DMC-ODS BILLING MANUAL

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TABLE OF CONTENTS

CHAPTER ONE - INTRODUCTION

1.0 Introduction

The Short Doyle/Medi-Cal (SD/MC) claims processing system allows California counties to submit electronic claims for reimbursement of covered Drug Medi-Cal-Organized Delivery System (DMC-ODS) services provided by Drug Medi-Cal enrolled and certified providers to Medi-Cal-eligible beneficiaries. The Department of Health Care Services (DHCS) Local Governmental Financing Division (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 approved 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 procedure codes or modifiers are appropriate or on the documentation that must accompany the procedure codes submitted on a claim.

This chapter includes:

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

1.1 About This Manual

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

1.1.1 Objectives

The primary objectives of this Billing Manual are to:

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

- 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 DMC-ODS services including but not limited to:

- Determination of Aid Code.
- Maintenance of eligibility information technology systems (e.g., Medi-Cal Eligibility Determination System [MEDS]).
- Adjudication of DMC-ODS claims.
- Processing of claims for Federal Financial Participation (FFP) payments
- Submission of expenditures to the Centers for Medicare & Medicaid Services (CMS) to obtain FFP

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

County expenditures represent a combination of State realignment funds, local county funds and other sources such as grants. 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 (W&I Code)

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

1.3.6 California Code of Regulations (CCR)

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

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

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

1.3.8 DHCS Information Notices

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

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

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

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

1.3.10 Companion Guide for the 835 Healthcare Claim Payment/Advice

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

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

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

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

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

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

1.3.14 ASC X12N/005010X221 Health Care Claim Payment/Advice (835) Implementation Guide

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

1.3.15 Claim Adjustment Reason Codes-Remittance Advice Remarks (CARC-RARC)

This is posted on the MEDCCC Library and contains more detailed information about the meaning of the denial codes received.

1.4 Medi-Cal Claims Customer Service Office (MEDCCC)

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

identified. MEDCCC assists counties with streamlining the claim process, resulting in improved processes, and understanding of requirements at both the county and State levels.

What counties can expect when contacting MEDCCC:

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

To ensure the accuracy of the inquiry and responses, MEDCCC requests that counties email inquiries to MEDCCC@dhcs.ca.gov.

CHAPTER TWO – GETTING STARTED

2.0 Introduction

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

- Enrolling in the DHCS Application Portal
- Provider Numbers and National Provider Identifiers
- Provider Enrollment and Medi-Cal Certification
- Companion Guide and Appendix

2.1 DHCS Application Portal

The DHCS Application Portal (Portal) is a collection of web applications that allow DMC-ODS trading partners (e.g., counties, Contracted Providers, and authorized Vendors) to access information securely over the Internet. DHCS will continue to allow trading partners to have two Approvers per system. Each county's behavioral health director appoints Approvers.

All system approver certification forms are available on the DHCS Drug Medi-Cal Application Information 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 Portal. Otherwise, the Approvers will be prompted to create an account.

After DHCS has added an Approver as a new member, they will receive an invitation to join SD/MC-ADP (Substance Use Disorder). The Designated Approvers will also be able to send their own staff invites to the Portal as users.

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

2.2 Provider Numbers and NPIs

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

- A State-assigned provider number

» A National Provider Identifier (NPI)

Federal regulations require that individual healthcare providers and organizations obtain NPIs. DHCS maintains a Drug Medi-Cal Providers website designed to assist providers and share the resources available to understand provider processes including information about obtaining an NPI. DHCS also makes available Drug Medi-Cal Provider Enrollment information related to provider obligations on the Drug Medi-Cal Providers website. Providers must identify, by NPI, the rendering provider and the billing and service facility locations in healthcare claim transactions. To request a provider number, use the Provider Application and Validation for Enrollment portal.

2.3 Provider Enrollment and Medi-Cal Certification

The Provider Enrollment Division (PED) within DHCS is responsible for the receipt, review, and approval of all DMC certification applications. To provide DMC-ODS services, providers must first be DMC certified by DHCS PED. Certification is unique to a particular facility location and specifies the DMC services that can be provided at that location. Certification also distinguishes between services that can be provided within the regular (non-perinatal) DMC program, and those that may be provided within the perinatal DMC program for substance use disorder services for pregnant and postpartum women. For more specific certification information, contact PED by email, DHCRecert@dhcs.ca.gov , or visit the DHCS Provider Enrollment Division website. Additionally, DHCS requires that DMC providers complete a recertification process every five years to maintain their DMC certification. To bill and receive reimbursement for DMC services, most DMC certified providers must have a contract either with the county in which the provider site is located, or directly with DHCS. DMC certified providers serving beneficiaries in one of the seven DMC-ODS regional counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) must have a contract with at least one of the seven regional counties. If a DMC certified provider serves an EPSDT beneficiary from a DMC State Plan County, the provider must have an association with any county within the state to be able to render services to EPSDT beneficiaries. DMC certified providers that are Indian Health Care Providers may serve a beneficiary from any county.

2.4 Companion Guide and Appendix

DHCS publishes a Companion Guide and a Companion Guide Appendix for each Health Insurance Portability and Accountability Act (HIPAA) compliant transaction type used by

SD/MC (e.g., 835, 837). The Companion Guide details how to format HIPAA-compliant 837 files and what information the county can expect to receive on an 835 file. The Companion Guide Appendix provides technical details about claim submission procedures, appropriate code usage, error codes, conversion tables, and such.

CHAPTER THREE – CLIENT ELIGIBILITY

3.0 Introduction

This chapter contains information about Medi-Cal eligibility including:

- Client Eligibility
- Aid Codes

3.1 Client Eligibility

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

3.1.1 Medi-Cal Eligibility Determination

DHCS is responsible for instituting procedures for establishing Medi-Cal eligibility criteria. The determination of beneficiary eligibility and the collection of beneficiary eligibility data is typically the responsibility of the County Department of Social Services. Detailed information regarding beneficiary eligibility criteria may be obtained through the DHCS Medi-Cal Eligibility Division (MCED) website.

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

- Medi-Cal eligibility is established on a monthly basis.
- External auditors can review verification of beneficiary Medi-Cal eligibility after the claimed month of service.
- Medi-Cal eligibility may require that a beneficiary's Share of Cost (SOC) be met before Medi-Cal will pay for any services.
- Clients who are eligible for Supplemental Security Income (SSI) are Medi-Cal eligible.
- Medi-Cal eligibility may be established retroactively through legislation, court hearings, and/or decisions.
- HIPAA 270/271 transactions are available from DHCS to verify beneficiary Medi-Cal eligibility.
- Counties and/or providers should verify beneficiary Medi-Cal eligibility prior to submitting claims for reimbursement.

3.1.2 Eligibility Review

Once Medi-Cal eligibility is established, authorized county staff may review beneficiary eligibility information. With few exceptions, the source of this eligibility verification information will be the DHCS Point of Service System which can be reached at 1.800.456.2387.

3.1.3 Monthly MEDS Extract File (MMEF)

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

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

3.1.4 MEDS and MEDSLITE

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

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

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

For additional information about the kind 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) can be found on the MEDCCC Library. The Aid Codes Chart provides useful information about the following:

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

CHAPTER FOUR – COVERED SERVICES

4.0 Introduction

This chapter provides explanations of covered DMC-ODS services.

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

4.1 DMC-ODS Covered Services

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

4.1.1 Assessment: BHIN 24-001

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

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

4.1.2 Care Coordination: BHIN 24-001

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

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

Care Coordination is covered as a service component of most DMC-ODS levels of care (i.e., outpatient, intensive outpatient, partial hospitalization, residential, inpatient, narcotic treatment program, withdrawal management, MAT, recovery services). Care coordination can be claimed using the dedicated codes in service table, on the same day as other outpatient, residential, or inpatient services appropriate for the client's level of care.

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

When Care Coordination is provided as a standalone service in a residential or inpatient level of care (LOC) it can be claimed by outpatient, residential, or inpatient providers. When billed as a standalone service, the rates are the outpatient rates for these procedure codes.

4.1.3 Clinician Consultation*:* Behavioral Health Information Notice (BHIN) 24-001

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

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

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

Only the DMC-ODS providers directly rendering care to the beneficiary can bill for Clinician Consultation. The "consulting" clinician cannot bill clinician consultation. When a rendering DMC-ODS clinician needs to consult with another clinician to support care delivery, the rendering DMC-ODS provider can use the Clinician Consultation procedure codes (99367, 99368, or 99451) to claim for the activity. Refer to the service table to see how these codes can be billed. The code type for clinical consultation codes is Care Coordination/Clinical Consultation.

4.1.4 Family Therapy: BHIN 24-001

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

4.1.5 Group Counseling: BHIN 24-001

Group Counseling consists of contacts with multiple beneficiaries at the same time. Group Counseling shall focus on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.

4.1.6 Individual Counseling: BHIN 24-001

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

4.1.7 Medical Psychotherapy: BHIN 24-001

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

4.1.8 Medication Services: BHIN 24-001

Medication Services includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include Medication for MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medications Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services.

4.1.9 Medication for Addiction Treatment (also known as medication assisted treatment (MAT) for Opioid Use Disorders (OUD): BHIN 24-001

Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat OUD.

MAT for OUD may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the "Levels of Care" section. This service includes:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services

- Patient Education, which is education for the beneficiary on addiction, treatment, recovery, and associated health risks.
- Prescribing and monitoring MAT for OUD, which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

4.1.10 "Medication for Addiction Treatment (also known as medication assisted treatment (MAT) for Alcohol Use Disorders (AUD) and Other Non-Opioid Substance Use Disorders": BHIN 24-001

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

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- Patient Education, which is education for the beneficiary on addiction, treatment, recovery and associated health risks.
- Prescribing and monitoring MAT for AUD and Other Non-Opioid Substance Use Disorders, which consists of prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT services for AUD and Other Non-Opioid Substance Use Disorders
- Recovery Services
- SUD Crisis Intervention Services
- Withdrawal Management Services

4.1.11 Medications for Addiction Treatment – Medications: BHIN 24-001

As described in BHIN 24-001, DMC-ODS counties shall ensure that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with SUD diagnoses that are treatable with medications or biological products.

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

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

MAT may be billed separately from Recovery, Counseling and Care Coordination services.

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

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

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the individual is experiencing the behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where an individual 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.

Mobile crisis teams must be able to perform all mobile crisis service components. Service components include:

- **Crisis assessment** to evaluate the current status and environment of the beneficiary experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger, determining a short-term strategy for restoring stability and identifying appropriate follow-up care.
- **Mobile crisis response** consisting of an expedited on-site intervention with a beneficiary experiencing a behavioral health crisis with the goal of stabilizing the individual within a community setting and de-escalating the crisis.
- **Crisis planning** to develop a plan to avert future crises, including identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps that the beneficiary can take to avert or address a crisis.
- **Facilitation of a warm handoff** if the beneficiary requires urgent treatment in an alternative setting. The mobile crisis team must identify an appropriate facility or provider, and provide or arrange for transportation, as needed.
- **Referrals to ongoing supports** by identifying and connecting a beneficiary to ongoing behavioral health treatment, community-based supports, social services, and/or other supports that could mitigate the risk of future crises. This

may include identifying appropriate services, making referrals or appointments, and otherwise assisting a beneficiary to secure ongoing support.

- **Follow up check-ins** to continue resolution of the crisis, provide further crisis planning, check up on the status of referrals, and provide further referrals to ongoing supports.

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.

4.1.13 Patient Education: BHIN 24-001

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

4.1.14 Peer Support Service: BHIN 24-001

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

Peer support services are an optional benefit that DMC-ODS counties may choose to offer.

Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services as defined below:

- 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 services means activities and coaching led by Peer Support Specialists to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

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

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

4.1.15 Recovery Services: SPA 21-0058

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective

self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care, or as a service delivered as part of these levels of care.

Recovery Services include the following service components:

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

Recovery Service procedure codes can be used to claim for Recovery Services. Refer to the Service Table for a list of recovery services codes.

Recovery Services can be delivered as a standalone service, or as a service delivered as part of the following levels of care:

- Outpatient Treatment Services (also known as Outpatient Drug Free or ODF services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Partial Hospitalization Services (ASAM Level 2.5)
- Residential Treatment Services corresponding to at least one of the following levels:
    - Level 3.1-Clinically Managed Low-Intensity Residential Services
    - Level 3.3-Clinically Managed Population-Specific High Intensity Residential Services

    - Level 3.5-Clinically Managed High Intensity Residential Services
    - Level 3.7-Medically Monitored Intensive Inpatient Services
    - Level 4.0-Medically Managed Intensive Inpatient Services
- Narcotic Treatment program
- Withdrawal Management (WM) Services in the following outpatient and residential settings:
    - Level 1-WM
    - Level 2-WM
    - Level 3.2-WM
    - Level 4-WM.

Recovery services can be claimed on the same day as Residential services and for the same beneficiary by outpatient and residential providers.

Recovery Service procedure codes must include the appropriate level of care modifier. When claimed as a standalone service on an outpatient basis, procedure codes H2017, H2035 and H2015 with a U6 modifier can be used. Refer to the service table for more information about these codes.

When billed as a standalone service, the rates for these recovery services are outpatient rates.

4.1.16 SUD Crisis Intervention Services: SPA 21-0058

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

4.1.17 Withdrawal Management Services: SPA 21-0058

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

- Assessment
- Care Coordination

- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid SUDs
- Peer Support Services

Observation, which is the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

4.1.18 Contingency Management Services: BHIN 23-040

Contingency Management (CM) is an evidence-based, cost-effective treatment for substance use disorders that is only available to beneficiaries with stimulant use disorder. CM reinforces individual positive behavior change consistent with meeting treatment goals. DHCS is piloting Medi-Cal coverage of CM in select DMC-ODS counties between the first quarter of 2023 and March 2024 through the federally approved CalAIM Section 1115(a) Demonstration Waiver (No. 11-W-001939/9). DHCS will extend the pilot period through at least the duration of the CalAIM demonstration period (ending December 31, 2026).

The CM benefit is intended to complement substance use disorder (SUD) treatment services and other evidence-based practices for StimUD already offered by DMC-ODS providers. Eligible Medi-Cal beneficiaries will participate in a structured 24-week outpatient CM service, followed by six or more months of additional treatment and recovery support without incentives. The initial 12 weeks of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests (UDT) negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives consist of cash-equivalents (e.g., gift cards), consistent with evidence-based clinical research for treating SUD. CM should be offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and CFR 440.130(d).

CM services are only available to Medi-Cal beneficiaries who meet the following conditions:

- Are enrolled in Medi-Cal and meet access criteria for a comprehensive, individualized course of SUD treatment.

- Residing in a participating DMC-ODS county that elects and is approved by DHCS to implement CM[1].
- Receiving services in a non-residential level of care operated by a DMC-ODS provider offering CM in accordance with DHCS policies and procedures.

CM services are only covered when medically necessary and appropriate as determined by an initial substance use disorder assessment showing:

- Moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition).
- Clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria.
- That the CM benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based on the fidelity of treatment to the evidence-based practice.

The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.

Beneficiaries may access CM when transitioning to or from residential care or carceral settings, including services initiated on the day of admission and discharge or release respectively. Providing CM services on the date of admission and the date of discharge from a DMC-ODS residential level of care is an acceptable circumstance justifying multiple service billing for both a residential treatment service and a CM service at a non-residential level of care. Beneficiaries can receive CM services on the date of admission or the date of discharge from residential services.

CM should never be used in place of medications for addiction treatment (MAT). CM may be offered in addition to MAT for people with co-occurring stimulant and alcohol or opioid use disorders.

Eligible Medi-Cal beneficiaries shall be referred to, and admitted into, treatment through a participating provider's routine beneficiary admission process. Consistent with other DMC-ODS programs, there is no minimum age limit for an individual to receive CM

[1] The BHIN uses the term Recovery Incentives Program. However, it also states that "the Recovery Incentives Program only covers CM for StimUD." The billing manual therefore only uses the term CM for readability.

services if they meet all eligibility criteria. In addition, pregnant and parenting people with StimUD are eligible to receive CM services. Medi-Cal beneficiaries.

4.2 DMC – ODS Levels of Care

4.2.1 Outpatient Treatment Services (ODF): BHIN 24-001

Outpatient treatment services are provided to beneficiaries when medically necessary (offering up to nine hours a week for adults, and six hours a week for adolescents). Services may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone. Providers are required to either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Outpatient treatment services (also known as Outpatient Drug Free or ODF) include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid SUDs
- Patient Education
- Recovery Services
- Crisis Intervention Services

4.2.2 Intensive Outpatient Treatment Services (ASAM Level 2.1): BHIN 24-001

Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment (offering a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents).

Services may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by

telephone. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Intensive Outpatient Treatment Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid substance use disorders
- Patient Education
- Recovery Services
- Crisis Intervention Services

4.2.3 Partial Hospitalization: BHIN 24-001

Partial Hospitalization Services are delivered to beneficiaries when medically necessary in a clinically intensive programming environment (offering 20 or more hours of clinically intensive programming per week). Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of beneficiaries with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Services may be provided in person, by synchronous telehealth, or by telephone. Level 2.5 Partial Hospitalization Programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting. Providing this level of service is optional for DMC-ODS Counties. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). Partial Hospitalization Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

4.2.4 Residential Treatment Services: BHIN 24-001

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

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

Residential Treatment Services include the following services:

- Assessment
- Care Coordination
- Counseling
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid SUDs
- Patient Education

- Recovery Services
- SUD Crisis Intervention Services

The daily bundled rate for residential services includes the service components listed above, except for MAT, Care Coordination, and Recovery Service. Therefore, to receive the residential day rate, a residential provider must provide at least one of the following service components: Assessment, counseling, family therapy, medication service, patient education, or SUD crisis intervention service. Residential providers should not submit separate claims for these services for beneficiaries admitted to the Residential LOC.

Care coordination, Peer Support Specialist services, MAT for OUD and MAT for AUD are reimbursed separately from the per diem rate. Residential providers can claim for these services as outpatient services on an outpatient basis if the provider is certified to provide the outpatient services. The rate for those services will be the outpatient rate.

4.2.5 Narcotic Treatment Program: BHIN 24-001

Narcotic Treatment Program (NTP), also described in the ASAM criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), disulfiram, and naloxone. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication. The NTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month.

Narcotic Treatment Program Services include the following service components:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD

- MAT for AUD and non-opioid substance use disorders
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Counties can claim for counseling, care coordination and recovery services on the same day as NTP services for the same beneficiary. Claims will be paid based on the rate for the practitioner providing the service.

Pursuant to Information Notice 15-028, NTP counseling is limited to 200 minutes per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP subcontractors may bill and be reimbursed for additional counseling. Medical justification for the additional counseling must be clearly documented in the patient record and completed within 14 days of treatment.

4.2.6 Withdrawal Management Services: BHIN 24-001

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

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

Withdrawal Management Services are provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the

beneficiary to their best possible functional level. Withdrawal Management Services include the following service components:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and non-opioid SUDs
- Observation
- Recovery Services

4.2.7 CalAIM Justice-Involved Reentry Initiative

DMC-ODS counties may claim reimbursement through Short-Doyle Medi-Cal for behavioral health links provided by DMC-ODS network providers to Medi-Cal members enrolled in Justice Involved Reentry Initiative aid codes. Codes that may be claimed to SDMC as part of the Justice-Involved Reentry Initiative are identified in column Y, JI Warm Linkage Codein the Service Table. 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.

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 Approved Claims
- Requesting Delay Reason Codes

5.1.0 Accepting and Rejecting Claims

When a claim file is submitted, the SD/MC claiming system will either accept or reject claims within the claim file. If any portion of a claim does not meet the Workgroup for Electronic Data Interchange Strategic National Implementation Process HIPAA Transaction and Code Sets Final Rules ("SNIP edits"), SD/MC will reject the entire claim. If the claim meets the SNIP edits, SD/MC will accept the claim.

SD/MC posts three reports to the county's folder in the DHCS Portal after completing the SNIP edits. The first is the 999 Functional Acknowledgment, which tells the county whether the claim file or individual claim within the claim file was accepted or rejected. The second report is the TA1 Interchange Acknowledgement Report, which tells the county if the rejection was due to structural issues with the claim file or syntax errors in the claim. The third report is the SR Acknowledgement Report, which tells the county how many claims within the claim file were accepted, how many were rejected, and provides more granular information about the reason for rejection.

5.2.0 Approving and Denying Claims

The SD/MC claiming system adjudicates all claims that pass the SNIP edits and are accepted. Adjudication involves application of all business requirements described in this chapter of the billing manual. Claims or service lines that meet all the business requirements are approved and claims or services lines that do not meet a business requirement are denied.

5.2.1 Zero Dollar Claims

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

5.2.2 Beneficiary Share of Cost

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

5.2.3 Beneficiary Eligibility

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

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

5.2.4 County of Residency/County of Responsibility

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

5.2.5 Beneficiary Date of Birth

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

5.2.6 Beneficiary Gender

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

5.2.7 Beneficiary Date of Death

A provider may not provide a service to a beneficiary after the beneficiary has died. SD/MC will deny all service lines with a date of service that occurred after the

beneficiary's date of death as recorded in MEDS. Services provided on the date of death will be adjudicated.

5.2.8 Dates of Services Within a Claim

For any single claim, all dates of service must be within the same calendar month, except for claims for inpatient hospital services. The discharge date on the claim for inpatient hospital services may occur on the first day of the following month. For example, a claim for an individual who was admitted to the hospital on October 28 and discharged on November 1 would be admissible. SD/MC will deny service lines submitted with dates of service that do not conform to this guidance.

5.2.9 Claims for Inpatient Stays that Cross One or More Months

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

5.2.10 Service Lines and Date Ranges

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

5.2.11 Date of Service and Date of Submission

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

5.2.12 Duplicate Services

Inpatient and 24-Hour Services

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

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

Outpatient Services

Outpatient services are listed in the service table. Except for Sign language or Oral Interpretive services (T1013), Interactive complexity (90785), mobile crisis (H2011, place of service 15) health behavior interventions for the family without the patient present (96170 and 96171), and claims for group services/claims that have an HQ modifier, a claim is considered a duplicate if all of the following data elements are the same as another service approved in history:

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

Duplicate services are not allowed.

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

5.2.13 Claiming for Interpretation, Health Behavior Intervention, and Interactive Complexity

Sign language or oral interpretation (T1013), Interactive Complexity (90785), and health behavior intervention (codes 96170 and 96171) occur along with another service, such as counseling. These codes must be submitted on the same claim as the primary service. DMC eligible providers can submit claims for interpretation (T1013) when they use an oral interpreter to provide counseling to a patient who needs sign language or interpretive services.

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 time may not exceed the time spent providing a primary service. For example, if a counseling session lasted 45 minutes, a maximum of three units of T1013 may be claimed.

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.

A claim for interpretation, should include the taxonomy code and NPI of the individual who provided the primary service. The standard rate per unit of oral or sign language interpretation is based on the Bureau of Labor Statistics data.

Only one unit of interactive complexity (90785) is allowed with any service. Either 90785 or T1013 can be billed in any given encounter; 90785 and T1013 cannot be billed together. A claim for interpretation should be submitted if the service is delivered by a provider other than the provider of the primary service.

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 a county submits a claim that includes psychiatric diagnostic evaluation 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.

5.2.14 Claim Timeliness – Original Claims

The timeline for initial submission of DMC-ODS claims is critical. Original claims must be submitted within 12 months of the month of services (W&I Code, Section WIC 14021.6(g)). An original claim submitted after 6 months from the month of service without a DHCS approved Delay Reason Code (DRC) will be denied. Please see section 5.2.368 for more information about requesting a DRC. Please refer to Appendix 6 for a list of DRCs.

5.2.15 Service Facility Location

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

5.2.16 Service Facility Validation

SD/MC verifies that the service facility identified on the claim was enrolled in Medi-Cal and certified to render the service claimed on the day the service was provided. As discussed in Section 2.3, DHCS records in the Provider Application and Validation for Enrollment portal each organizational provider's NPI number and the expanded substance use disorder treatment services the provider is certified to render. SD/MC will deny a service line if the provider, as determined by the service facility NPI number on the claim, is not certified to provide the service billed.

5.2.17 Institutional Services-Codes

Under DMC-ODS, counties have the option of providing medically monitored and/or managed intensive residential treatment services under ASAM Levels of Care 3.7 and 4.0. These services are classified as institutional claims and must be submitted using an 837I transaction file. All claims for institutional services must include a valid revenue code, valid Procedure Coding System (PCS) code and valid Demonstration Project Indicator (DPI) segment. SD/MC will deny all service lines for institutional services that do not have valid revenue, PCS and DPI codes. Refer to BHIN 19-032 for additional information.

5.2.18 Date of Admission and Date of Discharge

All claims for inpatient hospital services must include the beneficiary's date of admission. As discussed in section 5.2.9, interim claims for inpatient hospital services do not require a discharge date. SD/MC will deny all service lines for inpatient hospital services that do not include an admission date.

5.2.19 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 H2011, 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.

SD/MC will deny all service lines for outpatient services where the first four characters of the rendering provider's taxonomy code does not identify a SD/MC Allowable Discipline for the procedure code on the service line. SD/MC does not verify the taxonomy code against the rendering provider's NPI. The AOD Counselor provider type is designated using the five-character taxonomy code 101Y**A**. Four-character taxonomy code 101Y refers to Licensed Professional Clinical Counselors.

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.

As specified in the Service Table, certified Medi-Cal peer support specialists may only submit claims to Short Doyle Medi-Cal (SD/MC) for Medi-Cal peer support services (H0038 and H0025) under the peer taxonomy code. If the Medi-Cal Peer Support Specialist meets the qualifications for another practitioner type, the Medi-Cal Peer Support Specialist may submit a separate claim under a different taxonomy code for any non-Medi-Cal Peer Support Services. For additional information, refer to the Medi-Cal Support Services Specialist Program-Frequently Asked Questions.

As specified in the Service Table, certified Medi-Cal peer support specialists may only submit claims to Short Doyle Medi-Cal (SDMC) for Medi-Cal peer support services (H0038 and H0025) and contingency management (H0050) under the peer taxonomy code. If Medi-Cal Peer Support Specialist meets the qualifications for another practitioner type, the Medi-Cal Peer Support Specialist may submit a separate claim under a different taxonomy code for any non-Medi-Cal Peer Support Services. For additional information, refer to the Medi-Cal Peer Support Services Specialist Program-Frequently Asked Questions.

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.

5.2.20 Clinical Trainees

When claiming for clinical trainees, counties 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

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 by Clinical Trainees.

The supervisor's NPI must be reported at the claim level (loop 2310D) and/or at the service line level (loop 2420D). 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 that do not report a supervisor's NPI will be denied. 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 beneficiary. This is the supervisor's NPI that 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 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.

5.2.21 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 the service was provided via telehealth or telephone, the place of service must be 02 or 10.

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.

Currently, Medicaid does not reimburse services provided to residents of a public institution, which includes jails and prisons. Until the CalAIM Justice-Involved Initiative is implemented, SD/MC will deny all service lines for outpatient services with place of service code 09 (Correction Facility).

5.2.22 Level of Care Modifiers

All services are required to be submitted with a level of care modifier. The following levels of care modifiers are used by DMC - ODS Counties:

- U1 (ASAM 3.1 Residential)
- U2 (ASAM 3.3, Residential)
- U3 (ASAM 3.5, Residential)
- U7 (Outpatient Services (ODF))
- U8 (Intensive Outpatient Services (IOD))
- U9 (Residential Withdrawal Management, 3.2-WM)
- UA (ASAM OTP/NTP)/HG (Opioid treatment program (OTP)) and
- UB (ASAM 2.5 Partial Hospitalization).

Services will be denied if a procedure modifier defining level of care has not been submitted or if the submitted outpatient procedure code is not allowable with the submitted modifier(s). Refer to the service table for a list of the valid procedure/modifier combinations. Claims for NTP services must be submitted with both HG and UA modifiers.

Recovery Services and Level of Care Modifiers

Service lines for recovery services must be submitted with the U6 (recovery services) modifier as well as a level of care modifier. Please see the service table for a list of

recovery services codes. Service lines submitted for a recovery service that do not contain the U6 modifier will be denied. The U6 modifier does not represent a level of care. It represents a classification of services that can be provided in all levels of care.

5.2.23 Perinatal and Non-Perinatal Services

All service lines on a claim must be either perinatal or non-perinatal. SD/MC will deny a claim if it has both perinatal and non-perinatal service lines.

To indicate that a service is perinatal, the service line must include modifier HD. Claims submitted with service lines that contain the HD modifier must also set the pregnancy indicator to yes or the claim will be denied.

5.2.24 Dependent Codes

The service table lists all outpatient procedure codes. The procedure codes listed in Column C 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. SD/MC will deny a service line with the primary procedure code if a Dependent on Code was not billed on the same claim or approved on the same day for the same beneficiary in history.

5.2.25 Units of Service - Outpatient Services

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

5.2.26 Maximum Units - Outpatient Services

All claims for outpatient services must use units of service. Column R, labeled "Maximum Units that Can be Billed per Beneficiary 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 Beneficiary per Day" Column. Only the time it takes to provide direct services 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.

Some service encounters may need to be claimed with two procedure codes, the primary code, and an add-on code to comply with this rule. Some services have a specific primary procedure code and a specific add-on code. The primary procedure code and add on code must be submitted on the same claim. SD/MC will deny a service

line billed with an add-on procedure code if the primary procedure code is not present in the same claim.

5.2.27 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 used in 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 beneficiary and spends five minutes doing so but the assessment is interrupted and the provider assesses the beneficiary 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 mid-point 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 31 minutes of psychiatric diagnostic evaluation in the morning and 20 minutes of psychiatric diagnostic evaluation in the afternoon, the provider will claim one unit of 90791 (psychiatric diagnostic evaluation) because 31-60 minutes of psychiatric diagnostic evaluation 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. When claiming these codes, when a provider delivered the lower bound of the service indicated in the range, they can claim one unit of that code. 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. For example, 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.

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
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (eg, sodium amobarbital (Amytal) interview)	90 mins	At 46 minutes of service
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	15 mins	At 8 minutes of service
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	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?
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
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	15 mins	At 8 minutes of service
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	15 mins	At 8 minutes of service

[Text Wrapping Break][1] Medicare does not assign a time to these codes. The 15-minute time per unit of service was therefore retained.

5.2.28 Other Health Coverage – Medicare

Medi-Cal is the payer of last resort. This means that providers must submit claims to Medicare for Medi-Cal eligible services performed by Medicare-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 DMC 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. Licensed clinical social worker
5. Clinical psychologist
6. Licensed Marriage and Family Therapists
7. 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. 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 obtained the applicable doctor's or master's degree), they should claim SD/MC directly and use modifier HL. The system has been updated in March and the change is retroactive to the date of the federal final rule to ensure that counties will be able to claim for all services provided.

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 DMC 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 is rendered by a Medicare recognized provider. Subsequently, the claim submitted to Medi-Cal must contain information about the Medicare claim. .

Please note that although SDMC 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. Subsequently, the claim submitted to Medi-Cal must contain OHC information about the Medicare claim even if the OHC is $0.

Procedures codes H0004 (Individual Counseling), H0005 (Group Counseling), H0020 (Methadone administration) S5000 (Prescription drug: generic), and S5001 (Prescription drug: brand name) are not exempt from Medicare COB when related to Narcotic Treatment Program (NTP)/ Medication Assistance Treatment (MAT) dosing. These codes must first be billed to Medicare when related to NTP/MAT dosing unless the medication is drug type 3 (Disulfiram), 6 (Acamprosate), 7 (Buprenorphine combination), or 10 (Naltrexone: Long-Acting Injection).

Medicare does not cover drug types 3, 6, 7, and 10.

NTP services and Medicare Part B beneficiaries:

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

5.2.29 Other Health Care Coverage – Non-Medicare

Medi-Cal should always be the payer of last resort. This means that providers must submit a claim to a beneficiary's other health coverage for eligible services before submitting a claim to Medi-Cal. With the exception of MAT claims that use codes H0033 and H0034, 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.

Services that can be billed directly to Medi-Cal

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

1. Recovery Services (H008, H009, H2015. H2017, H2035)
2. Treatment Planning (H2014, H2021, H2017)
3. Mobile Crisis (H2011 with Place of Service 15)
4. Transportation Staff Time (T2007)
5. Transportation Mileage (A0140)
6. Contingency Management (H0050 with modifier HF)
7. Peer Support Services (H0025 or H0038)
8. Case Management (T1017)
9. Prenatal care, at-risk assessment (H1000)

In addition, services to beneficiaries who are enrolled in minor consent aid codes do not have to have OHC information.

5.2.30 Lockout Rules

Outpatient Lockouts:

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

The Service Table identifies the combinations of procedure codes that cannot be billed for the same beneficiary on the same day. Excel column C, 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 C when provided to the same beneficiary 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 C under extraordinary circumstances.

The combination of the Code in Column C and each lockout code in Columns K or L represents a lockout situation when both are provided to the same beneficiary 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 over-riding modifier. Target codes are listed in Column L.

Target codes in Column L are identified by one or two asterisks (*). Target codes with one asterisk are not locked out when combined with the procedure code in Column 2 if the target code is billed with one of the following over-riding modifiers: 59, XE, XP or XU. Target codes with two asterisks are not locked out when combined with the procedure code in Column 1 if the target code is billed with one of the following over-riding modifiers 27, 59, XE, XP, or XU.

Withdrawal Management 1, 2 and 3.2 Lockouts:

The only services that can be billed on the same day as Ambulatory Withdrawal Management services are additional MAT, methadone dosing, care coordination, physician consultation, peer support specialist services, mobile support, and contingency management. The only services that can be billed with Residential Withdrawal

Management 3.2 are additional MAT, methadone dosing, care coordination, recovery support services, clinician consultation and peer support specialist services.

Medication Services Lockouts:

Procedure codes used to claim reimbursement for Medication Services are listed in the Service Table. Certain medication services have lockouts and are not allowed to be billed on the same day**.** Refer to the Service Table for the medication lockouts.

Medication (MAT/NTP) service codes may be billed with individual and group counseling, care coordination and recovery services. Claims will be paid based on the rate for the practitioner providing the service.

5.2.31 Emergency and Pregnancy Indicator

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

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.

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

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

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

5.2.33 Withdrawal Management and Residential Hospital with ASAM 3.7 and 4.0 Services

DMC-ODS counties can voluntarily cover and receive reimbursement through the DMC-ODS program for inpatient services at ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, FAPHs, or CDRHs. Regardless of whether the DMC-ODS County covers ASAM Levels 3.7 or 4.0, the DMC-ODS County implementation plan must describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0. BHIN

24-001 clarifies coverage of voluntary inpatient detoxification through the Medi-Cal Fee-For-Service program.

These services are classified as institutional services and any related claims must be submitted on an inpatient claim (837I). Withdrawal Management and/or Residential Hospital with ASAM 3.7 and 4.0 services must be submitted using only Revenue Code 0953, a Procedural Code System (PCS) Code, and Demonstration Project Indicator (DPI) as outlined in BHIN 19-032 Exhibits A and B. Inpatient claims must be submitted using one unit per day. The service will be denied if the number of units billed exceeds the maximum days allowed. For example, if withdrawal management is billed for dates of service November 1, 2021 – November 4 and the units billed are six, the service will be denied.

5.2.34 Covered Diagnosis

Inpatient and residential claims must have at least one DMC **covered** substance use disorder ICD-10 diagnosis code as indicated in Appendix 5-Covered Diagnoses. Covered diagnosis codes are a subset of valid ICD-10 codes. Counties are required to use the appropriate ICD-10 codes to submit inpatient and residential claims for reimbursement. If the diagnosis code is not a covered ICD-10 code, the service will be denied.

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

5.2.35 Replacing Approved and Denied Claims

Replacement claims for **previously approved claims** must be submitted within 15 months from the month of service. If the claim is submitted after the 15-month period, the replacement claim will be denied.

A replacement claim can be submitted if an 835 has been issued and if the claim being replaced has not being voided. Replacement claims for outpatient services, day services, or 24-hour services must have the Billing Employer Identification Number. The replacement claim must also have two of the following four data elements on each service line and the replacement claim must match the corresponding service lines in the original claim: Procedure code or revenue code (as appropriate), date of service, place of service, and service facility NPI.

5.2.36 Voiding Approved Claims

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

5.2.37 Requesting Delay Reason Codes

Counties 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 claim is because proof of eligibility was unknown or unavailable, due to litigation, there was a delay in certifying the provider, there was a third party processing delay, there was a delay in eligibility determination, special circumstances that cause a billing delay such as a court decision or fair hearing, determination by DHCS that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control. by contacting MEDCCC at MEDCCC@dhcs.ca.gov. Please refer to Appendix 6 for a list of DRCs.

CHAPTER SIX – FUNDING

6.0 Introduction

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

- Federal Share – FMAP Percentage and Aid Codes
- State Share and Proposition 30
- One Hundred Percent County Funded

6.1.0 Federal Share: FMAP Percentage and Aid Codes

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

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

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

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

6.2.0 State Share and Proposition 30

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

The state will reimburse counties 100 percent of the non-federal share for DMC-ODS services provided as a result of a new state requirement implemented after 2011 realignment. Either the beneficiary 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 beneficiary's aid code to identify the service as a state requirement.

6.2.1.1 Medi-Cal Optional Expansion Full Scope Beneficiaries

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

- Outpatient Treatment Services (ODF), services submitted with modifier U7
- Narcotic Treatment Program (NTP), services submitted with modifiers UA/HG

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

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

6.2.1.2 Non-Perinatal Full Scope Not Federally Eligible Beneficiaries

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

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

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

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

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

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

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

Young Adult Expansion

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

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

Older Adult Expansion

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

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

Full-Scope Adults Aged 26 through 49 Medi-Cal Expansion

Adults ages 26 through 49 are eligible for full-scope Medi-Cal regardless of immigration status, if 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 as a result of older adult expansion by the beneficiaries' aid code. The state will reimburse counties 100 of the non-federal share percent for non-pregnancy services provided to beneficiaries enrolled through the Adult Expansion. Services provided in the listed levels of care below are subject to these funding reimbursement requirements.

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

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

6.2.2 Community-Based Mobile Crisis Services

SPA 22-0043 added community-based mobile crisis services benefit. This benefit, as described in section 4.1.12, provides rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health and/or SUD (behavioral health) crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services are a state requirement. Therefore, when a county claims for providing those services for non-UIS Medi-Cal beneficiaries, the state will reimburse counties 100 percent of the non-federal share. The county should use modifier HW to indicate that this service is provided as a result of a state mandate. For information on how to claim for Mobile Crisis services refer to the Service Table.

6.2.3 Federally Required Proposition 30 Services

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

6.2.4 One Hundred Percent County Funded

The county is responsible to finance 100% of the cost to provide services to beneficiaries in the eligibility groups described below.

Qualified Non-Citizens

California provides full scope Medi-Cal benefits to Qualified Non-Citizens who are not federally eligible because they have not been in the United States for at least five years. Federal reimbursement is not available for non-pregnancy services provided to Qualified Non-Citizens enrolled through the State Only Medi-Cal Program. State reimbursement is not available for DMC-ODS services provided to Qualified Non-Citizens unless the service was provided as a result of a State Requirement as described in Section 6.2.1or unless the beneficiary is pregnant. 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 DMC-ODS` 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 the beneficiary is pregnant. 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.

Minor Consent Beneficiaries

California provides limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, family planning, outpatient mental health services,

pregnancy and postpartum services to minors who are at least 12 years of age and under the age of 21. Federal reimbursement is not available for services provided to minor consent beneficiaries. Counties must cover 100 percent of the cost for services provided to minor consent beneficiaries. Minor consent beneficiaries are enrolled in specific aid codes that are listed in the Medi-Cal Aid Codes Chart.

CHAPTER SEVEN – 2023 AND 2024 CPT UPDATES

The American Medical Association's (AMA) CPT Professional Edition Codebook with Rules and Guidelines is updated annually. 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 however 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

The Service Table describes the procedure codes associated with each service type: Assessment, Crisis Intervention, Medication Services, Mobile Crisis, Treatment Planning, Individual Counseling, Group Counseling, Care Coordination, Recovery Services, Discharge, Family Therapy and Peer Support Services. There is also a group of codes called Supplemental. Supplemental codes are codes that must be used with another code. As stated above (and except for Care Coordination Services, Recovery Services, Peer Support Services, and MAT Services), outpatient services are not allowable when billed on the same date of service as the following 24-hour services except on the dates of admission or discharge:

- H0019: U1: Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where the stay is typically longer than 30 days) without room and board.
- H0019: U2: Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where the stay is typically longer than 30 days) without room and board.
- H0019: U3: Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where the stay is typically longer than 30 days) without room and board.
- H0012:U9: Alcohol and/or drug services (residential addiction program outpatient). Subacute detoxification.

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

purpose of the collateral's participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:

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

b. Care Coordination: Consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination can be provided in a clinical or non-clinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone.

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

d. Discharge Plan: When requested by the beneficiary's physician, a hospital must arrange for the development and implementation of a discharge plan for the beneficiary.

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

f. Group Counseling: Group counseling consists of contacts with multiple beneficiaries at the same time. Group counseling focuses on the needs of the participants and is provided to a group that includes 2-12 individuals.

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

h. Medication Services: Medication services include prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication services do not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other non-opioid substance use disorders. Medication services include prescribing, administering, and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services.

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

j. Peer Support Services: Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to

set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

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

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

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

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 Codebook, 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 Codebook. The CPT Codebooks 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 county 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 for a description of the Place of Service codes. If a claim does not list a place of service, it will be denied. If a service is provided via telehealth, the place of service **must** be either 02 or 10 unless the service is mobile crisis. No service code may be claimed for place of service 09.

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 ASAM OTP/NTP (UA:HG): This column indicates whether the outpatient code in column "Code" can be billed with an NTP service. A "No" in this column means that the outpatient code can be billed with an NTP service and a "Yes" in this column means that it cannot be billed with an NTP service.
13. Locked Out Against ASAM 3.1 Residential (U1): This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 3.1 Residential service. A "No" in this column means that the outpatient code can be billed with an ASAM 3.1 Residential service and a "Yes" in this column means that it cannot be billed with an ASAM 3.1 Residential service.
14. Locked Out Against ASAM 3.3 Residential (U2): This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 3.3 Residential service. A "No" in this column means that the outpatient code can be billed with an ASAM 3.3 Residential service and a "Yes" in this column means that it cannot be billed with an ASAM 3.3 Residential service.
15. Locked Out Against ASAM 3.5 Residential (U3): This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 3.5 Residential service. A "No" in this column means that the outpatient code

can be billed with an ASAM 3.5 Residential service and a "Yes" in this column means that it cannot be billed with an ASAM 3.5 Residential service.

16. Locked Out Against ASAM 2.5 Partial Hospitalization (UB): This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 2.5 Partial Hospitalization. A "No" in this column means that the outpatient code can be billed with an ASAM 2.5 Partial Hospitalization and a "Yes" in this column means that it cannot be billed with an ASAM 2.5 Partial Hospitalization.
17. Locked Out Against ASAM 3.2 Clinically Managed Residential Withdrawal Management (U9): This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 3.2 Clinically Managed Residential Withdrawal Management. A "No" in this column means that the outpatient code can be billed with an ASAM 3.2 and a "Yes" in this column means that it cannot be billed with ASAM 3.2.
18. Locked Out Against ASAM 3.7-Medically Monitored Intensive Inpatient Services: This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 3.7 Medically Monitored Intensive Inpatient Services. A "No" in this column means that the outpatient code can be billed with an ASAM 3.7 and a "Yes" in this column means that it cannot be billed with an ASAM 3.7.
19. Locked Out Against ASAM 4.0-Medically Managed Intensive Inpatient Services: This column indicates whether the outpatient code in column "Code" can be billed with an ASAM 4.0 Medically Managed Intensive Inpatient Services. A "No" in this column means that the outpatient code can be billed with an ASAM 4.0 and a "Yes" in this column means that it cannot be billed with an ASAM 4.0.
20. 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 in column "Code" 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.
21. 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 in column "Code". Claims for interpretation may not exceed the time associated with claims for the code in column "Code." One unit of sign language or interpretation is equal to 15 minutes.

22. Units of 96170 Associated with 1 Unit of Code: This column specifies how many units of initial health behavior intervention, family (without the patient present) can be claimed with the code in column "Code". Initial health behavior intervention must be submitted on the same claim as the code in column "Code". Claims for initial health behavior intervention may not exceed the time associated with the claim for the code in column "Code". One unit of initial health behavior intervention is equal to 30 minutes.

23. Units of 916171 Associated with 1 Unit of Code: This column specifies how many units of additional health behavior intervention, family (without the patient present) can be claimed with the code in column "Code". Additional health behavior intervention must be submitted on the same claim as the code. Claims for additional health behavior intervention may not exceed the time associated with the claim for the code. One unit of additional health behavior intervention is equal to 15 minutes.

24. Medicare COB Required?: This column specifies whether a claim for a procedure, if rendered to a Medi-Medi beneficiary, must 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 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 the procedure was not provided by a Medicare-recognized professional listed above to a Medi-Medi beneficiary, the service should not be submitted to Medicare.

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

26. Maximum Units That Can Be Billed Per Provider Per Beneficiary 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.

Codes must be billed in whole units. Fractional units will be denied. When selecting a CPT code, providers should follow the CPT Codebook for instructions on how to bill each code using time. DHCS policy states that only direct patient care should be counted toward selection of time. Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a provider engages in that are either already included in the rate for the service code or are claimed separately by the county.

27. Allowable Modifiers: this column lists the modifiers that are allowed with the procedure code 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 that service. There are some instances (such as lack of over-riding modifier) when lack of a modifier will cause a service 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 alphanumeric 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 alphanumeric characters, the provider is obligated to provide the entire taxonomy code on the 837P claim. For beneficiaries who are also eligible for Mental Health Services, please see the Mental Health Billing Manual to reference taxonomy codes under the Mental Health Services program.

To indicate that the service was provided by an intern 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 alphanumeric codes that can be used to describe that discipline. Please note that in the case of AOD Counselors, the first five alpha numeric characters are displayed.

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Alcohol and Other Drug	101YA
	146D

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Counselors (AOD Counselors)	146L
	146M
	146N
	171M
	374K
	2258
	2260
	4053
Licensed Vocational Nurse	164W
	164X
Marriage and Family Therapist (MFT) or Licensed Professional Clinical Counselor	1012
	101Y
	102X
	103K
	106H
	1714
	222Q

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	225C
	2256
Clinical Trainee	3902
Nurse Practitioner (NP)	363L
Occupational Therapist	225X
Medical Student in Clerkship	1744
Medical Assistant	363A**M**
Licensed Psychiatric Technician	106S
	167G
	3747
Pharmacist (Pharma)	1835

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
Physician Assistant (PA)	363A
Physician (MD/DO)	202C
	202D
	202K
	204C
	204D
	204E
	204F
	204R
	207K
	207L
	207N
	207P
	207Q
	207R
	207S
	207T

Discipline	First Four Alpha-Numeric Characters of Taxonomy Code
	207U
	207V
	207W
	207X
	207Y
	207Z
	2080
	2081
	2082
	2083
	2084
	2085
	2086
	2088
	208C
	208D
	208G
	208M
	208U

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

Appendix 2- Definitions

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

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

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 Drug Medi-Cal System and providers who are outside the Drug Medi-Cal System. H2021 can only be used to show that a delivery-system coordination of care has occurred. For other kinds of coordination, other service codes must be used.

Dependent Procedure: These are procedure codes 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 beneficiary by the same rendering provider on the same date on the same claim.

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

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

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

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

Intern: A registered, pre-licensed mental health professional who is registered with the appropriate licensing board and working in a clinical setting under supervision. An intern 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.

Lockouts: Lockouts are codes that cannot be billed together. Sometimes lockouts can be overridden with an appropriate modifier. Lockouts that can be overridden are indicated with either one or two asterisks in the lockout column in 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.

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

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

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

Services Provided by Interns/Residents: To indicate that the service was provided by an intern 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 Alcohol and Other Drug Specialist 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. Beneficiary's Last Name
11. Beneficiary's First Name
12. Beneficiary's Suffix
13. Beneficiary's Address
14. Eligibility Worker Code
15. Client Index Number

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

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

Appendix 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. Beneficiary's gender
4. Beneficiary's primary ethnicity code
5. Beneficiary's spoken language code
6. Beneficiary's written language code
7. Government Responsibility indicator
8. Beneficiary's first and last name
9. Beneficiary's date of birth
10. Eligibility termination date
11. Beneficiary'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. Beneficiary's address
24. Beneficiary's primary and alternate phone numbers
25. Beneficiary's primary aid code history by month
26. Beneficiary'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 beneficiary 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- Covered Diagnoses

ICD-10 Code	Code Description
F10.10	Alcohol abuse, uncomplicated
F10.11	Alcohol abuse, in remission
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.130	Alcohol abuse with withdrawal, uncomplicated
F10.131	Alcohol abuse with withdrawal delirium
F10.132	Alcohol abuse with withdrawal with perceptual disturbance
F10.14	Alcohol abuse with alcohol-induced mood disorder
F10.159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10.180	Alcohol abuse with alcohol-induced anxiety disorder
F10.181	Alcohol abuse with alcohol-induced sexual dysfunction
F10.182	Alcohol abuse with alcohol-induced sleep disorder
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.20	Alcohol dependence, uncomplicated
F10.21	Alcohol dependence, in remission
F10.220	Alcohol dependence with intoxication, uncomplicated
F10.221	Alcohol dependence with intoxication delirium

ICD-10 Code	Code Description
F10.230	Alcohol dependence with withdrawal, uncomplicated
F10.231	Alcohol dependence with withdrawal delirium
F10.232	Alcohol dependence with withdrawal with perceptual disturbance
F10.24	Alcohol dependence with alcohol-induced mood disorder
F10.259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F10.26	Alcohol dependence with alcohol-induced persisting amnestic disorder
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.280	Alcohol dependence with alcohol-induced anxiety disorder
F10.281	Alcohol dependence with alcohol-induced sexual dysfunction
F10.282	Alcohol dependence with alcohol-induced sleep disorder
F10.288	Alcohol dependence with other alcohol-induced disorder
F10.99	Alcohol use, unspecified with unspecified alcohol-induced disorder
F11.10	Opioid use, uncomplicated
F11.11	Opioid use, in remission
F11.120	Opioid use with intoxication, uncomplicated
F11.121	Opioid abuse with intoxication delirium
F11.122	Opioid abuse with intoxication with perceptual disturbance
F11.13	Opioid abuse with withdrawal

ICD-10 Code	Code Description
F11.14	Opioid abuse with opioid-induced mood disorder
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.20	Opioid dependence, uncomplicated
F11.21	Opioid dependence, in remission
F11.220	Opioid dependence with intoxication, uncomplicated
F11.221	Opioid dependence with intoxication delirium
F11.222	Opioid dependence with intoxication with perceptual disturbance
F11.23	Opioid dependence with withdrawal
F11.24	Opioid dependence with opioid-induced mood disorder
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.99	Opioid use, unspecified with unspecified opioid-induced disorder
F12.10	Cannabis abuse, uncomplicated
F12.11	Cannabis abuse, in remission
F12.120	Cannabis abuse with intoxication, uncomplicated

ICD-10 Code	Code Description
F12.121	Cannabis abuse with intoxication delirium
F12.122	Cannabis abuse with intoxication with perceptual disturbance
F12.13	Cannabis abuse with withdrawal
F12.159	Cannabis abuse with psychotic disorder, unspecified
F12.180	Cannabis abuse with cannabis-induced anxiety disorder
F12.188	Cannabis abuse with other cannabis-induced disorder
F12.20	Cannabis dependence, uncomplicated
F12.21	Cannabis dependence, in remission
F12.220	Cannabis dependence with intoxication, uncomplicated
F12.221	Cannabis dependence with intoxication delirium
F12.222	Cannabis dependence with intoxication with perceptual disturbance
F12.23	Cannabis dependence with withdrawal
F12.259	Cannabis dependence with psychotic disorder, unspecified
F12.280	Cannabis dependence with cannabis-induced anxiety disorder
F12.288	Cannabis dependence with other cannabis-induced disorder
F12.99	Cannabis use, unspecified with unspecified cannabis-induced disorder
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13.11	Sedative, hypnotic or anxiolytic abuse, in remission

ICD-10 Code	Code Description
F13.120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13.121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13.130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13.131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13.132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13.14	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced mood disorder
F13.159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced psychotic disorder, unspecified
F13.180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced anxiety disorder
F13.181	Sedative, hypnotic, or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sexual dysfunction
F13.182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic, or anxiolytic-induced sleep disorder
F13.188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic, or anxiolytic-induced disorder
F13.20	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F13.21	Sedative, hypnotic or anxiolytic dependence, in remission
F13.220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13.221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13.230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13.231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium

ICD-10 Code	Code Description
F13.232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13.99	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F14.10	Cocaine abuse, uncomplicated
F14.11	Cocaine abuse, in remission
F14.120	Cocaine abuse with intoxication, uncomplicated
F14.121	Cocaine abuse with intoxication with delirium
F14.122	Cocaine abuse with intoxication with perceptual disturbance
F14.13	Cocaine abuse, unspecified with withdrawal
F14.14	Cocaine abuse with cocaine-induced mood disorder
F14.159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14.180	Cocaine abuse with cocaine-induced anxiety disorder
F14.181	Cocaine abuse with cocaine-induced sexual dysfunction
F14.182	Cocaine abuse with cocaine-induced sleep disorder
F14.188	Cocaine abuse with other cocaine-induced disorder
F14.20	Cocaine dependence, uncomplicated
F14.21	Cocaine dependence, in remission
F14.220	Cocaine dependence with intoxication, uncomplicated

ICD-10 Code	Code Description
F14.221	Cocaine dependence with intoxication delirium
F14.222	Cocaine dependence with intoxication with perceptual disturbance
F14.23	Cocaine dependence with withdrawal
F14.24	Cocaine dependence with cocaine-induced mood disorder
F14.259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14.280	Cocaine dependence with cocaine-induced anxiety disorder
F14.281	Cocaine dependence with cocaine-induced sexual dysfunction
F14.282	Cocaine dependence with cocaine-induced sleep disorder
F14.288	Cocaine dependence with other cocaine-induced disorder
F14.99	Cocaine use, unspecified with unspecified cocaine-induced disorder
F15.10	Other stimulant abuse, uncomplicated
F15.11	Other stimulant abuse, in remission
F15.120	Other stimulant abuse with intoxication, uncomplicated
F15.121	Other stimulant abuse with intoxication delirium
F15.13	Other stimulant abuse with withdrawal
F15.14	Other stimulant abuse with stimulant-induced mood disorder
F15.159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15.180	Other stimulant abuse with stimulant-induced anxiety disorder

ICD-10 Code	Code Description
F15.181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15.182	Other stimulant abuse with stimulant-induced sleep disorder
F15.188	Other stimulant abuse with other stimulant-induced disorder
F15.20	Other stimulant dependence, uncomplicated
F15.21	Other stimulant dependence, in remission
F15.220	Other stimulant dependence with intoxication, uncomplicated
F15.221	Other stimulant dependence with intoxication delirium
F15.222	Other stimulant dependence with intoxication with perceptual disturbance
F15.23	Other stimulant dependence with withdrawal
F15.24	Other stimulant dependence with stimulant-induced mood disorder
F15.259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15.280	Other stimulant dependence with stimulant-induced anxiety disorder
F15.282	Other stimulant dependence with stimulant-induced sleep disorder
F15.288	Other stimulant dependence with other stimulant-induced disorder
F15.99	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F16.10	Hallucinogen abuse, uncomplicated
F16.11	Hallucinogen abuse, in remission
F16.120	Hallucinogen abuse with intoxication, uncomplicated

ICD-10 Code	Code Description
F16.121	Hallucinogen abuse with intoxication with delirium
F16.14	Hallucinogen abuse with hallucinogen-induced mood disorder
F16.159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16.180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16.20	Hallucinogen dependence, uncomplicated
F16.21	Hallucinogen dependence, in remission
F16.220	Hallucinogen dependence with intoxication, uncomplicated
F16.221	Hallucinogen dependence with intoxication with delirium
F16.24	Hallucinogen dependence with hallucinogen-induced mood disorder
F16.259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16.280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16.99	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F18.10	Inhalant abuse, uncomplicated
F18.11	Inhalant abuse, in remission
F18.120	Inhalant abuse with intoxication, uncomplicated
F18.121	Inhalant abuse with intoxication delirium
F18.14	Inhalant abuse with inhalant-induced mood disorder
F18.159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified

ICD-10 Code	Code Description
F18.17	Inhalant abuse with inhalant-induced dementia
F18.180	Inhalant abuse with inhalant-induced anxiety disorder
F18.188	Inhalant abuse with other inhalant-induced disorder
F18.20	Inhalant dependence, uncomplicated
F18.21	Inhalant dependence, in remission
F18.220	Inhalant dependence with intoxication, uncomplicated
F18.221	Inhalant dependence with intoxication delirium
F18.24	Inhalant dependence with inhalant-induced mood disorder
F18.259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F18.27	Inhalant dependence with inhalant-induced dementia
F18.280	Inhalant dependence with inhalant-induced anxiety disorder
F18.288	Inhalant dependence with other inhalant-induced disorder
F18.99	Inhalant use, unspecified with unspecified inhalant-induced disorder
F19.10	Other psychoactive substance abuse, uncomplicated
F19.11	Other psychoactive substance abuse, in remission
F19.120	Other psychoactive substance abuse with intoxication, uncomplicated
F19.121	Other psychoactive substance abuse with intoxication delirium
F19.122	Other psychoactive substance abuse with intoxication with perceptual disturbances

ICD-10 Code	Code Description
F19.130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19.131	Other psychoactive substance abuse with withdrawal delirium
F19.132	Other psychoactive substance abuse with withdrawal with perceptual disturbance
F19.14	Other psychoactive substance abuse with psychoactive substance-induced disorder
F19.159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19.181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19.182	Other psychoactive substance abuse with psychoactive substance abuse-induced sleep disorder
F19.188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F19.20	Other psychoactive substance dependence, uncomplicated
F19.21	Other psychoactive substance dependence, in remission
F19.220	Other psychoactive substance dependence with intoxication, uncomplicated
F19.221	Other psychoactive substance dependence with intoxication delirium
F19.222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19.230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19.231	Other psychoactive substance dependence with withdrawal delirium
F19.232	Other psychoactive substance dependence with withdrawal with perceptual disturbance

ICD-10 Code	Code Description
F19.24	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19.259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19.281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19.282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19.288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder

Appendix 6- Drug Medi-Cal Delay Reason Codes (DRC)

DRC No	Requirements	Notes
1	Delay is due to a failure of the beneficiary or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary. » Provider or county must identify the beneficiary as having been Medi-Cal eligible on the date of service within one year following the end of the month in which the service was rendered. » Claims must be submitted to and received by DHCS not later than 60 days from the date the beneficiary was first identified as a Medi-Cal beneficiary. » Provider and/or county must maintain documentation of the date of service and date the beneficiary was identified as a Medi-Cal beneficiary. » Provider and/or county's documentation of date of service may include: o Medi-Cal ID card, Medi label or Proof of Eligibility label o Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage by that carrier. o Photocopy of the Medi-Cal Beneficiary Card or Medi/POE labels.	N/A
2	Delay is due to the initiation of legal proceedings to obtain payment from a liable third party pursuant to Section 14115 of the Welfare and Institutions Code. » Claims must be submitted to and received by DHCS not later than one year after the end of the month in which services were rendered.	N/A

DRC No	Requirements	Notes
4	Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, where the circumstance is either delay in the certification or recertification of the provider to participate in the DMC program by the State or delay by DHCS in enrolling a provider. » Claims must be submitted to and received by DHCS not later than one year after the end of the month in which services were rendered. » Documentation of justification for request of Good Cause must be forwarded to DHCS by the county/direct contract provider, and must include: o Date of services and insurance claims reports, newspaper clippings, photographs of damages, etc. » Documentation must be maintained by county and/or provider on site.	Delay by DHCS in certifying providers.
7	Billing involving other coverage, including but not limited to Medicare, Kaiser, Ross-Loos, or CHAMPUS. » Claims must be submitted to and received by DHCS not later than the earliest of one year after the end of the month in which services were rendered and 60 days from the data of notification that third party payment was denied. Provider and/or county must maintain documentation of the data of service and the notification of the denial of payment by the third party.	Third party processing delay.
8	Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to a delay or error in the beneficiary's Medi-Cal	N/A

DRC No	Requirements	Notes
	eligibility being determined or certified by the state or county. This also applies to retroactive Medi-Cal eligibility. » Claims must be submitted to and received by DHCS not later than one year after the end of the month in which services were rendered. » Provider and/or county must maintain documentation of the date of service and a copy of application of Medi-Cal benefits (e.g., Supplemental Security Income [SSI] or State Supplementary Payment [SSP]) and a copy of beneficiary retroactive eligibility determination.	
10	Special circumstances that cause a billing delay such as a court decision or fair hearing decision. Claims must be submitted to and received by DHCS not later than 60 days from the resolution of the circumstances justifying the delay. Provider and/or county must maintain documentation on file which includes: » Justification, cause, and reason of delay; and » Resolution of the delay, including the date of resolution.	Administrative delay in prior approval process.
11	Determined by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to: » Damage to or destruction of the provider's business office or records by a natural disaster; includes fire, flood, or earthquake, or » Circumstances resulting from such a disaster have substantially interfered with processing bills in a timely manner;	Other » Theft, sabotage (attachment required).

DRC No	Requirements	Notes
	» Theft, sabotage or other deliberate, willful acts by an employee; » Other circumstances which may be clearly beyond the provider and/or county's control and have been reported to the appropriate law enforcement or fire agency when applicable. Circumstances that *will not* be considered beyond the control of the provider, include, but are not limited to: » Negligence by employees. » Misunderstanding of or unfamiliarity with Medi-Cal regulations. » Illness or absence of any employee trained to prepare bills. » Delays caused by U.S. Postal Service or any private service. Claims must be submitted to and received by DHCS not later than one year after the end of the month in which services were rendered. » Documentation of justification for request of Good Cause must be forwarded to DHCS by the county/direct contract provider, and must include: o Date of services and insurance claims reports, newspaper clippings, photographs of damages, etc. » Documentation must be maintained by county and/or provider on site.	
15	N/A	Natural disaster.