; and extra minutes do not create additional units. A "contact" is defined as an encounter that may

be face-to-face (in-person) with the member, using telehealth, or contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

The claim must include the rendering provider's NPI of the ACT, FACT, CSC team lead, or IPS employment supervisor, and one service line per service encounter using the procedure code assigned to the specific EBP. Service encounters with a collateral contact must include the UK modifier. Each service line may only include one unit of service. One unit of service for Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Multisystemic Therapy (MST), IPS Supported Employment Program (IPS SEP), and Coordinated Specialty Care (CSC) is equal to one encounter. SDMC will allow a county to report a member receiving more than two EBP services on the same day. For the purposes of monthly payment, however, a maximum of two EBP services will count if one is a face-to-face service and the other a collateral service. However, more than two units of EBP service per day will count toward 12 or more contacts per month. If a member receives 12 or more contacts or fewer than three face-to-face contacts for ACT or FACT in a month, the BHP may bill for appropriate, unbundled Medi-Cal covered outpatient behavioral health services in addition to the monthly bundled rate. Unbundled Medi-Cal covered outpatient behavioral services can only be billed once the member reaches 12 contacts in a month.

DHCS will pay the MHP a full monthly rate for a member in an ACT/FACT or MST program when an eligible provider has rendered 6 or more days of service with a member or a collateral within a calendar month, with at least 4 of those days being face-to-face with the member. Collateral services will count towards the number of contacts in the month; however, they will not count as face-to-face contacts. DHCS will pay the MHP a partial monthly rate for a member in an ACT/FACT or MST program when an eligible provider has rendered 4 or 5 days of service to the member within a calendar month, with at least 3 of those days being face-to-face with the member. The bundled rate will cover the first 12 encounters in a month. An MHP may submit claims using the appropriate modifier on an FFS basis for unbundled behavioral services that would have otherwise been ACT/FACT contacts. If an unbundled behavioral service is being submitted after the member received 12 ACT contacts, the outpatient service should have the TS modifier; if the unbundled behavior service is claimed after the member received 12 FACT contacts, the outpatient service should have the X1 modifier. State funds will shift to the county if TS or X1 modifiers are used on a service line.

DHCS will pay the MHP a full monthly rate for a member in a CSC or IPS SE program when an eligible provider has rendered 4 or more days of service to the member or a

collateral, with at least 3 of those days being face-to-face with the member. When services are provided to a collateral individual, those services will count towards the number of contacts in the month; however, they will not count as face-to-face contacts. DHCS will pay the MHP a partial monthly rate for a member in a CSC or IPS SEP program when an eligible provider has rendered 2 or 3 days of service to a member or their collateral within a calendar month, with at least 1 day being face-to-face with the member.

SD/MC will calculate the total number of BH-CONNECT monthly units and determine whether to adjudicate a full, partial, or $0 payment. If the sum of the units of service for face-to-face and collateral meets the threshold for the full monthly rate, SD/MC will adjudicate at the full monthly rate; if the sum of the units of service for face-to-face and collateral meets the threshold for a partial monthly rate, SD/MC will adjudicate the partial monthly rate. If a claim is submitted, but the sum of the units of service for face-to-face and collateral is less than what is needed for the partial monthly rate, SD/MC will approve the claim at $0. For services that do not meet the partial monthly rate, counties can void the monthly EBP claim and submit a new original for the outpatient services they rendered. A BHP may bill the full or partial bundled rate for ACT, FACT and CSC services when a member is in an inpatient or residential setting. The full rate may only be claimed during the month of a member's admission or discharge. If a member is in the residential or inpatient setting for the entirety of the month, only the partial rate may be claimed. The requirements for claiming ACT, FACT, and CSC while a member is in an inpatient or residential setting can be found in Table 3 in BHIN 25-009.

For example, a county might claim:

- Assertive Community Treatment (ACT) services on 1/1/2025:
  - ACT service #1 – bill H0040 –1 unit of face-to-face service provided
  - ACT service #1a—bill H0040:UK—1 unit. The UK modifier indicates collateral contact.
- Assertive Community Treatment (ACT) services on 1/2/2025:
  - ACT service #2 – bill H0040 – 1 unit of face-to-face service provided
- Assertive Community Treatment (ACT) services on 1/3/2025:
  - ACT service #3 – bill H0040 – 1 unit of face-to-face service provided
- Assertive Community Treatment (ACT) services on 1/4/2025:
  - ACT service #4 – bill H0040 – 1 unit of face-to-face service provided

- Assertive Community Treatment (ACT) services on 1/5/2025:
    - ACT service #5 – bill H0040 – 1 unit of face-to-face service provided

Total = 6 units and at least 4 units were face to face.

SD/MC will make the calculation and pay the county at the full monthly rate for ACT.

However, if a county provides six units of ACT in January 2025 on six different days and three of the ACT units are face to face and three of them are collateral, SD/MC will reimburse the county for a partial month.

Only one monthly EBP service can be billed on one claim in a calendar month. However, different monthly EBPs can be billed on discrete claims. EBPs cannot be billed using a date range.

If one service line is denied (e.g., if in the example above the service line for H0040 on 1/1/2025 is denied), the claim will split and SDMC will pay the county based on the number of service lines that were approved in a given month (i.e., based on the approved claim). Thus, if the claim would have paid at a full rate, SDMC will pay at a partial rate if enough lines are denied because SDMC will only pay for approved service lines. If the county needs to replace the claim to account for all the monthly EBPs it provided the member that month, it should replace the *approved* claim.

If a county chooses to submit other services on the monthly EBP claim and later needs to replace the claim, the entire claim including the other services will need to be replaced.

Please refer to DHCS's Policy Guide for additional information.

5.27.0 Extending Assessment and Therapy CPT Codes without an Add-On Code

The tables below list the therapy and assessment CPT codes that do not have a dedicated add-on codes and the maximum time associated with each code.

CPT Code	Maximum Time Allowed for Therapy CPT Code
90837	67 minutes
90845	52 minutes
90847	57 minutes
90849	91 minutes

CPT Code	Maximum Time Allowed for Therapy CPT Code
90853	57 minutes
90870	27 minutes
90880	67 minutes

CPT Code	Maximum Time Allowed for Assessment CPT Code
90791	67 minutes
90792	67 minutes
90865	97 minutes
90885	67 minutes
96105	67 minutes
96110	67 minutes
96125	67 minutes
96127	67 minutes
96146	67 minutes

To enable counties to claim all the time associated with any therapy or assessment CPT codes listed above, DHCS added two new HCPCS codes to SDMC: T2021 and T2024. T2021 is a therapy substitute code and T2024 is an assessment substitute code that can be claimed when the service time exceeds the maximum time allowed by the therapy or assessment CPT code. HCPCS code T2021 is a 15-minute code. One unit of T2021 can be claimed when the service time passes the midpoint (at 8 minutes).

For example, the MHP can claim one unit of 90837 if between 31 and 67 minutes of psychotherapy was provided. However, the county should claim five units of T2021 if between 68 and 82 minutes of psychotherapy is provided. Similarly, the MHPs should claim one unit of 90791 if between 31 and 67 minutes of psychiatric diagnostic evaluation. However, bill 5 units of T2024 if between 68 and 82 minutes of psychiatric diagnostic evaluation is provided. Please refer to the Service Table for additional examples.

5.28.0 Other Health Coverage – Medicare

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

Medicare Recognized Providers

The Medi-Cal State Plan identifies some provider types that are eligible to render specialty mental health services, which are not eligible to render Medicare services. If the rendering provider is not eligible to render Medicare services, the county may bill Medi-Cal directly. Medicare must be billed first when the Medicare-eligible service is provided by one of the following licensed provider types:

1. Physician
2. Physician assistant
3. Nurse practitioner
4. Clinical nurse specialist
5. Licensed clinical social worker
6. Clinical psychologist
7. Licensed Marriage and Family Therapists
8. Licensed Professional Clinical Counselors

Effective January 1, 2024, Marriage and Family Therapists (MFTs) and Mental Health Counselors (LPCCs in California) can bill Medicare independently for their services for the diagnosis and treatment of mental illnesses. 5. Medicare has established requirements for LPCCs and MFTs that are more stringent than California. If an MFT/LPCC does not meet the above requirements (e.g., if part of the MFT's 3,000 hours or two years of clinical supervised experience were accrued before the individual

[5] Refer to CMS Physician Fee Schedule, Marriage and Family Therapists and Mental Health Counselors for additional information.

obtained the applicable doctor's or master's degree), they should claim SD/MC directly and use modifier HL.

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

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

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

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

Medicare Eligible Services

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

Please note that although SD/MC and Medicare codes overlap, there are differences between the two systems. When billing Medicare, counties must follow Medicare

claiming rules as spelled out in the Medicare manual. If the counties are unsure about the specific Medicare rules in a particular circumstance, they may wish to contact California's Medicare Fiscal Intermediary.

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

T-Codes and Medicare

Counties may claim T2021 or T2024 without reporting Medicare COB. However, if a CPT code is being substituted by a T-Code and that CPT code requires COB, the COB should be claimed before claiming to SD/MC. Additionally, if a county receives payment from Medicare after receiving payment from SDMC, it must replace the claim and indicate Medicare COB information on the replaced claim. The county must claim reimbursement from Medicare pursuant to Medicare's rules.

Evidence Based Practices (EBP)

MHPs may provide one or more EBPs, which include Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Coordinated Specialty Care for First Episode Psychosis (CSC), Multisystemic Therapy (MST), Clubhouse and IPS Supported Employment without reporting Medicare COB. However, if a county receives payment from Medicare after receiving payment from SDMC, it must replace the claim and indicate Medicare COB information on the replaced claim.

This would happen if the provider is a Medicare-recognized provider, the member is enrolled in Medicare, and the rendering provider is providing a service (such as psychotherapy, CPT code 90832) that is reimbursed by Medicare as part of the EBP. If those conditions are met, the county should report the COB information on the appropriate service line and counties should submit claims for unbundled services to Medicare when appropriate.

The table below identifies service components for monthly BH-CONNECT services and lists components that are covered and reimbursable under Medicare for Medi-Cal members who are also enrolled in a Medicare Plan if the most appropriate service codes for the services provided are recognized by Medicare and the rendering provider is Medicare-recognized. If the service is Medicare billable, Medicare COB is required whether the service is bundled or unbundled. For example, if a Medicare-recognized provider renders a service in one of the BH-CONNECT's service categories to a Medi-Medi and the code for that service requires Medicare COB (in the service table, the Medicare COB Required column states Yes), then the provider should bill Medicare. For example, if, as part of ACT, a clinical social worker provides an assessment service best

described by 90791, they should bill Medicare; if, however, the assessment service the social worker provides is best described by H0031 then they should not bill Medicare.

BH Connect Service	Service Component	Medicare Coverage
Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)	Assessment	Yes
	Crisis Intervention	Yes
	Employment and Education Support Services	No
	Medication Support Services	Yes
	Peer Support Services	No
	Psychosocial Rehabilitation	No
	Referral and Linkages	Yes
Coordinated Specialty Care	Assessment	Yes
	Crisis Intervention	Yes
	Employment and Education Support Services	No
	Medication Support Services	Yes
	Peer Support Services	No
	Psychosocial Rehabilitation	No
	Referral and Linkages	Yes
	Therapy	Yes
	Treatment Planning	No
Clubhouse Services	Employment and Education Support Services	No
	Medication Support Services	Yes
	Peer Support Services	No
	Psychosocial Rehabilitation	No
	Referral and Linkages	Yes

BH Connect Service	Service Component	Medicare Coverage
	Treatment Planning	No
Multisystem Therapy	Assessment	Yes
	Crisis Intervention	Yes
	Referral and Linkage	Yes
	Therapy	Yes
	Treatment Planning	No

5.29.0 Other Health Coverage – Non-Medicare

Medi-Cal is the payer of the last resort. This means that providers must submit claims to a member's other health coverage for eligible services 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 the OHC already paid.

If OHC does not respond within 90 days, the provider may submit a claim to Medi-Cal on the 91st day. The claim submitted to Medi-Cal must contain OHC information about the Medicare claim.

T-Codes and Other Health Coverage

Counties serving beneficiaries who are covered by Other Health Coverage (OHC) must claim reimbursement from OHC using the appropriate CPT code(s) before submitting a claim with HCPCS codes T2021 or T2024 to Short Doyle. The county must claim reimbursement from OHC pursuant to OHC's rules.

Eligible Services

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

- Targeted case management (T1017)
- Therapeutic behavioral services (H2019)
- Therapeutic foster care (S5145)
- Peer Support Services (H0025 or H0038)

- Mobile Crisis (H2011 with Place of Service 15)
- Transportation Mileage (A0140)
- Transportation Staff Time (T2007)

5.30.0 Institutions for Mental Diseases (IMD)

Services provided to beneficiaries in an Institution for Mental Diseases (IMD) are generally not eligible for federal Medicaid reimbursement unless they opt into the Mental Health IMD FFP Program. An IMD is a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services (42 CFR 435.1010). The exceptions to this rule are if the member is 65 years or older or under 21 years old receiving services in an inpatient psychiatric facility; or the member's county of responsibility has opted into the IMD 1115 Waiver. DHCS Licensing posts a list of facilities that are classified as an IMD to the webpage that can be found on the Institution for Mental Diseases List webpage.

SD/MC will deny service lines for services provided by facilities on this list when the following conditions are met: the member is in the excluded age range and the member's county of responsibility has not opted into the IMD Waiver. A member may continue to receive "inpatient psychiatric services," provided that they were receiving services *immediately* before they turned 21. If so, then they may continue to receive the services *before the earlier of:* (1) the date the member no longer requires the service, or (2) the date the member reaches 22. When the facility is a Short-Term Residential Therapeutic Program and considered an IMD, SD/MC will deny the service line without regard to the member's age, even if the member's county of responsibility has opted into the IMD 1115 Waiver.

Mental Health (MH) IMD FFP Program

Effective January 1, 2025, BHPs may opt into the MH IMD FFP Program, which will authorize them to receive reimbursement, including FFP, for Medi-Cal covered SMHS provided to adult Medi-Cal members aged 21 to 64 during short-term stays in residential or inpatient psychiatric settings classified as IMDs if they meet certain requirements. These requirements are specified in BHIN 25-011. When a county opts-in, the county of Responsibility/Residence will be active, and only Medi-Cal members from a county that opted in can receive FFP funding for their IMD services. As part of the opt-in process, counties must submit a Participating Psychiatric List identifying the specific IMD NPIs they wish to participate in the program. FFP is only available for services

provided at these identified and approved facilities. BHPs that opted into IMD FFP Program are responsible for the non-FFP funding. This means that all non-FFP funds will be the county's responsibility. A claim will be denied if the billing county is not the member's county of responsibility, or the member does not reside in that county, and the IMDs NPI has not been identified as an approved facility.

The SD/MC and CA-MMIS systems have been updated to allow BHPs to submit claims under the MH IMD FFP Program. As stated in BHIN 25-011, participation in the IMD Program does not alter Mental Health Rehabilitation Centers, Psychiatric health Facilities, or Freestanding Acute Psychiatric Hospitals claiming requirements. Therefore claims for FFP IMD services will be claimed in the same manner as for non-IMD services. Additionally, FFS/MC hospitals will continue to submit claims to the CA-MMIS system, and SD/MC hospitals will continue to submit claims to the SD/MC system.

IMD FFP and DMC-ODS Services

Counties are typically not eligible to claim FFP for any expenditure for services provided by a facility designated as an IMD to residents 21 to 64. However, CalAIM Approval Letter and STCs (pages 42-47) granted DHCS expenditure authority to reimburse FFP for Medi-Cal services provided to short-term residents of IMDs receiving DMC-ODS Residential and Inpatient Treatment Services (ASAM 3.1, 3.3, 3.5, 3.7, and 4.0).

Community Transitional In-Reach (In-Reach) Services BHIN 25-041

In-reach services must be claimed monthly. BHPs may only submit one claim per month for each member who received In-Reach services that month at a qualifying facility as described in BHIN 25-041. If an encounter was a collateral service, the BHP should use modifier UK to indicate that it was a collateral service. There must be a minimum of four contacts on four different days and at least three of the contacts must be face-to-face for the BHP to receive reimbursement. No partial reimbursement will be allowed.

SD/MC will calculate the total number of In-Reach monthly units and determine whether to full or deny the claim. If the sum of the units of service for face-to-face and collateral meets the threshold for the full monthly rate, SD/MC will adjudicate at the full monthly rate; if the sum of the units of service for face-to-face and collateral does not meet the threshold for a full monthly rate, SD/MC will deny the claim. In-Reach services will be reimbursed at the FFS rate.

For example, a county might claim:

- In-Reach services on 1/1/2025:
    - In-Reach service #1 – bill G9012 –1 unit of face-to-face service provided

    - In-Reach service #1a—bill G9012:UK—1 unit. The UK modifier indicates collateral contact.
- In-Reach services on 1/2/2025:
    - In-Reach service #2 – bill G9012 – 1 unit of face-to-face service provided
- In-Reach services on 1/3/2025:
    - In-Reach service #3 – bill G9012 – 1 unit of face-to-face service provided
- In-Reach services on 1/4/2025:
    - In-Reach service #4 – bill G9012 – 1 unit of face-to-face service provided

Total = 5 units and at least 4 units were face to face.

SD/MC will make the calculation and pay the county at the monthly rate for In-Reach.

However, if a county provides six units of In-Reach in January 2025 on six different days and three of the In-Reach units are face to face and three of them are collateral, SD/MC will deny the claim.

In-Reach services cannot be billed using a date range.

If one service line is denied (e.g., if in the example above the service line for G9012 on 1/1/2025 is denied), the claim will split and SDMC will deny the claim. If the county needs to replace the claim to account for all the monthly In-Reach services it provided the member that month, it should replace the claim.

If a county chooses to submit other services on the monthly In-Reach claim and later needs to replace the claim, the entire claim including the other services will need to be replaced.

Please refer to DHCS's Policy Guide and BHIN 25-041 for additional information.

5.31.0 Combined Aggregate Limits

The California Code of Regulations establishes limits on the amount of time certain services may be provided to a member in a 24-hour period. Medication Support Services are limited to 4 hours (9 CCR 1840.372), Crisis intervention Services are limited to 8 hours (9 CCR 1840.366), and **effective January 1, 2025**, Crisis Stabilization Services are limited to 23 hours in a 24-hour period.

The Service Table lists the procedure codes that may be used to claim reimbursement for crisis intervention services. When adjudicating a service line with a Crisis Intervention Service procedure code, SD/MC determines whether the service billed exceeds the

combined aggregate limit. The combined aggregate is equal to the sum of time associated with all approved Crisis Intervention Services in history provided to the same member on the same day. The following table lists all the procedure codes and the time associated with each procedure code that SD/MC uses to calculate the combined aggregate for Crisis Intervention Services. SD/MC will deny a Crisis Intervention Service if the time associated with that service results in the combined aggregate exceeding 8 hours for that date of service. For the purposes of calculating the combined aggregate, SD/MC uses the minimum time for which a service can be billed. For example, one unit of psychotherapy for crisis (90839) can be 30 to 74 minutes. But for the purposes of calculating a combined aggregate, SD/MC calculates one unit of psychotherapy for crisis (90839) as 30 minutes.

CRISIS INTERVENTION COMBINED AGGREGATES	
PROCEDURE CODE	**TIME**
90839	30 minutes
90840	30 minutes
H2011	15 minutes

The Service Table lists all procedure codes that may be used to claim reimbursement for Medication Support Services. When adjudicating a service line with a Crisis Intervention Service procedure code, SD/MC determines whether the service billed exceeds the combined aggregate limit. The combined aggregate limit is equal to the sum of time associated with all approved Medication Support Services in history provided to the same member on the same day. The following table lists all the procedure codes and the time associated with each procedure code that SD/MC uses to calculate the combined aggregate for Medication Support services. SD/MC will deny Medication Support Services if the time associated with that service results in the combined aggregate exceeding 4 hours for that date of service. For the purposes of calculating the combined aggregate, SD/MC uses the minimum time for which a service can be billed. For example, one unit of intravenous infusion (96365) can be claimed for 1-60 minutes but for purposes of the combined aggregate calculation, one unit of intravenous infusion is assumed to be 1 minute. By contrast, since H0033 (Medication Administration-any type of administration) is a 15-minute code, for the purposes of the combined aggregate calculation, one unit of medication administration (any kind of administration), H0033 is assumed to be 15 minutes. Please note that the information

below corresponds to the "Minimum Time Needed to Claim 1 Unit" column in the Service Table.

MEDICATION SUPPORT SERVICES COMBINED AGGREGATES	
PROCEDURE CODE	**TIME**
90865	46 minutes
96365	1 minute
96366	31 minutes
96367	1 minutes
96368	15 minutes
96369	16 minutes
96370	31 minutes
96371	8 minutes
96372	1 minutes
96373	1 minutes
96374	15 minutes
96375	15 minutes
96376	15 minutes
96377	1 minutes
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes
99212	10 minutes
99213	20 minutes
99214	30 minutes
99215	40 minutes

MEDICATION SUPPORT SERVICES COMBINED AGGREGATES	
PROCEDURE CODE	**TIME**
99341	15 minutes
99342	30 minutes
99344	60minutes
99345	75 minutes
99347	20 minutes
99348	30 minutes
99349	40 minutes
99350	60 minutes
99605	8 minutes
99606	8 minutes
99607	8 minutes
H0033	15 minutes
H0034	15 minutes

The Service Table lists the procedure codes for Crisis Stabilization. Crisis Stabilization is billed with HCPCS code S9484 in 1-hour increments. The combined aggregate limit for Crisis Stabilization is equal to the sum of time associated with all approved Crisis Stabilization services in history provided to the same member on the same day. SD/MC will deny a Crisis Stabilization service if the time associated with that service results in the combined aggregate exceeding 23 hours for that date of service.

5.32.0 Lockout Rules

SD/MC enforces two types of lockout rules. The California Code of Regulations prohibits some specialty mental health services from being provided to a member on the same day or states that those outpatient services are part of the bundled residential or 24-hour service. SD/MC will deny a service line when the California Code of Regulations prohibits that service from being provided to a member on the same day or when the regulations include a service as part of a bundled service. The Centers for Medicare and Medicaid Services (CMS) also requires states to implement the National Correct Coding

Initiative (NCCI). NCCI identifies procedure codes that should not be billed on the same day for the same member unless certain conditions are met.[6] SD/MC will also deny a claim for a service when NCCI prohibits that service from being provided to a member on the same day as a service approved in history, unless certain conditions are met.

The Service Table identifies the combinations of procedure codes that cannot be billed for the same member on the same day. Column A, labeled "Code", lists each outpatient procedure code. Column J, labeled "Outpatient Lockout Codes," lists all procedure codes that are locked out for the procedure code in Column A when provided to the same member on the same day. Column K, labeled "Outpatient Overridable Lockouts with Appropriate Modifiers" identifies those codes that can be billed with the code listed in Column A under extraordinary circumstances.

The combination of the Code in Column A and each lockout code in Columns J or K represents a lockout situation when both are provided to the same member by the same provider on the same day. SD/MC will deny a claim for a service if it produces a lockout situation, when combined with a service approved in history, unless one of the codes is a target code with an overriding modifier. Target codes are listed in Column K.

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

Appendix 6 explains the method used to look up outpatient lockouts.

5.33.0 Emergency and Pregnancy Indicator

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

[6] 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.

If the county includes an emergency indicator on the claim, the SD/MC system will ignore it. DHCS no longer considers any behavioral health service to be an emergency service for the purpose of federal reimbursement.

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

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396(r)(5) of the Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services needed to correct and ameliorate mental illness and conditions. Federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a mental health condition. All mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services as established in W&I Code section 14184.402(b) that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services and must be covered for beneficiaries who meet the criteria for access to the specialty mental health delivery system. Services provided to a member must be medically necessary and clinically appropriate to address the member's presenting condition. DHCS currently provides the following specialty mental health services through the EPSDT benefit: Therapeutic Behavioral Services (TBS), Intensive Care Coordination (ICC), Child and Family Team (CFT), In-Home Behavioral Services (IHBS), and Therapeutic Foster Care (TFC). SD/MC will deny any service line for an EPSDT service if the member is not under 21 years of age, or is not enrolled in an aid code that is EPSDT eligible. Please consult the Aid Code Master Chart on the following DHCS webpage to determine whether or not a member's aid code is EPSDT eligible.

The following table displays the coding for each EPSDT service.

EPSDT Services	Procedure Code	Modifier
TBS	H2019	N/A
ICC	T1017	HK
CFT	H2000	HK
TFC	S5145	HE

EPSDT Services	Procedure Code	Modifier
IHBS	Multiple[7]	HK
PCIT	90832-90838	22

As discussed in the Companion Guide, Demonstration Project Identifier (DPI) in loop 2300 should indicate KTA when the member is part of the Katie A. subclass.

5.35.0 Replacing Approved and Denied Claims

Replacement claims are claims that correct previously submitted claims. An MHP may submit a claim to replace an approved or denied claim no later than 15 months after the month of service. SD/MC will deny a replacement claim submitted more than 15 months after the month of service.

A replacement claim can be submitted if an 835 has been issued and the claim being replaced has not been voided. Replacement claims for outpatient services, day services, or 24-hour services must have the following data elements match the claim it is replacing: Billing Employer Identification Number and County Code. If a Delay Reason Code (DRC) was submitted with the original claim, it must have the same DRC as the original claim. If the replacement criteria are not met, the claim will be denied.

5.36.0 Replacing Late Claims Due to CalAIM Claiming Challenges

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

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

Counties do not need to submit a Formal Delay Reason Code request for using Delay Reason Code 9 to MedCCC if they are using it only due to CalAIM claiming challenges.

[7] Please see Service Table and Ancillary Table 3-Modifiers for more information about which procedure codes may be billed with the HK modifier.

However, the MHP needs to provide a document on MHP letterhead to Service Now providing the following information:

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

5.37.0 Voiding Approved Claims

MHPs may void previously approved claims. A void reverses the previously approved claim and recoups the funds associated with that claim. MHPs may void a previously approved claim at any time. SD/MC does not require voids to be submitted within a certain time frame after the service was rendered.

5.38.0 Requesting Delay Reason Codes

MHPs may request a Delay Reason Code (DRC) to submit an original claim more than 12 months from the month of service or a replacement claim more than 15 months from the month of service if the delay in submitting the original or replacement claim is due to litigation, the original claim being rejected or denied for a reason unrelated to the billing limitation rules, or an administrative delay in the prior approval process. Please refer to Appendix 5 for a list of DRCs. Contact MEDCCC via the MedCCC Service Now Portal at DHCS MEDCCC - MEDCCC to request a DRC. If you do not yet have access, please reach out to your designated county manager to request access.

CHAPTER SIX – FUNDING

6.0 Introduction

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

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

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 member's aid code. If a member is assigned more than one aid code, SD/MC will select the aid code eligible for the service billed with the highest FMAP.

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

The federal share for services funded by the American Rescue Plan Act (ARPA) is 85 percent of the total approved. Mobile crisis services are currently the only ARPA-funded services. Effective April 1, 2027 the ARPA funding for Mobile crisis services will expire. If counties elect to continue to provide Mobile crisis services as an opt-in benefit, counties will be responsible for the non-federal share for claims received on or after 4/1/2027.

The federal share for non-pregnancy services provided to a member enrolled in the State Only Medi-Cal program is 0 percent. The federal government does not reimburse states for the cost of any non-pregnancy services, including emergency services, provided to beneficiaries with State-Only Medi-Cal. If there is an emergency indicator on the claim, SD/MC will ignore it.

6.2 State Share and Proposition 30

The State realigned financial responsibility for Medi-Cal Specialty Mental Health 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 for the Medi-Cal specialty mental health services program established after 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 Specialty Mental Health 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 Specialty Mental Services so that the State reimburses the county the appropriate portion of the non-federal share with State General Funds. If a member is eligible for services as a result of the Affordable Care Act (ACA), the state will be responsible for 100 percent of the non-federal share. If the member is eligible for services as a result of Family First Prevention Services Act (FFPSA), the state will be responsible for 50 percent of the non-federal share. If the member is eligible as a result of Senate Bill (SB) 75, young adult expansion, older adult expansion, or is receiving continuum of care services, the state will be responsible for one hundred percent of the non-federal share.

6.2.1 State Required Specialty Mental Health Services

The state will reimburse counties 100 percent of the non-federal share for specialty mental health services provided as a result of a new state requirement implemented after 2011 realignment. Either the member aid code or service modifier identifies whether the service was provided as a result of a new state requirement. This subsection discusses each of the new state requirements implemented after 2011 realignment and whether SD/MC uses a modifier or the member's aid code to identify the service as a state requirement.

Affordable Care Act Optional Expansion Population

The Affordable Care Act (ACA) gave states the option to expand eligibility for beneficiaries to enroll in their Medicaid program. California chose to expand eligibility for Medi-Cal. Beneficiaries enrolled in Medi-Cal as a result of the ACA Optional Expansion are assigned specific aid codes (i.e., ACA Aid Codes). Counties are required to provide Specialty Mental Health Services to Medi-Cal beneficiaries enrolled in ACA Aid Codes. The state reimburses counties 100 percent of the non-federal share of the total

approved amount for specialty mental health services provided to beneficiaries enrolled in ACA aid codes.[8] Services provided to beneficiaries enrolled in ACA aid codes do not need a modifier to be reimbursed 100 percent of the non-federal share.

Justice-Involved Reentry Initiative

The state will reimburse MHPs one hundred percent of the non-federal share for all warm linkage services with dates of service October 1, 2024, and later when those warm linkage services are provided to justice involved beneficiaries 90 days before their release. Codes that can be claimed to SD/MC as part of the Justice-Involved Reentry Initiative are identified in the Service Table when column "JI Warm Linkage Code?" contains a yes.

Continuum of Care Reform

The State implemented Continuum of Care Reform in January of 2017. Continuum of Care Reform required mental health plans to assess children and youth before being placed in an STRTP and to participate in a child and family team when the child or youth needs mental health treatment. To indicate that a service was provided as part of continuum of care reform, the MHP should use modifier HW with that service. The Service Table indicates which procedure codes can be used with modifier HW in the "Allowable Modifiers" column.

Senate Bill 75 – Medi-Cal for All Children

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

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

[8] Please see the aid code master chart for a list of ACA Aid Codes.

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 and date of birth. The state will reimburse MHPs 100 percent of the non-federal share for Specialty Mental Health Services provided to beneficiaries enrolled through the Young Adult Expansion. The service does not need a modifier.

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 MHPs for 100 percent of the non-federal share of the cost of care for Older Adult Expansion beneficiaries. The service does not need a modifier.

Ages 26 through 49 Adult Full Scope Medi-Cal Expansion

Adults ages 26 through 49 are eligible for full-scope Medi-Cal regardless of immigration status, as long as they meet all other eligibility requirements. As a result, adults who have unsatisfactory immigration status are enrolled in the State Only Medi-Cal Program. SD/MC determines which beneficiaries are eligible for the State Only Medi-Cal Program because of adult expansion by the beneficiaries' aid code. The state will reimburse MHPs for 100 percent of the non-federal share of the cost of care for Adult Full Scope Expansion beneficiaries. The service does not need a modifier.

Please refer to All County Welfare Directors Letter 23-08 for additional information.

Community-Based Mobile Crisis Intervention Services

DHCS added Community-Based Mobile Crisis Intervention Services to the State Plan to be effective on January 1, 2023. MHPs should use modifier HW to indicate that the mobile crisis, transportation mileage, and transportation staff time were provided as a result of a State mandate and is subject to Proposition 30.

6.2.2 Federally Required Specialty Mental Health Services

The state will reimburse counties 50 percent of the non-federal share for specialty mental health services provided as a result of a new federal requirement implemented after 2011 realignment. Either the member aid code or service modifier identifies

whether the service was provided as a result of a new federal requirement. This subsection discusses each of the new federal requirements implemented after 2011 realignment and whether SD/MC uses a modifier or the member's aid code to identify the service as a state requirement.

Family First Prevention Services Act (FFPSA)

The Family First Prevention Services Act (FFPSA) requires a qualified individual to provide certain services to children and youth before they are placed and while they are placed in a Short-Term Residential Therapeutic Program (STRTP); and states to provide 6-months of aftercare services after a child or youth is discharged from an STRTP. For more information about FFPSA, please refer to the joint DHCS and CDSS Information Notice 21-055. FFPSA can only be claimed for a child under 21.

To indicate that a service was provided as a result of FFPSA, the MHP must use modifier HV with that service. The Service Table indicates which procedure codes can be used with modifier HV in Column S titled "Allowable Modifiers." The State will reimburse the MHP 50 percent of the non-federal share if the service was provided to a child under 21 and has an HV modifier. If the child has unsatisfactory immigration status and is only eligible for these specific services as a result of FFPSA, SD/MC will deny the service line unless the HV modifier is present. If the HV modifier is present, the state will reimburse the MHP for 50 percent of the non-federal share of the cost of FFPSA services.

6.3 County Share

Counties are responsible for the share of all approved services that are not reimbursed with federal and/or state funds. Counties are not responsible for any portion of the amount approved for state required specialty mental health services as described in Section 6.2.1. Counties are responsible for half of the non-federal share of the amount approved for federally required specialty mental health services as described in Section 6.2.2. Counties are responsible for all the non-federal share of the amount approved for all other specialty mental health services. Some specialty mental health services provided to some beneficiaries are not eligible for federal and/or state reimbursement. The county is responsible for 100 percent of the cost to provide these services. The following discusses those services.

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 in the State Only Medi-Cal Program. State reimbursement is not available for specialty mental health services provided to Qualified Non-Citizens unless the service was provided as a result of a State Requirement as described in Section 6.2.1 or a Federal Requirement as described in Section 6.2.2. Counties are responsible for 100 percent of the cost of all other services provided to Qualified Non-Citizens.

Permanently Residing Under Color of Law (PRUCOL)

California provides full scope Medi-Cal benefits to individuals Permanently Residing in the United States Under Color of Law (PRUCOL) who are otherwise eligible for Medi-Cal. Some of PRUCOL beneficiaries are not eligible for federal benefits and are enrolled in the State Only Medi-Cal Program. Federal reimbursement is not available for non-pregnancy services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program. State reimbursement is not available for Specialty Mental Health Services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program unless the service was provided as a result of a State Requirement as described in Section 6.2.1 or a Federal Requirement as described in Section 6.2.2. Counties are responsible for 100 percent of the cost of all other services provided to PRUCOL beneficiaries enrolled in the State Only Medi-Cal Program.

CHAPTER SEVEN – OUT-OF-STATE CLAIMS

7.1.0 Out-of-State: Outpatient Services

Title 9, CCR, § 1810.355(b) states that out-of-state specialty mental health services cannot be billed to SD/MC except when it is customary practice to receive medical services in a border community outside the State. Border communities are listed in Title 9, CCR, § 1820.115(i).

7.2.0 Out-of-State: Inpatient Services

Title 22, CCR, § 51006 states that emergency services are available for emergency conditions. Emergency conditions include emergency psychiatric conditions. To be reimbursed for out-of-state inpatient emergency services, providers will need an approved Treatment Authorization Request (TAR). Please refer to Medi-Cal: Out-of-State Provider FAQs for additional details or call out-of-state provider support at (916) 636-1960.

CHAPTER EIGHT – 2026 CPT UPDATES

The CPT Codebooks include the following information:

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

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

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

CHAPTER NINE – ADDENDUM TO THE SERVICE TABLE

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Service Table describes procedure codes associated with each outpatient service type in the State Plan: Assessment, Medication Support Services, Peer Support Services, Psychosocial Rehabilitation, Referral and Linkages, Therapy and Treatment Planning. There is also a table for a group of codes called Supplemental. Supplemental codes are codes that must be used with another code.

The Service Table contains the following columns:

1. Code: This lists the procedure code. Procedure codes that describe services provided in a hospital setting are professional services claimed by the MHP separate from the per diem rate for routine and ancillary services.
2. Code Type: This column describes the service type that a particular code was placed in. A code may be grouped in the following service types:
    a. Assessment: A service activity designed to collect information and evaluate the current status of a member's mental, emotional or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member.
    b. Medication Support Services: Include prescribing, administering, dispensing, and monitoring drug interactions and contraindications of psychiatric medications or biologicals that are necessary to alleviate the suffering and symptoms of mental illness. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

        Medication support services may be provided face-to-face, by telephone or by telehealth and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization. This service includes one or more of the following components:

        - Evaluation of the need for medication
        - Evaluation of clinical effectiveness and side effects
        - Medication education, including instruction in the use, risks and benefits of and alternatives for medication

- Treatment Planning

c. Mobile Crisis: Community-based mobile crisis intervention 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 member requires additional stabilization and/or treatment services with referrals to appropriate health, social, and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile crisis services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restore the member to the highest possible functional level. 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 member a behavioral health crisis. Locations may include, but are not limited to the member's home, school or workplace, on the street, or where a member 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. There is no time limitation associated with a single mobile crisis encounter. However, a combined aggregate of 24 units of mobile crisis services can be claimed in a 24-hour period.

d. Peer Support Services: Are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of 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: 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 and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity: 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 member's treatment to attain and maintain recovery within recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and other providing care or support to the member, family members, or significant support persons.

e. Psychosocial Rehabilitation: A recovery or resiliency-focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting beneficiaries to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression, such as art, recreation, dance, or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning, including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of beneficiaries.

f. Referral and Linkages: Services and supports to connect a member with primary care, specialty medical care, substance use disorder treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support.

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

h. Therapeutic Behavioral Service (TBS): An adjunctive program that supports other services patients are currently receiving. TBS is an intensive, individualized, one-to-one behavioral health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.

i. Therapy: Service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or a group of beneficiaries and may include family therapy directed at improving the member's and at which the member is present.

j. Treatment Planning: A service activity to develop or update a member's course of treatment, documentation of the recommended course of treatment, and monitoring a member's progress.

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

a. New vs. established patients: Some evaluation and management (E/M) codes are described as being services for a new or 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, physician assistant or advanced practice nurse. In general, E/M services can be rendered by a Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist. 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.

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

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

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

6. Can This Code Be Extended with an Add-On or Prolonged Code?: This column specifies whether the code in column "Code" can be extended with an add-on or prolonged service code. A "Yes" in this column means that this code can be extended with an add-on or prolonged service code and a "No" in this column either means that it cannot be extended with an add-on or prolonged service code. A code may not be extended for one of two reasons: 1) the time associated with the service is limited to the service associated with the service code and additional service time will not be reimbursed or 2) if additional time needs to be reported, it should be reported via the next code in the series. The column also specifies whether HCPCS codes T2021 or T2024 can be used to substitute for this code and at what point they may be used.
7. Example Calculation: This column provides examples of how to calculate units of primary and add-on/prolonged service codes. It also specifies when no calculation is necessary and when the county should, instead, claim the next code in the series.
8. SD/MC Allowable Disciplines: This column lists the disciplines that are allowed to perform each procedure. A professional claim must have a taxonomy code that is associated with the discipline rendering the service or the claim will be denied. A list of the first four or five alpha-numeric characters of the relevant taxonomies is located in Appendix 1-Taxonomy Codes. The MHP is responsible for ensuring that providers deliver services within their scope of practice. If a service is performed by an individual registered with the appropriate board or resident, the service code should have modifier HL or GC after it. A resident and registered associate should claim using an HL or GC code, as appropriate after the service code. In addition, if an MFT/LPCC does not meet the requirements to register as a Medicare provider (e.g, if part of the MFT's 3,000 hours or two years of clinical supervised experience were accrued before the individual obtained the applicable doctor's or master's degree), they should use modifier HL. A service code that uses an HL or GC modifier should not be submitted to Medicare first; it should be submitted to SDMC directly.
9. Allowable Place of Service: CPT codes must be reported in allowable places of service. This column lists the number of the place(s) of service where the different procedures are allowed. Refer to Table 2-Place of Service Codes for professional Claim or 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 section 5.18.0 if a service is provided via telehealth, the place of service must be either 02 or 10 unless the services is mobile crisis.

10. Outpatient Non-Overridable Lockout Codes: Some outpatient codes cannot be billed together under any circumstances. This column lists those outpatient codes that cannot, in any circumstances, be claimed with the code in column "Code".

11. Outpatient Overridable Lockouts With Appropriate Modifiers: Some codes can only be billed together in extraordinary circumstances. The codes that can be billed with the code listed in column "Code" under extraordinary circumstances are listed in this column. If a code has a single * after it, then it can be used with the code listed in column "Code" if the code listed in column "Outpatient Overridable Lockouts With Appropriate Modifiers" is followed by modifier 59, XE, XP, or XU. If a code has two ** after it, then it can be claimed with the code in column "Code" if the code in column "Outpatient Overridable Lockouts With Appropriate Modifiers" is followed by modifier 27, 59, XE, XP, or XU. Please note that it would be inappropriate to use a code describing one service to "prolong" a code that describes a different service. If a service needs to be prolonged, use add-on codes or prolonged service codes.

12. Locked Out Against Inpatient?: This column indicates whether a code can be billed on the same date as a claim with Revenue Code 0100 or Revenue Code 0101. A "No" in this column means that the outpatient code can be billed on the same date as a claim with a Revenue Code and a "Yes" in this column means that it cannot be billed with a Revenue Code except on the days of admission or discharge.

13. Locked Out Against Residential H0019?: This column indicates whether codes can be billed on the same date as a residential code. Most outpatient codes can be billed on the same date of service as residential codes except on the dates of admission or discharge with the exception of H2011 with place of service 15, A0140, and T2007A "No" in this column means that the code can be claimed with a residential service; a "Yes" in this column means that it cannot be claimed with a residential service except on the days of admission or discharge.

14. Locked Out Against Crisis Residential H0018? Most outpatient codes cannot be billed on the same date of service as crisis residential codes except on the dates of admission or discharge. However, some can. A "No" in this column

means that the code can be claimed with a crisis residential service; a "Yes" in this column means that it cannot be claimed with a crisis residential service except on the days of admission or discharge.

15. Locked Out Against Psychiatric Health Facility?: This column indicates whether codes can be billed on the same date as a psychiatric health facility service. Most outpatient codes cannot be billed on the same day as a psychiatric health facility service except on the dates of admission or discharge. However, some can. A "No" in this column indicates that the code can be claimed with a psychiatric health facility service; a "Yes" in this column means that it cannot be billed on the same day as a psychiatric health facility service except on the days of admission or discharge.
16. 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 code can be submitted per line. So, dependent codes would need to be on the same claim but on a different line than the code they are dependent on. If a code is an add-on or prolonged service code as stated in the description, it must be reported with the code it is extending.
17. Units of T1013 Associated with 1 Unit of Code: This column specifies how many units of sign language or oral interpretive services can be claimed with one unit of the code in column "Code". Sign language or oral interpretation must be submitted on the same claim as the code. Claims for interpretation may not exceed the claims for the code. For additional information, refer to Section 5.7.0.
18. Medicare COB Required?: This column specifies whether a procedure, if rendered to a Medi-Medi member, must first be submitted to Medicare before being submitted to SDMC if it is rendered by a Medicare-recognized provider and the service does not carry an HL or GC modifier. Medicare-recognized providers are: Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Clinical Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors, and Clinical Psychologists. A "Yes" in the column indicates that the procedure must be submitted to Medicare first. A "No" in the column indicates that it does not need to be

submitted to Medicare first and can be billed directly to SD/MC. If a procedure was not provided by a Medicare-recognized professional listed above, the service should not be submitted to Medicare.

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

20. Maximum Units that Can be Billed per Rendering Provider per Member Per Day: This column lists the maximum number of units that the procedure listed in column "Code" may be billed in a 24-hour period by the rendering provider. All codes must be billed 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 and refer to the definition of Time in Appendix 2- Definitions.

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

CHAPTER TEN – 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 alpha-numeric characters of a taxonomy code allowed for that service code. See the service table for the rules governing outpatient service codes. Even though SD/MC only verifies the first four alpha-numeric characters, the provider is obligated to provide the entire taxonomy code on the 837P claim.

Taxonomy codes reflect the professions listed in the State Plan. Any taxonomy code that describes a specific rendering provider can be used on an 837P form to describe that rendering provider. DHCS relies on MHP to ensure that rendering providers are practicing within their scope of practice

To indicate that the service was provided by a registered professional use modifier HL after the service code. If the pre-licensed professional does not have their own NPI, indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. If the pre-licensed professional has their own NPI, they may use their own NPI as the rendering professional. To indicate that the service was provided by a resident use modifier GC after the service code. On the claim, indicate that the supervising professional is the billing provider. Services that have modifiers HL or GC after them, even if they are otherwise eligible for Medicare COB, should be sent directly to SD/MC.

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

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

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Alcohol and Other Drug Counselor	101Y**A**
	146D
	146L
	146M
	146N
	171M
	2258
	2260
	374K
	4053
Community Health Worker	172V
Clinical Nurse Specialist	364S
Licensed Psychiatric Technician	106S
	167G
	3747
Licensed Vocational Nurse	164W
	164X
	1012

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Marriage and Family Therapist or Licensed Professional Clinical Counselor	101Y
	102X
	103K
	106H
	1714
	222Q
	225C
	2256
Clinical Trainee	3902
Mental Health Rehabilitation Specialist	174H
	1837
	2217
	224Y
	224Z
	2254
	225A
	2263
	246Y

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	246Z
	2470
	374T
	376K
Nurse Practitioner	363L
Occupational Therapist	225X
Other Qualified Provider	171R
	3726
	373H
	374U
	376J
Peer Specialist	175T
Pharmacist	1835
Physician Assistant	363A
Medical Assistant	363AM
Physician	202C
	202D
	202K

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T
	207U
	207V
	207W
	207X
	207Y

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	207Z
	2080
	2081
	2082
	2083
	2084
	2085
	2086
	2088
	208C
	208D
	208G
	208M
	208U
	208V
	2098
Medical Student in Clerkship	1744
Psychologist	102L

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	103G
	103T
Registered Nurse	163W
	3675
	376G
Licensed Clinical Social Worker	106E
	1041

Appendix 2- Definitions

Claim: A request for payment that a provider submits to the MHP or the MHP 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. Claim files are submitted by MHPs.

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

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

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

Community Health Worker (CHW): CHWs must have lived experience that aligns with and provides a connection between the CHW and the community being served. Historically, CHWs have been employed across public health,

medical, and behavioral health settings CHWs must demonstrate minimum qualifications through one of the pathways listed below. The manner in which a CHW demonstrates his/her qualifications will not impact the service codes used.

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

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

County of Residence: the field in MEDS, and/or MEDSLITE, indicating the county in which the member resides or the county in which a justice involved individual plans to reside upon their release.

County of Responsibility: the field in the DHCS Medi-Cal Eligibility Data System (MEDS) and/or MEDSLITE, that indicates the county that has control of the case record in MEDS, and/or MEDSLITE, and can make eligibility and demographic information updates to the MEDS, and/or MEDSLITE, record. Except as described below, this county has financial responsibility for SMHS, and/or SUD treatment services, consistent with the county contract with DHCS. Providers can verify Medi-Cal eligibility in three ways: Point of Service Device, Benefits Identification Card reader, Automated Eligibility Verification System, or the MediCal website.

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

Direct Patient Care: If the service code billed is a patient care code, direct patient care means time spent with the patient for the purpose of providing healthcare. Counties should only consider direct patient care time, as defined in the billing manual, when choosing the most appropriate code to bill. However, this does not mean that counties would not be reimbursed for activities such as chart review, documentation, and other activities associated with preparing to see a patient or post service time. The rates DHCS pays to counties are adjusted to incorporate the cost for staff time not spent on direct patient care, which includes activities the provider engages in before and after seeing a patient, and “no shows".

Electronic Healthcare Transaction: A transaction typically encompasses multiple claims for one or more individuals.

Group Practice: The entity that owns and is responsible for the member’s medical record describing the services provided by a licensed or pre-licensed professional. If professional services are provided to the member by county-operated and/or county-employed health care professionals, the MHP is considered to be the “group practice” because the MHP owns and is responsible for the member’s medical record. If the member receives their specialty mental health services from a county-contracted provider (a community-based organization or other provider), then the clinic or the clinic’s owner in that location owns and is responsible for the member’s medical record. If a psychiatrist, advanced practice nurse and

physician assistant all work for a practice at a discrete location, then that practice owns the medical record and is considered the group practice. If the psychiatrist owns the practice at a discrete location and the advanced practice nurse and physician assistant work for the psychiatrist, then the psychiatrist-owner is considered to be the group practice as he/she owns and is responsible for the member's medical record.

Lockouts: Lockouts are codes that cannot be billed together. Sometimes lockouts can be overridden with an appropriate modifier. Lockouts that can be overridden are listed in column titled Outpatient Overridable Lockouts with Appropriate Modifiers in the Service Table.

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

Peer Support Specialist: A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet ongoing educational requirements. Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

Registrant: A pre-licensed mental health professional, including a waivered psychologist who is not yet licensed, who is registered with the appropriate licensing board and working in a clinical setting under supervision. A registrant should use the taxonomy code most appropriate for the practitioner and should bill using the HL modifier after the service code to indicate that the services were provided by a registered, pre-licensed mental health professional working in a clinical setting under supervision in order to bypass the Medicare COB requirement. For claiming purposes, a waivered psychologist who is not yet licensed in California would be considered a registrant and should use modifier HL.

Resident: According to the Medical Board of California, a resident is an individual who is issued a Postgraduate Training License [and] is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited postgraduate

training program in California. The resident may engage in the practice of medicine only in connection with their duties as a resident in the approved training program, including its affiliate sites, or under those conditions as are approved by the director of their program. A Postgraduate Training License is issued to an individual who has graduated from an approved medical school, passed all required examinations, has not completed 36 months of ACGME postgraduate training, and is enrolled in an approved California residency program. A resident should use the GC modifier in order to bypass the Medicare COB requirement.

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

Services Provided by Registrants/Residents: To indicate that the service was provided by a registrant use modifier HL after the service code. If the pre-licensed professional does not have their own NPI, indicate the NPI and taxonomy of the fully licensed supervisor as the rendering provider. If the pre-licensed professional has their own NPI, they may use their own NPI to indicate they were the rendering provider. To indicate that the service was provided by a resident use modifier GC after the service code. On the claim, indicate that the supervising professional is the billing provider. Services that have modifiers HL or GC after them, even if they are otherwise eligible for Medicare COB, should be sent directly to Medi-Cal.

Student: Individuals who are enrolled in a post-secondary educational degree program in the State of California but who are not yet in practicum. These individuals should use a taxonomy code within the Mental Health Rehabilitation Specialist, Other Qualified Professional, or Certified Peer Specialist categories as appropriate.

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

Waivered Professional: A professional from another state whose license is recognized by California. Waivered professionals can bill under their own license and do not need to use an HL or a GC modifier.

Appendix 3- Monthly Medi-Cal Eligibility File (MMEF) Data Elements

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

1. Med-Cal Eligibility Data System (MEDS) identification number
2. Health Insurance Claim (HIC) number
3. Social Security
4. Date of Birth
5. Gender
6. Ethnicity
7. Primary Language
8. Social Security Number Verification Code
9. Case Name
10. Member's Last Name
11. Member's First Name
12. Member's Suffix
13. Member's Address
14. Eligibility Worker Code
15. Client Index Number
16. Government Responsibility
17. County Case ID

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

37. The Medi-Cal managed care plan in which the member has been enrolled or dis-enrolled
38. Member's health care coverage by an insurance company
39. Identifies if the member has been placed on or removed from restricted status
40. Identifies the aid code under which the member is eligible for the specific Special Program.
41. Identifies the county of responsibility for the specific Special Program aid code
42. Member's Special Program normal/exceptional eligibility
43. Indicates what percentage of the obligation the recipient is responsible for
44. Indicates the Stop/Start of Healthy Families if the member is not enrolled for the entire month.

Appendix 4- MEDSLITE Data Elements

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

1. Med-Cal Eligibility Data System (MEDS) identification number
2. Client Index Number
3. Member's gender
4. Member's primary ethnicity code
5. Member's spoken language code
6. Member's written language code
7. Government Responsibility indicator
8. Member's first and last name
9. Member's date of birth
10. Eligibility termination date
11. Member's current primary eligibility aid code and county identification
12. County of responsibility
13. County of residency
14. MEDS current renewal date
15. Reason for termination
16. Current eligibility status
17. County ID

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

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

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

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

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

Appendix 5- Specialty Mental Health Delay Reason Codes (DRC)

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

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

Appendix 6- Determining Hard and Over-ridable Lockouts

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

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

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

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

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

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

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

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

And

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

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

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

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