



Drug Medi-Cal Billing Manual

Substance Use Disorder

Program, Policy, and Fiscal Division

Fiscal Management and Accountability Section

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Introduction

Introduction

This manual provides information for counties and providers contracting with the California Department of Health Care Services (DHCS) regarding the submission of claims for Drug Medi-Cal (DMC) services rendered by certified DMC providers as required by California Health and Safety Code Section 11758.46(c)(1).¹

- [Definitions of Key Terms](#)
- [About This Manual](#)
- [Program Background and Authorities](#)
- [DMC Beneficiaries](#)
- [DMC Services](#)

1.1 Definitions of Key Terms

The following terms are relevant to the information provided in this chapter and this manual:

- **County:** A county that submits DMC claims for their own DMC certified county operated programs or DMC certified county contracted programs. DHCS primarily contracts with counties (who in turn operate and/or contract with providers) for DMC services.²
- **Direct Provider (DP):** A DMC certified alcohol and other drug service provider that contracts directly with DHCS and submits DMC claims directly to DHCS.
- **Trading partners:** Counties and DPs that submit DMC claims.
- **Covered Entity:** According to the Administrative Simplification standards adopted by the U.S. Dept. of Health & Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),³ a covered entity is:⁴
 - a health care provider that conducts certain transactions in electronic form
 - a health care clearinghouse, or

¹ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46

² Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40

³ Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., 2nd sess.

⁴ 45 C.F.R., subtitle A, part 162

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- a health plan

Additional information about determining covered entity status may be found on the “Are You a Covered Entity?” page of the U.S. Dept. of Health & Human Services Centers for Medicare & Medicaid Services website.⁵

1.2 About This Manual

The objectives of the manual are to:

- Provide uniform guidance to DHCS trading partners on DMC billing procedures and requirements.
- Provide references to documents and sources containing information useful to DHCS trading partners, including:
 - Relevant California and federal laws and regulations
 - DHCS Mental Health Substance Use Disorder Services (MHSUDS) Information Notices and ADP Bulletins⁶
 - Other relevant reference documents

Scope

This manual provides information about processes and procedures related to DMC billing. For detailed information on the format and content of the electronic claims, remittance advices, status request/response transactions, and unsolicited claims status used in the DMC billing process, consult the Short Doyle Medi-Cal Phase II ADP Standard Companion Guide.⁷ Questions related to the Companion Guide should be directed to DMCSDMCII-HelpDesk@dhcs.ca.gov. The Companion Guides supplement the information in the corresponding Accredited Standards Committee (ASC) X12 Implementation Guides. The Implementation Guides may be purchased online through the X12 store⁸.

⁵ U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, “Are You a Covered Entity?” <https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html>

⁶ Cal. Dept. of Health Care Services, “MHSUDS Information Notices” <http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx>

⁷ Cal. Dept. of Health Care Services, Privacy and HIPAA, Companion Guides http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/1.03_WEDI_X12_AD_P_CG_TI_09052013_Approved_2_2.pdf

⁸ Accredited Standards Committee X12 EDI Products <http://store.x12.org/store/>

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1.3 Program Background and Authorities

Medicaid Program

Medicaid is a federal program that is funded with Title XIX and Title XXI of the Social Security Act. The program was designed to enable states to furnish medical assistance to families with dependent children, as well as aged, blind, disabled individuals who lack the financial means to meet the cost of necessary medical services, and to provide rehabilitative and other services to such families and individuals.⁹ Under Medicaid, each participating state must establish a state plan for medical assistance possessing certain mandatory features.¹⁰ The federal government pays a portion of the eligible costs of covered services (Federal Medical Assistance Percentage or FMAP) with the remainder paid by the state.¹¹ FMAP is calculated annually by state based on the *per capita* income of the state compared to that of the United States as a whole. FMAP data is provided online by the U.S. Department of Health and Human Services.¹²

California Medical Assistance Program (Medi-Cal)

Medi-Cal, administered by DHCS, includes California's participation in the federal Medicaid program.

Drug Medi-Cal

With the broader Medi-Cal program, DHCS administers the Drug Medi-Cal Program. DMC reimbursement is issued to counties and direct providers that have a contract with DHCS for approved DMC services provided to Medi-Cal beneficiaries.

Privacy, Security, and Confidentiality and DMC Beneficiary Information

The federal Public Health Service Act and related regulations provide for strict confidentiality of patient records in substance use programs, including the DMC Program, allowing disclosure only in specific circumstances and providing for criminal penalties for violations.¹³

In addition, HIPAA regulations have established rules to ensure the privacy and security of all patient medical records (not just those of patients in substance use programs).¹⁴

⁹ 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v

¹⁰ 42 U.S.C. chap. 7, subchap. XIX, §1396a(a)

¹¹ 42 U.S.C. chap. 7, subchap. XIX, §1396(b)

¹² U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm>

¹³ 42 U.S.C. §290dd-2; 42 C.F.R. part 2

¹⁴ Id. at §264; 45 C.F.R. part 164, subpart C (§164.302 *et seq.*) [security rule], and 45 C.F.R. part 164, subpart E (§164. 500 *et seq.*) [privacy rule]

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The privacy rule prohibits the use and disclosure of protected health information (PHI) by health plans, health care providers, and other covered entities except as specifically permitted.¹⁵ Also, for purposes where use or disclosure of PHI is permitted, the rule in most cases requires that the covered entity “make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose.”¹⁶

The security rule requires each covered entity to: (1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits, (2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information, and (3) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted [...] and to ensure compliance with the security rule by the entity’s workforce.¹⁷

The security rule provides a number of implementation specifications that covered entities are required to fulfill. Some require implementation; others require assessment and implementation when reasonable and appropriate for the particular environment, or adoption of an equivalent alternative measure if one exists, plus documentation of the reasons why it is not reasonable and appropriate.¹⁸

Additional information and resources regarding HIPAA rules is available from DHCS's “Privacy and HIPAA” web page.¹⁹

Health Care Transactions and Code Sets

HIPAA regulations also require that every covered entity that performs business transactions electronically must use specified standard transactions, code sets, and identifiers.²⁰ The transactions that DHCS, in the DMC Program, conduct electronically are:

- Professional health care claims: ASC X12 837P - Health Care Claim: Professional, Version 5010, January 2012, Washington Publishing Company.²¹ This is the electronic claim file that the trading partner submits to the Short Doyle Medi-Cal (SDMC) system via Information Technology Web Services (ITWS).
- Institutional health care claims: ASC X12 837I – Health Care Claim: Institutional, Version 5010, January 2012, Washington Publishing Company.²² This is the

¹⁵ 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(a)

¹⁶ 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(b)(1)

¹⁷ 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(a)

¹⁸ 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(d)

¹⁹ Cal. Dept. of Health Care Services, “Privacy and HIPAA,” <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx>

²⁰ 45 C.F.R., subtitle A, vol. 1, part 162, §162.923

²¹ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1102(b)(3)

²² 45 C.F.R., subtitle A, vol. 1, part 162, §162.1102(b)(4)

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electronic claim file used by counties to submit institutional claims to the SDMC system via ITWS.

- Health Care Remittance Advice: The ASC X12 835 - Health Care Claim Payment/Advice, Version 5010, January 2012, Washington Publishing Company.²³ This is the electronic claim file that provides trading partners information about the payment or denial of claims.
- Health Care Claim Status: ASC X12 276/277 - Health Care Claim Status Request and Response, Version 5010, January 2012, Washington Publishing Company.²⁴ This is the electronic request for DMC claim status and the responses to such requests.
- 277 PSI: Production Status Information (unsolicited). This is automatically generated by the SDMC system.
- 999: This is a functional acknowledgement that is generated in response to transactions from the trading partners.
- TA1: This is an interchange acknowledgement that the electronic file was accepted or rejected by the SDMC system.
- SR Report: This is an error report.

Each standard transaction identifies the code sets used in the transaction. The Healthcare Common Procedure Coding System (HCPCS) are used to identify clinical procedures,²⁵ and the International Classification of Disease, 10th Revision (ICD-10) Clinical Modification and Procedure Coding System²⁶ are used to identify diagnoses. Services rendered prior to October 1, 2015 should use ICD-9 code sets.

Standard identifiers are used to identify individuals or organizations on standard transactions. The two standard identifiers mandated under HIPAA rules are the National Provider Identifier (NPI) as the standard unique health identifier for health care providers²⁷ and the Employer ID Number (EIN)²⁸ as the standard unique employer identifier.²⁹ The use of these identifiers in standard transactions is mandatory. Entities entering into DMC contracts with DHCS must have an EIN and all DMC-certified

²³ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1602(b)

²⁴ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1402(b)

²⁵ U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, "HCPCS General Information", <http://www.cms.hhs.gov/MedHCPCSGenInfo>

²⁶ 45 C.F.R., subtitle A, vol. 1, part 160 and 162

²⁷ 45 C.F.R., subtitle A, vol. 1, part 162, §162.406

²⁸ Also known as the Federal Tax Identification Number, see U.S. Department of the Treasury, Internal Revenue Service. "Employer ID Numbers (EINs)," <http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Employer-ID-Numbers-EINs>.

²⁹ 45 C.F.R., subtitle A, vol. 1, part 162, §162.605

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providers must have an NPI for each certified location. Individual service providers such as counselors who are identified on standard transactions (for example as rendering providers) must also have NPIs. Both EINs and NPIs must be provided to DHCS.

1.4 DMC Beneficiaries

Beneficiaries who are eligible for DMC services include beneficiaries eligible for federal Medicaid, for whom services are reimbursed from federal, state, and/or county realignment funds.

DMC eligible beneficiaries are assigned aid codes based on the program(s) which they have established eligibility.³⁰

Aid Codes

The DHCS Master Aid Code Chart is located on the DHCS website and provides useful information including:³¹

- Aid Code and description
- Type of benefits
- Share of Cost, if any
- Federal Financial Participation (FFP) type

1.5 DMC Services – State Plan

The following services may be reimbursed from DMC funds when provided in accordance with the laws and regulations governing the DMC Program.

Narcotic Treatment Program (NTP) Services

Narcotic treatment program services includes intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, medication services, and the provision of methadone and/or levoalphacetyl-methadol (LAAM), as prescribed by a physician to alleviate the symptoms of withdrawal from opiates. LAAM, however, formerly available in the United States under the brand name ORLAAM®, has been withdrawn from the market by the manufacturer and is not currently produced in or

³⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2, part. 5 (§50201 *et seq.*)

³¹ Cal. Dept. of Health Care Services, Master Aid Code Chart, <http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>

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imported into the United States.³² NTP services must be rendered in accordance with the requirements set forth in Chapter 4 commencing with Section 10000 of Title 9, CCR.³³

Effective January 1, 2014, 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 (in ten minute increments). Medical justification for the additional counseling must be clearly documented in the patient record. Trading partners may bill for a date range to account for multiple service units. Effective January 1, 2015, group size shall be limited to no less than two and no more than twelve beneficiaries at the same time.

Outpatient Drug Free (ODF) Services

Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within their scope of practice or licensure.³⁴

ODF Group Counseling

Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month unless waived by a physician.³⁵ Groups shall be conducted with no less than two and no more than twelve beneficiaries at the same time. Ninety minutes equals one unit of service. Fractional units of service are not allowed. Trading Partners should pro-rate the cost of service, not the units. Trading Partners must have a mechanism in place to track and report actual units of service (UOS), and number of minutes by modality.

ODF Individual Counseling

Individual counseling shall be limited to intake, crisis intervention, collateral services, and treatment and discharge planning.³⁶ Fifty minutes equals one unit of service. Fractional units of service are not allowed. Trading Partners should pro-rate the cost of the service, not the units. Trading Partners must have a mechanism in place to track and report actual units of service (UOS), and number of minutes by modality.

³² U.S. Food and Drug Administration, <http://www.fda.gov>

³³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(1)

³⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(2)

³⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(2)(A)

³⁶ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(2)(B)

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Intensive Outpatient Treatment

Intensive outpatient treatment (IOT), formally called day care habilitative services, includes intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within their scope of practice or licensure. IOT services shall be provided to any DMC eligible beneficiaries at least three (3) hours per day, three (3) days per week. Effective January 1, 2015, group size shall be limited to no less than two and no more than twelve beneficiaries at the same time. The service shall consist of regularly assigned, structured, and supervised treatment.³⁷

Perinatal Residential Services

Perinatal residential substance abuse services includes intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide and/or order these services within their scope of practice or licensure.³⁸ Perinatal residential substance abuse services shall be provided in a residential facility licensed by DHCS, pursuant to Chapter 5. Services are reimbursable only when provided in a facility with a treatment capacity of sixteen beds or less, not including beds occupied by children of the residents. Room and board is not reimbursable under the DMC Program.

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

Federal EPSDT statutes and regulations require States to furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.³⁹ SUD services are outlined in California's Medicaid State Plan and are available to children and youth as medically necessary.⁴⁰ Effective July 1, 2017, trading partners may bill residential services for EPSDT beneficiaries by using the same billing codes as are currently used for perinatal residential services except the "HD" modifier should be removed for EPSDT non-perinatal residential claims.

³⁷ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1; note that Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(a)(2) uses the term *rehabilitative* rather than *habilitative*.

³⁸ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(4)

³⁹ 42 U.S.C. section 1396a(a) (43) and 42 U.S.C. section 1396d(r)

⁴⁰ Medicaid State Plan, Attachment 3.1-A, Section 13.d, and Attachment 3.1-B, Section 13.d

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Naltrexone Treatment Services

Naltrexone treatment services including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance abuse, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within their scope of practice or licensure.⁴¹ These services are only reimbursable under the DMC Program for a beneficiary who has a confirmed, documented history of opiate addiction; is at least 18 years of age; is opiate free; and is not pregnant.

1.6 Drug Medi-Cal Reimbursement Rates

The maximum reimbursement rates for each type of DMC service are set annually by DHCS and disseminated in DHCS MHSUDS Information Notices.⁴² The statewide maximum allowance (SMA) for non-NTP services and uniform statewide daily reimbursement (USDR) for NTP services are developed in accordance with California Welfare and Institutions Code Section 14021.6 and Health and Safety Code Section 11758.42.⁴³

Reimbursements for non-NTP DMC services are settled to the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the SMA for the services provided.

Reimbursements for NTP DMC services are settled to the lesser of the USDR for the services provided or the provider's usual and customary charge to the general public for similar services.⁴⁴

1.7 County Administrative Costs

In order to comply with instructions from the Centers for Medicare and Medicaid Services, California changed its process of paying counties for their administration of DMC services. For DMC claims with service dates on or after July 1, 2014, DHCS must reimburse counties via the DMC reimbursement rate for only the certified total direct service expense, and reimburse counties for DMC county administrative expenses through a separate invoicing process as outlined in MHSUDS Information Notice 14-033.⁴⁵

⁴¹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1(d)(5)

⁴² Cal. Dept. of Health Care Services, "MHSUDS Information Notices"
<http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx>

⁴³ Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, part. 1, §14021.6; Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.42

⁴⁴ Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 7, §51516.1(a); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(h)(1)

⁴⁵ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 14-033"
http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/Information_Notices/14-033.pdf

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1.8 Drug Medi-Cal Monitoring

Pursuant to federal and state law and regulation requiring utilization reviews and controls for Medicaid/Medi-Cal services,⁴⁶ DHCS conducts postservice prepayment reviews, referred to as Drug Medi-Cal monitoring reviews (DMCM), and postservice postpayment (PSPP) utilization reviews at DMC provider sites to determine compliance with standards of care and other DMC requirements. DMCM and PSPP reviews provide quality assurance and accountability for DMC services, assist counties and providers in identifying and resolving compliance issues, and provide opportunities for training and technical assistance to counties and providers.

At the conclusion of each DMCM and PSPP review, DHCS issues a written report detailing any deficiencies found, PSPP reports identify recovery for any payments made for units of service which are found to be out of compliance. The state-county contract or state-direct provider contract outlines the corrective action plan process.

Additional information about PSPP reviews can be found on DHCS's "Drug Medi-Cal Monitoring" web page or trading partners may contact DMCAnswers@dhcs.ca.gov.⁴⁷

⁴⁶ 42 U.S.C., chap. 7, subchap. XIX, §1396(a)(30)-(33); 42 C.F.R., vol. 4, Chapter 4, §456.2–456.6; 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1

⁴⁷ Cal. Dept. of Health Care Services, Drug Medi-Cal, "DMC Provider Resource Tool-Kit Monitoring," http://www.dhcs.ca.gov/services/adp/Pages/dmc_drug_medical_monitoring.aspx

Getting Started

Introduction

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

- [Certification and Licensure of DMC Providers](#)
- [Alcohol and Drug Counselor Certification](#)
- [Getting Started Once DMC Certified](#)
- [Submission and Receipt of Claims Information](#)
- [Getting Help](#)

2.1 Certification and Licensure of DMC Providers

The Provider Enrollment Division (PED) is responsible for the receipt, review, and approval of all DMC certification applications.

DMC Certification Requirement

In order to provide DMC 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 services for pregnant and postpartum women.⁴⁸ For more specific certification information, contact PED by email, DHCSDMCRecert@dhcs.ca.gov, or by phone, (916) 323-1945.⁴⁹

If an existing DMC certified provider intends to relocate and/or provide other DMC services not currently certified for, the provider must be certified for the new location and/or services to provide services that are eligible for DMC reimbursement. DMC services are only allowed/effective from the certification date for the specific change. Additionally, DHCS requires that DMC providers complete a recertification process every five years in order to maintain their DMC certification.

Applicants submitting a DMC certification application must submit a letter to the SUD Program Administrator of the county in which the clinic will be located informing the county that they are submitting an application. A copy of such letter must be included in the DMC application.

⁴⁸ 22 Cal. Code Regs., div. 3, subdiv. 1, ch. 3, part 4, § 51341.1(c) regarding DMC services for pregnant and postpartum women

⁴⁹ Cal. Dept. of Health Care Services, Provider Enrollment Division
<http://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>

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Prospective applicants for DMC certification are encouraged to watch a webinar provided by DHCS that explains the requirements of the application process and the procedures once a provider is DMC certified. The session also serves as a source of technical assistance through the application process. The webinar is located on the DHCS PED website in the video gallery.⁵⁰ In order to bill and receive reimbursement for DMC services,⁵¹ the DMC certified providers must have a contract either with the county of where the provider site is located, or directly with DHCS.

Obtain National Provider Identifiers (NPIs)

All DMC providers are required to obtain a National Provider Identifier (NPI). The NPI should be identified in the DMC application. Federal HIPAA regulations require that individual health care providers and organizations obtain NPIs. Information on requesting an NPI can be found at the National Plan and Provider Enumeration System (NPPES) website.⁵² Counselors at DMC-certified providers are required to obtain a rendering provider NPI.

Mandatory Licensing of Narcotic Treatment or Residential Facilities

Any narcotic treatment program or any facility which is maintained and operated to provide 24-hour, residential, non-medical, alcoholism or drug use recovery or treatment services to adults must be licensed by DHCS.⁵³ Contact the Substance Use Disorder Compliance Division (SUD-CD) for information regarding narcotic treatment program or residential facility licensing.

Email: DHCSNTP@dhcs.ca.gov

Phone: (916) 322-6682

Fax: (916) 440-5230

Voluntary Alcohol and Other Drug Certification

DHCS offers a voluntary alcohol and other drug (AOD) facility certification to programs that provide the following services: day treatment, outpatient, and nonresidential detoxification. The AOD certification is granted to programs that exceed minimum levels of quality service and are in substantial compliance with state program standards, specifically the alcohol and/or other drug certification standards. Certification is available to both residential and nonresidential programs. The majority of facilities licensed by DHCS are also AOD certified. Obtaining certification is considered advantageous in gaining the confidence of both potential residents and third party

⁵⁰ Cal. Dept. of Health Care Services, Provider Enrollment Division, Drug Medi-Cal Training Presentation
<http://www.dhcs.ca.gov/formsandpubs/Pages/DHCSVideos.aspx>

⁵¹ 22 Cal. Code Regs., div. 3, subdiv. 1, ch. 3, part. 1 §51000.30; 22 Cal. Code Regs., div. 3, subdiv. 1, ch. 3, part. 3, §51200

⁵² National Plan and Provider Enumeration System <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

⁵³ Cal. Health & Safety Code §§ 11834.01–11834.02, 11834.30; 9 Cal. Code Regs., div. 4, ch. 5, subchap. 1, part. 2, §10501(a)(27)

Getting Started

payers. Providers seeking information on AOD certification should contact the SUD-CD at (916) 322-2911.

AOD Licensing and AOD Certification Documents and Forms

AOD License and AOD certification forms and related documents are available from DHCS Complaints, Licensing & Certification Branch website.⁵⁴

2.2 Alcohol and Drug Counselor Certification

Regulations governing certification of AOD counselors⁵⁵ require that by October 1, 2005, or within six (6) months of the date of hire, whichever is later, all non-licensed or non-certified individuals providing counseling services in an AOD program shall be registered to obtain certification as an AOD counselor by a certifying organization approved by DHCS to register and certify AOD counselors. Registrants shall complete certification as an AOD counselor within five (5) years of the date of registration. The certifying organization may allow up to two (2) years additional time for a leave of absence due to a medical problem or other hardship, consistent with the policy developed by the certifying organization.

These regulations also impose continuing education requirements on licensed and certified AOD counselors.⁵⁶ Contact SUD-CD for information regarding counselor certification requirements.

2.3 Getting Started Once DMC Certified

In order to provide, bill, and receive reimbursement for DMC services, providers must complete several items.

Contracts with DHCS

A county must have a signed contract with DHCS to receive DMC reimbursement for their county operated DMC certified providers or their county contracted DMC certified providers.⁵⁷

DHCS DMC certified providers must have either a signed, approved contract with their county or a signed, approved contract with DHCS to provide, bill, and receive reimbursement for DMC services.⁵⁸

⁵⁴ Cal. Dept. of Health Care Services, Licensing and Certification Branch

<https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Licensing.aspx>

⁵⁵ 9 Cal. Code Regs., div. 4, ch. 8 (§ 13000 *et seq.*)

⁵⁶ 9 Cal. Code Regs., div. 4, ch 8, §§ 13015, 13055

⁵⁷ Cal. Health & Safety Code, div. 10.5, ch. 3, §11758.20; Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40

⁵⁸ Cal. Health & Safety Code, div. 10.5, ch. 3.4, §11758.46(g)(1)-(2)

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California Outcomes Measurement System (CalOMS) and DMC Number

As part of the DHCS DMC certification process, each DMC certified provider is assigned a provider number for reporting CalOMS data and also a DMC number. The CalOMS number is a six-digit number (the two-digit county code and a four-digit number assigned by DHCS). CalOMS Treatment is a statewide beneficiary-based data collection and outcomes measurement system.⁵⁹ All publicly or privately funded drug treatment programs are required to submit CalOMS data to DHCS.

The DMC number is a four-digit number assigned by DHCS, and is used by DHCS for internal purposes.

Requesting a Provider Identification Number (PIN)

All DMC providers are issued an eight-digit provider identification number (PIN) by Xerox, in order to verify a beneficiary's eligibility status through the automated eligibility system.

Any certified DMC provider that has not yet received a PIN may request one by submitting a written request and faxing it to (916) 322-1176 or mailing it to:

Department of Health Care Services
Fiscal Management and Accountability Section
P.O. Box 997413
Sacramento, CA 95899-7413

Requesting a Temporary PIN

Temporary PINs are available for providers who do not yet have a permanent PIN or have misplaced their permanent PIN, and are only valid until midnight on the day of issuance.

Temporary PINs can only be used on the Supplemental Automated Eligibility Verification System (SAEVS) by calling (800) 427-1295 to verify eligibility and perform Share of Cost (SOC) transactions. To request a temporary PIN, call the Point of Service (POS) Help Desk at (800) 541-5555.

2.4 Submission and Receipt of Claims Information

All DMC claim submissions, claim status requests, solicited and unsolicited claim status information, and remittance advices are exchanged between DMC trading partners and DHCS through the ITWS portal operated by DHCS using the transactions described in Chapter 1 Section 1.3.

⁵⁹ Cal. Dept. of Health Care Services "CalOMS Treatment," <http://www.dhcs.ca.gov/provgovpart/Pages/CalOMS-Treatment.aspx>

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Each organization (DMC trading partner or vendor authorized on behalf of a DMC trading partner) using the ITWS for DMC billing purposes must designate approvers for ITWS, who are persons authorized to approve ITWS enrollment requests for staff members of that organization. Vendors authorized on behalf of a DMC trading partner must be designated as such on the trading partner's approver certification prior to designating their own approvers. Approver certification forms are available on ITWS.⁶⁰

Once the organization has designated approvers for the ITWS, users who will access the ITWS must enroll (staff must enroll as users to have access to the ITWS even if they are already designated as approvers.) ITWS is a collection of web applications maintained by DHCS that allow trading partners to access information securely over the Internet. Requests for access to specific areas of ITWS are approved by approvers appointed by each county director.

Appendix B of this manual provides step-by-step details on ITWS enrollment. For further information contact DHCS's Fiscal Management and Accountability Section (FMAS) at (916) 323-2043.

2.5 Getting Help

DHCS Website

The DHCS website can answer many questions, and trading partners are encouraged to use it as a primary resource.⁶¹

For unresolved billing issues, trading partners should contact DMCSDMCII-HelpDesk@dhcs.ca.gov.

⁶⁰ Cal. Dept. of Health Care Services ITWS, "DHCS Approver Certification Forms," https://itws.dhcs.ca.gov/docs/public/authforms_adp.asp

⁶¹ Cal. Dept. of Health Care Services, <http://www.dhcs.ca.gov>

Beneficiary Eligibility

Introduction

This chapter includes information about the Medi-Cal eligibility and beneficiary financial liability. It includes:

- [Beneficiary Medi-Cal Eligibility](#)
- [Identity and Eligibility Verification Requirements](#)
- [Medi-Cal Eligibility Verification Systems](#)
- [Technical Assistance For Medi-Cal Eligibility Verification Systems](#)

3.1 Beneficiary Medi-Cal Eligibility

The following sections describe Medi-Cal eligibility determination and Medi-Cal identity and eligibility verification requirements.

Eligibility Determination

The determination and collection of beneficiary eligibility data typically lies with the county welfare department. Procedures for determining Medi-Cal eligibility are the responsibility of DHCS. Detailed information regarding eligibility criteria may be obtained through the DHCS website.⁶²

Some helpful Medi-Cal eligibility concepts include:

- Beneficiary Medi-Cal eligibility data should be verified at least monthly.
- Some Medi-Cal beneficiaries must meet a specified share of cost (SOC) for medical expenses before Medi-Cal will pay claims for services provided in that month.⁶³ SOC is determined by the county welfare department and is based on the beneficiary's or family's income and living arrangement. Members of the family may have the same or different share of cost amounts. The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.⁶⁴
- Verification of beneficiary Medi-Cal eligibility is often reviewed by external auditors after the claimed month of service. For this reason, trading partners must maintain proof of beneficiary Medi-Cal eligibility in their records.

⁶² Cal. Dept. of Health Care Services, "Providers & Partners,"

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-Cal%20Eligibility%20Division.aspx>

⁶³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2

⁶⁴ Cal. Dept. of Alcohol and Drug Programs, "ADP Bulletin 99-39,"

http://www.dhcs.ca.gov/formsandpubs/ADPBulletins/ADP_Bulletins_1999/ADP_99-39.pdf

Beneficiary Eligibility

- Medi-Cal eligibility may be established retroactively through decisions resulting from court or administrative hearings.

3.2 Identity and Eligibility Verification Requirements

Medi-Cal Identification Cards

All Medi-Cal beneficiaries have identification cards. DHCS issues a plastic Benefits Identification Card (BIC) to each Medi-Cal beneficiary. In exceptional situations, county welfare departments may issue temporary paper identification cards for Immediate Need and Minor Consent program beneficiaries.⁶⁵

All DMC claims must be submitted using the beneficiary's ID number as listed on the beneficiary's BIC or paper Medi-Cal ID card.

Mere possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month.

Good Faith Effort to Verify Identity

It is the provider's responsibility to verify that the person is the individual to whom the BIC was issued. Identification verification should be performed prior to rendering service.

If a recipient is unknown, the provider must make a good faith effort to verify the recipient's identification before rendering Medi-Cal services. *Good faith effort* means verifying the recipient's identification by matching the name and signature on the BIC against the signature on a valid California driver's license, a California identification card issued by the Department of Motor Vehicles, another acceptable picture ID card, or other credible document of identification.⁶⁶

Eligibility Review

Programs that provide DMC services are responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service.

⁶⁵ Cal. Welf. & Ins. Code, Div. 9, Part 3, Chap. 7, Art. 1.3, §§14043–14045;

Cal. Dept. of Alcohol and Drug Programs, Bulletin 08-01,
http://www.dhcs.ca.gov/formsandpubs/ADPBulletins/ADP_Bulletins_2008/ADP_Bulletin_08-01.pdf

⁶⁶ Cal. Dept. of Health Care Services, "Eligibility: Recipient Identification Cards," Dec. 2006,
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/eligreccrd_z01.doc

Beneficiary Eligibility

To verify the Medi-Cal eligibility of a beneficiary, the DMC provider must first have an eight-digit Provider Identification Number (PIN). Refer to Chapter 2, section 2.3 of this manual for details.

3.3 Medi-Cal Eligibility Verification Systems

The three options for verifying the eligibility of a Medi-Cal beneficiary are described in the following sections.

Automated Eligibility Verification System (AEVS)

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers having a valid PIN to access recipient eligibility via a touch-tone telephone. User instructions and other information regarding the AEVS are available in the *DHCS AEVS User Guide*.⁶⁷ Providers should document and retain the Eligibility Verification Confirmation returned by AEVS in the beneficiary's file to document eligibility verification.

Point of Service (POS) Device

The POS device is an automated transaction device that allows checking eligibility by swiping the beneficiary's BIC or by manually entering information. Instructions are in the *POS Device User Guide* that you receive with your POS device.

The POS device can perform additional functions besides eligibility verification, some of which (such as claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

A POS device may be requested by completing the following forms:

1. Medi-Cal Eligibility Verification Enrollment Form⁶⁸
2. POS Device Usage Agreement⁶⁸
3. Medi-Cal Point of Service Network/Internet Agreement⁶⁹

Mail all three forms to:

POS Help Desk

⁶⁷ Cal. Dept. of Health Care Services, Medi-Cal, AEVS User Guide, <http://files.medi-cal.ca.gov/pubsdoco/userguides.asp>.

⁶⁸ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Eligibility Verification Enrollment Form, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrms_z01.doc

⁶⁸ Cal. Dept. of Health Care Services, Medi-Cal, POS Device Usage Agreement, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrm2dev_z01.doc

⁶⁹ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal POS Network/Internet Agreement, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/pointfrm1net_z01.doc

Beneficiary Eligibility

3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

Transaction Services on the DHCS Medi-Cal Website

Medi-Cal Transaction Services allow Medi-Cal providers to perform a variety of secure transactions over the internet, including eligibility verification. Additional information about the Medi-Cal Transaction Services system, including the required forms and usage information, is available in the DHCS Medi-Cal Website Quick Start Guide.⁷⁰ Note that Medi-Cal Transaction Services system can perform additional functions besides eligibility verification, some of which (notably, claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

3.4 Technical Assistance for Medi-Cal Eligibility Verification Systems

If you have questions regarding the AEVS or the interpretation of AEVS and POS return codes and messages, contact the Telephone Service Center (TSC) at (800) 541-5555. For faster access to resources, refer to the Main Menu Prompt Options Guide⁷¹ and the TSC Specialized Operator Reference Guide.⁷²

If you need assistance using the POS device or have questions regarding the shipment of a POS device or other materials, contact the POS Help Desk at (800) 541-5555.

You may need to provide the operator your NPI, a PIN, and the fact that your NPI is certified by DHCS in the SDMC system as an Other Intermediary 02. Help desk operators will provide a work request number as well as their names. Please retain this information until the issue is resolved.

If further assistance is needed, please send details to:

POS Help Desk
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

⁷⁰ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Website Quick Start Guide, <http://www.medi-cal.ca.gov/pubs/quickstart.htm>

⁷¹ Cal. Dept. of Health Care Services, Medi-Cal, Telephone Service Center, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrelfrm1ref_z01.pdf.

⁷² Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Specialized Operator Reference Guide, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrelfrm2_z01.pdf

Claims Processing Overview

Introduction

This chapter provides an overview to claims processing and includes:

- [Claim Submission Requirements](#)
- [Transaction Sets used in DMC Billing](#)
- [Claims Processing Overview](#)

4.1 Claim Submission Requirements and Timelines

Claim Submission Timeline—Original Claims

An original claim must be received by DHCS not later than six months after the end of the month in which the service was provided, unless the provider has good cause for late claim submission.⁷³

If a claim is submitted later than six months after the end of the month in which service was provided, the provider must have good cause for the late submission. If the reason meets the criteria for Delay Reason Codes 4, 8, or 11, the county or direct contract provider must prepare a Good Cause Certification form and must include the appropriate delay reason code in the claim.⁷⁴ For Delay Reason Codes 4 and 11, pre-approval by DHCS is required prior to submitting form DHCS 6065A.⁷⁵ For Delay Reason Code 8, for which pre-approval is not required, form DHCS 6065B⁷⁶ must be submitted. Delay Reason Codes are used to document the reason that a DMC claim was submitted beyond the deadline of six months after the end of the month the service was provided.

Technical information on the use of Delay Reason Codes in claims is included in the Short-Doyle Medi-Cal Phase II ADP Standard Companion Guide Transaction Information.⁷⁷

⁷³ Cal. Dept. of Health Care Services, “MHSUDS Information Notices” , Issue No. 18-004
https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Info_Notice_18-004-Implementation_of_AB_395_for_NTPs.pdf

⁷⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5

⁷⁵ Cal. Dept. of Health Care Services, Good Cause Certification form 6065A,
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁷⁶ Cal. Dept. of Health Care Services, Good Cause Certification form 6065B,
<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁷⁷ Cal. Dept. of Health Care Services, Companion Guide
http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/1.03_WEDI_X12_AD_P_CG_TI_09052013_Approved_2_2.pdf

Claims Processing Overview

Claim Submission Timeline—Replacement Claims

A Replacement claim must be submitted not later than six months after the date the replaced claim was finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835)⁷⁸. Extensions will not be granted.

Claim Certification Requirements

All claims submitted to DHCS must be supported by a signed certification by the provider. The detailed requirements for the certification vary by the type of contract each provider has.

Claim Certification for Direct Contract Providers

Direct contract providers are required to fax or mail a copy of a signed DMC Claim Submission Certification form (DHCS 100185)⁷⁹ to the Fiscal Management and Accountability Section (FMAS). A separate DMC Claim Submission Certification form must be submitted for each EDI file. Claims cannot be paid until DHCS has a properly completed DMC Claim Submission Certification form on file.

Claim Certification for County Contracted Providers

County contract providers are required to submit a signed DMC Claim Submission Certification form (DHCS 100186)⁸⁰ for each DMC submission provided to the county for processing. The county must have, and complete the County Use portion of, a completed DMC Claim Submission Certification form certifying the claims for each county contracted provider prior to submitting an EDI file to DHCS for adjudication. The forms shall be retained by the county and made available to DHCS on demand.

Claim Certification for County Operated Providers

For each EDI file submitted that contains claim file information for county operated providers, the county is required to complete a DMC Claim Submission certification form (DHCS 100187)⁸¹ certifying all claims within the file submitted for county operate providers. This form must be completed prior to submitting the EDI file to DHCS. The form shall be retained by the county and made available to DHCS on demand.

⁷⁸ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 6, §51008.5

⁷⁹ Cal. Dept. of Health Care Services, Claim Certification form for Direct Providers, <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁸⁰ Cal. Dept. of Health Care Services, Claim Certification form for County Contracted Providers, <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁸¹ Cal. Dept. of Health Care Services, Claim Certification form for County Operated Providers, <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

Claims Processing Overview

Drug Medi-Cal Certification for Federal Reimbursement

For each EDI file submitted, the trading partner is required to submit a Certified Public Expenditure (CPE) form (DHCS 100224A)⁸² attesting that the total-funds (total computable) amount of its claimed expenditures are eligible for FFP. The certification must reflect the payment by the public agency to the contracted provider for DMC services provided to Medi-Cal beneficiaries. The certified amount should reflect either; the approved amount of the electronic claim file after the claim has been adjudicated; or the claimed amount identified on the electronic claim file which could account for both approved and denied claims. A county may only certify its total-funds expenditures for DMC services provided by private entities in the amount the county has actually paid the private entity for DMC services, and that the counties can appropriately document as having been provided. CPE's must be supported by auditable documentation that identifies the relevant category of expenditure under the state plan, and demonstrates the actual expenditures incurred by the county in providing services to Medi-Cal beneficiaries⁸³.

4.2 Transaction Sets Used in DMC Billing

The HIPAA-mandated transaction standards used by DHCS in DMC billing are identified in Section 1.3 of this manual, "Health Care Transactions and Code Sets".

All transactions submitted by or returned to trading partners are transferred via the ITWS system, as described in Section 2.4 of this manual.

Health Care Claims Transactions

There are three types of claims that may be submitted to DHCS using the 837P or 837I transaction set:

- Original claims are claims submitted for the first time (never adjudicated). If an error is received in response to the HIPAA validation process, submitter may submit a subsequent claim correcting the errors detailed in the Implementation Acknowledgements 999.
- Replacement claims are requests to treat a previously finalized claim as null and void, and to adjudicate a corrected claim in place of the prior claim, retaining the original submission date of the replaced claim.
- Void claims are requests to treat a previously finalized claim as null and void.

⁸² Cal. Dept. of Health Care Services, Claim Certification for Federal Reimbursement, <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁸³ Cal. Dept. of Health Care Services, "MHSUDS Information Notices" , Issue No. 15-019 <http://www.dhcs.ca.gov/formsandpubs/ADPBulletins/MHSUDS%20Information%20Notice%2015-019.pdf>

Claims Processing Overview

Void Claims

Trading partners should submit a void claim when they have identified that a claim that was previously finalized should not have been billed to DMC. Once a claim has been voided, it cannot be voided again, nor can it be replaced.

If some claim information is inaccurate, but the claim should still have been billed, do not void the claim but instead submit a replacement claim (see next section).

Guidelines on voiding claims and void scenarios are provided in the Short-Doyle Medi-Cal Phase II ADP Standard Companion Guide Transaction Information.⁸⁴

Replacement Claims

A Replacement Claim allows trading partners to replace a previously finalized 837P or 837I claim.

Trading partners should replace claims when they have identified that either:

- The previously-submitted claim was submitted with incorrect information, or
- Service lines were erroneously included in or omitted from the claim.

Guidelines on replacement claims and replacement scenarios are provided in the Short-Doyle Medi-Cal Phase II ADP Standard Companion Guide Transaction Information.⁸⁵

4.3 Claims Processing Overview

DMC Claims Submission and Adjudication

1. Trading partner prepares claim file and supporting documentation.
 - a. Trading partner prepares file containing 837P or 837I transaction sets with DMC claims.
 - b. Responsible trading partner officials must complete DMC Claims Submission Certification Form described in Section 4.1.
 - c. If any claims submitted in the file include delay reason codes, a Good Cause Certification form (DHCS 6065A or DHCS 6065B) is prepared to support the use of the delay reason codes.

⁸⁴ Cal. Dept. of Health Care Services, Companion Guide
http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/1.03_WEDI_X12_AD_P_CG_TI_09052013_Approved_2_2.pdf

⁸⁵ Cal. Dept. of Health Care Services, Companion Guide
http://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/1.03_WEDI_X12_AD_P_CG_TI_09052013_Approved_2_2.pdf

Claims Processing Overview

- d. If any claims submitted in the file include requests for manual eligibility override, supporting documentation for those manual overrides is assembled and prepared.
2. Trading partner submits claim file and supporting documentation to DHCS.
 - a. Trading partner submits file containing 837P or 837I transaction sets via ITWS.
 - b. Direct contract providers submit DMC Claim Submission Certification form to DHCS.
 - c. If any claims submitted in the file include the use of delay reason codes 4, 8, and 11, submission, by fax, of DHCS 6065A or DHCS 6065B is required. For delay reason codes 4 or 11, pre-approval from DHCS is required prior to submitting the DHCS 6065A. Trading partner submits documentation supporting the use of those delay reason codes to DHCS. Additional information on Good Cause Certification for use of delay reason codes is found in Section 6.6 of this manual.
 - d. If any claims submitted in the file include requests for manual eligibility overrides, trading partner submits documentation supporting eligibility of the beneficiaries for whom manual overrides are requested to DHCS.
3. When SDMC receives the file from ITWS, the SDMC system validates that the file received is a validly-formatted file. The SDMC system will produce and post a file containing a TA1 and SR Report for every functional group identified in the submitted file, acknowledging the receipt of the functional group and identifying any syntactic errors identified in it.
4. DHCS will await receipt of the appropriate certification documents for any claims requiring certification of manual eligibility overrides.
5. Claims requiring certification of manual eligibility overrides will be released by DHCS when the corresponding certification and support documentation has been reviewed and approved.
6. Claims that do not require delay reason certification or manual eligibility override, or which do require either or both of those and have had the required certification reviewed by DHCS, will be adjudicated by the SDMC system.
7. After adjudication, any claims which do not require payment or recovery processing by DHCS (denied original claims, and void and replacement claims for which no prior claim was located) will be reported on 835 transaction sets made available to trading partners via ITWS, while those claims that require payment or recovery processing prior to finalization will have their status reported on 277PSI.
8. After adjudication, all claim information is transmitted to the SMART system by the SDMC system.
9. When the SMART system receives claim information from the SDMC system, any claims requiring payment or recovery processing will be identified.

Claims Processing Overview

DHCS Claim Payment and Recovery Processing

1. In each weekly payment processing cycle, DHCS reviews all claims requiring payment or recovery that has not yet been taken. CPE is required from counties and direct providers in order to process payment. If the Direct Provider certification form or the CPE is not received, claims will be deferred and not processed for payment.
2. For each claim requiring a payment that cannot be made in full because of an insufficient contract balance, a payment hold, or other reason, the non-payable amount is identified as deferred; if no payment amount has been identified for the claim, the deferral of the entire payment will be transmitted to SDMC to be reported on an 835 if it was not previously reported as such. If a payment has been identified for this claim, the deferred amount will be reported along with the payment amount once the payment has been issued.
3. For each claim requiring a payment which can be made in part or in full, a payment request is automatically generated for DHCS's Accounting Unit.
4. For each claim requiring a recovery, a recovery request is automatically generated for DHCS's Accounting Unit.
5. DHCS's Accounting Unit will prepare payment schedules for all payment requests, offsetting against any outstanding recovery requests for the same trading partner; if the recoveries for a trading partner fully offset payments, the claims and adjustments involved will be transferred to SDMC to generate an 835, otherwise, the payments and adjustments will be listed together on an 835 once payment is issued.
6. DHCS will transmit payment schedules to the State Controller's Office (SCO).
7. SCO will generate warrants for each trading partner according to the schedule submitted by DHCS.
8. SCO will mail payment warrants to trading partners.
9. SCO will transmit warrant information to DHCS.
10. The warrant information with payment, recovery, and deferral information will be transmitted to the SDMC system.
11. The SDMC system will generate 835s detailing payments, recoveries, and deferred payments to trading partners via ITWS.

Multiple Service Billings & Monthly Service Limits

Introduction

This chapter provides an overview to DMC multiple service billings, lockouts and overrides and includes:

- [Multiple Service Billings](#)
- [Maximum Service Units and Lockouts](#)

5.1 Multiple Service Billings – DMC State Plan

Multiple service billings are claims for a second unit of service by the same DMC provider, on the same day, and for the same recipient that may be approved for reimbursement. Generally, only one unit of service (except for Narcotic Treatment Program services) may be provided to a Medi-Cal-eligible recipient per treatment date. However, multiple service billings are permissible in specific exceptional circumstances.⁸⁶

A multiple service billing claim must include the appropriate HIPAA procedure modifier as described in the Short-Doyle Medi-Cal Phase II ADP Standard Companion Guide Transaction Information.⁸⁷

When a multiple service billing is submitted, the provider must prepare and retain in the beneficiary's patient record, a Multiple Billing Override Certification (DHCS 6700)⁸⁸ documenting the circumstances justifying the multiple service billing.

Restrictions

Multiple service billings are allowed for a return visit for a single additional service in a day for ODF, Naltrexone, and IOT services.⁸⁹

For ODF and Naltrexone treatment services:

- The return visit shall not create a hardship on the beneficiary; and
 - The return visit shall be clearly documented in the beneficiary's progress notes with the time of day each visit was made. The progress note shall

⁸⁶ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 6, §51490.1

⁸⁷ Cal. Dept. of Health Care Services, Companion Guide

https://itws.dhcs.ca.gov/systems/sdmc/docs/public/short_doyle_-_medi-cal_phase_ii.asp_d_2_2.pdf

⁸⁸ Cal. Dept. of Health Care Services, Multiple Billing Override Certification, <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

⁸⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 6, §51490.1(d)

Multiple Service Billings & Monthly Service Limits

clearly reflect that an effort was made to provide all necessary services during the one visit and the return visit was unavoidable; or,

- The return visit shall be a crisis or collateral service. Collateral services shall be documented in the beneficiary's treatment plan in accordance with the beneficiary's short/long-term goals. The beneficiary's progress notes shall specifically reflect the steps taken to meet the goals defined in the beneficiary's treatment plan. For IOT services, the return visit shall be a crisis service. Crisis service shall be documented in the progress notes.

The county and/or provider shall prepare and keep on file a statement which documents the reason the beneficiary required a return visit. This statement shall be produced upon the request by DHCS for audit or monitoring purposes.

Multiple service billings are not permitted for:

- Any DMC service other than ODF, Naltrexone, or IOT services;
- Services provided by different providers on the same day; and
- Services provided from different DMC service types in the same day.

5.2 Maximum Service Units and Lockouts

Table 1 summarizes allowable multiple service billing combinations, monthly NTP counseling service limits, and excluded same-day DMC.

Multiple Service Billings & Monthly Service Limits

TABLE 1: ALLOWABLE AND EXCLUDED SAME-DAY SERVICES

For Same Beneficiary on Same Date of Service									
Service Name	NTP Methadone Dosing	NTP LAAM Dosing	NTP Individual Counseling	NTP Group Counseling	IOT	RES	NAL	ODF Individual Counseling	ODF Group Counseling
Narcotic Treatment Program (NTP) Methadone Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Levoalphacetylmethadol (LAAM) Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Individual Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
NTP Group Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
Intensive Outpatient Treatment (IOT)	NO	NO	NO	NO	YES	NO	NO	NO	NO
Perinatal Residential (RES)	NO	NO	NO	NO	NO	NO	NO	NO	NO
Naltrexone (NAL)	NO	NO	NO	NO	NO	NO	YES	NO	NO
Outpatient Drug Free (ODF) Individual Counseling	NO	NO	NO	NO	NO	NO	NO	YES	YES
Outpatient Drug Free (ODF) Group Counseling	NO	NO	NO	NO	NO	NO	NO	YES	NO
NO	These services are not permitted to be reimbursed for the same beneficiary on the same day.								
NTP	These services are permitted to be reimbursed for the same beneficiary on the same day, subject to a limit of a total of 200 minutes of individual and/or group counseling per calendar month per beneficiary. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP contractors may bill and be reimbursed for additional counseling (in 10 minute increments).								
YES	These services are permitted to be reimbursed on the same day for the same beneficiary, subject to multiple billing restrictions. The appropriate multiple service billing procedure modifier must be identified for the return visit.								

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Introduction – DMC – Organized Delivery System

This chapter is only applicable to counties that have an executed Intergovernmental Agreement with DHCS to administer Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver services. All federal and state regulations that pertain to billing for regular state plan services are still applicable to the DMC-ODS services unless otherwise noted in this chapter.

- Scope
- Authority
- Opting in
- DMC ODS Reimbursement Rates
- Monitoring
- Multi Service Billings, Maximum Service Units and Lockouts
- Services
- Additional Resources

6.1 Scope

This chapter provides information about the requirements related to DMC billing for DMC-ODS services. The submission and format of the electronic claims, remittance advices, status request/response transactions, and unsolicited claims status has not changed for the DMC-ODS claim files. However, new HCPCS codes and modifiers have been established and can be located in MHSUDS Information Notice 17-045⁹⁰. The Companion Guide will be revised at a later date to include DMC-ODS specific information. Until then, counties should consult the MHSUDS Information Notices posted on the DHCS website for guidance.

6.2 Authority

The DMC-ODS is a pilot program authorized and financed under the authority of the State's 1115 Medi-Cal 2020 Demonstration Waiver. Expenditures are governed by the Medi-Cal 2020 DMC-ODS Waiver Special Terms and Conditions (STC)⁹¹. For more

⁹⁰ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 17-045"

http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_Information_Note_17-045.pdf

⁹¹ Cal. Dept. of Health Care Services, "Special Terms and Conditions", Pages 89-119 and 265-282

<https://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx>

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information regarding expenditure authorities, please read MHSUDS Information Notice number 15-034⁹².

6.3 Opting In

The DMC-ODS is a Medi-Cal benefit that is available only to counties that choose to opt in. Direct provider contracts will not be allowed to deliver services to beneficiaries from a DMC-ODS county.⁹³ Counties that are interested in providing DMC-ODS Waiver services are required to submit an Implementation Plan and an annual Fiscal Plan. More information regarding the Implementation Plan and Fiscal Plan can be found in MHSUDS Information Notice 16-005⁹⁴ and 16-050⁹⁵. Questions can be directed to DMCODSWAIVER@dhcs.ca.gov.

In addition, counties must sign a State/County Intergovernmental Agreement with DHCS, subject to Centers for Medicare and Medicaid Services (CMS) approval. For more information regarding the Intergovernmental Agreement, please contact DHCS Contracts Unit Supervisor at (916) 327-2696.

Upon DHCS and CMS approval of the Implementation Plan, Fiscal Plan, an executed Intergovernmental Agreement, and completion of all other requirements to provide DMC-ODS services, counties will then be able to bill for DMC-ODS services.

6.4 DMC-ODS Reimbursement Rates

Counties propose county specific fee-for-service interim rates for all modalities except the OTP/NTP modality. The state maximum allowed (SMA) rate is not applicable to DMC-ODS services, though the uniform statewide daily reimbursement rate still applies to OTP/NTP dosing, individual counseling and group counseling. More information on interim rate development and cost settlement for interim rates may be found in Attachment AA DMC-ODS Certified Public Expenditure Protocol.⁹⁶

⁹² Cal. Dept. of Health Care Services, "MHSUDS Information Notice 15-034"
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notece_15-034_DMC-ODS_Fiscal_Provisions.pdf

⁹³ Cal. Dept. of Health Care Services, "Special Terms and Conditions", Pages 89-119 and 265-282
<https://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx>

⁹⁴ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 16-005"
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notece_16-005.pdf

⁹⁵ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 16-050"
http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_IN_16-050.pdf

⁹⁶ Cal. Dept. of Health Care Services, "Attachment AA. DMC-ODS Certified Public Expenditure Protocol"
https://www.dhcs.ca.gov/provgovpart/Documents/CPE_Protocol-Attachment-AA.pdf

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6.5 Monitoring Requirements

DHCS will continue to conduct an annual monitoring review to ensure the counties are monitoring their providers at least once per year. More information regarding monitoring reviews may be found in the DMC-ODS STC⁹⁷ located on the DHCS DMC-ODS webpage or you may contact your assigned DHCS county monitoring analyst.

6.6 Quality Assurance Utilization Reviews

Counties may claim the FFP reimbursement share of Quality Assurance/Utilization Review expenses through a quarterly invoicing process, outside of SDMC, as described in MHSUD Information Notice 17-011⁹⁸.

6.7 Multi-Service Billings, Maximum Service Units and Lockouts

In order to facilitate the correct placement for beneficiaries, DHCS will allow a beneficiary to receive more than one service per day by various providers. When billing for these services however, the multiple billing override codes shall not be used. Multiple billing codes are not permitted for DMC-ODS services when submitting for reimbursement and thus, will result in a denied claim.

A beneficiary may also receive different services on the same day from the same provider, and at the same time, could receive other services on the same day from a different provider.⁹⁹ For example, this would allow methadone dosing for a beneficiary who resided in a residential treatment facility. However, there are some exceptions to this rule as illustrated in Table 2.

⁹⁷ Cal. Dept. of Health Care Services, "Special Terms and Conditions", Pages 89-119 and 265-282
<https://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx>

⁹⁸ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 17-011"
https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_17-011_Quality_Assurance_Utilization_Reviews.pdf

⁹⁹ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 17-023"
https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_IN_17-023.pdf

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6.8 DMC-ODS Services

DMC-ODS counties are required to provide all DMC-ODS services to eligible beneficiaries. The services include a continuum of care based on the American Society of Addiction Medicine (ASAM) criteria, which ensures beneficiaries may enter SUD treatment at a level that is appropriate to their needs, and step up or down to a different intensity of treatment based on their responses. The following services are reimbursable under the DMC-ODS Waiver.

Outpatient Services (ASAM Level 1)

Outpatient services are provided to beneficiaries up to nine hours per week for adults, and less than six hours per week for adolescents. Outpatient services includes assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination..

For individual counseling, one unit of service is equal to a 15-minute increment. DMC-ODS claims may be submitted with either minutes or fractional units of service, using codes UN or MJ. Code UN should be used for claims submitted using fractional units of service, and code MJ should be used for claims submitted using minutes of service.

Travel time and documentation time is billable for DMC-ODS Outpatient Services. Travel time is used for community based services where the counselor drives from the clinic setting to the location where the service is provided. This includes return travel to the clinic. In order to bill for transportation, the counselor must document the date and start and end time for each portion (to and from) of travel time.

Documentation time is specific to the beneficiary and the time it takes for the counselor to write a progress note for an individual counseling session, or each beneficiary that participated in a group counseling session. If there is more than one counselor providing the group counseling, each practitioner must complete a separate progress note for each beneficiary. Documentation time should also include the date, start and end time for each progress note.

For group counseling, one or more therapists/counselors treat two or more beneficiaries at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Counties should calculate the minutes/units to submit on a claim using the following formula:

Number of minutes for the group + travel time / Number of beneficiaries in the group = Total minutes per beneficiary + documentation time.

For example: 90 minute group + transportation to the site, 15 minutes + transportation back to the provider site, 15 minutes = 120 minutes / number of beneficiaries in the

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group, 12, + documentation time, 5 minutes for a specific beneficiary = 15 minutes or 1 unit of service.

Intensive Outpatient Services (ASAM Level 2.1)

Structured programming services are provided to beneficiaries a minimum of nine hours with a maximum of nineteen hours a week for adults, and a minimum of six hours with a maximum of nineteen hours a week for adolescents. Services consist of assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.

One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Units of service for group counseling should be calculated using the same formula as described in outpatient services.

Partial Hospitalization (ASAM Level 2.5) (This service is optional)

Services feature twenty or more hours of clinically intensive programming per week. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified patient needs which require daily management but that can be appropriately addressed in a structured outpatient setting. Services consist of intake, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention, treatment planning, and discharge services. This service is claimed as a single unit per day.

Residential Treatment (ASAM Level 3.1, 3.3, and 3.5)

This treatment is a non-institutional, 24-hour non-medical, short-term program that provides rehabilitation services which includes intake, individual and group counseling, patient education, family therapy, safeguarding medications, collateral services, crisis intervention, treatment planning, transportation services, and discharge services. Residential services may be provided to non-perinatal and perinatal beneficiaries in facilities with no bed capacity limit. Authorization limitations are outlined in MHSUDS IN 16-042.¹⁰⁰ In order for residential treatment to be reimbursed on a daily basis, the service provided must include a required structured activity on the date of billing as outlined in MHSUDS IN18-001.¹⁰¹

¹⁰⁰ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 16-042"

https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_IN_16-042.pdf

¹⁰¹ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 18-001"

https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_Info_Note_18-001-Residential_Reimbursement.pdf

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Residential Treatment (ASAM Level 3.7 and 4.0)

This institutional treatment is provided in a Chemical Dependency Recovery Hospital or an Acute Free Standing Psychiatric Hospital. This level of care is provided in an inpatient setting due to the need for medically monitored or medically managed treatment. Inpatient Residential treatment components include the same as offered in ASAM 3.1, 3.3, and 3.5. An 837I transaction set is required to bill for this service. For more information, including certification for this service and funding, refer to MHSUDS IN 16-037.¹⁰²

Withdrawal Management (ASAM Levels 1, 2, and 3.2)

Withdrawal Management services includes intake, observation, medication services, and discharge services. Providers must have a residential license and be certified to provide residential detoxification for ASAM 3.2 Residential Withdrawal Management. Providers must have an AOD Detox Certification to provide ASAM 1 or 2 Withdrawal Management. Contact DHCS SUD Compliance Division at (916) 322-2911 for questions regarding certification for this service.

Withdrawal Management (ASAM Levels 3.7 and 4.0)

This institutional treatment is provided in a Chemical Dependency Recovery Hospital or an Acute Free Standing Psychiatric Hospital. This level of care is provided in an inpatient setting due to the need for medically monitored or medically managed treatment. Inpatient Withdrawal Management treatment components include the same as offered in ASAM 3.2 Withdrawal Management. An 837I transaction is required to bill for this service. For more information, including certification for this service and funding, refer to MHSUDS IN 16-037.¹⁰³

Opioid (Narcotic) Treatment Program (ASAM OTP Level 1)

NTPs/OTPs are required to offer and prescribe medications to patients covered under the DMC-ODS Waiver; including Methadone, Buprenorphine, Naloxone and Disulfiram. A National Drug Code (NDC) is required on the 837P for Buprenorphine, Naloxone, and Disulfiram, not for Methadone. One unit per day is allowed for dosing. Both individual counseling and group counseling continue to use a 10-minute increment, as is current practice in regular DMC NTP billing.

¹⁰² Cal. Dept. of Health Care Services, "MHSUDS Information Notice 16-037"

https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_16-037.pdf

¹⁰³ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 16-037"

https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_16-037.pdf

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Additional Medication Assisted Treatment (ASAM OTP Level 1) (This service is optional)

This treatment includes ordering, prescribing, administering, and monitoring of all medications for SUDs.

Physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

Counties may choose to utilize long-acting injectable naltrexone (Vivitrol) in allowable DMC facilities. Vivitrol will be reimbursed for onsite administration, however, counties must cover the non-federal share. Counties may set the rate for specific medications such as Buprenorphine, Disulfiram, Naloxone, Vivitrol, and Acamprosate. NDCs for these medications are required on the 837P. For more clarification regarding MAT services, refer to the “Frequently Asked Questions” document located on the DHCS ODS web page.¹⁰⁴

Certain medications cannot be billed on the same day:

- Buprenorphine cannot be billed on the same day with either Buprenorphine or Vivitrol.
- Disulfiram cannot be billed on the same day with Disulfiram, Vivitrol, or Acamprosate.
- Naloxone (Narcan) cannot be billed on the same day with Naloxone.
- Vivitrol cannot be billed on the same day with Vivitrol, Buprenorphine, Disulfiram, or Acamprosate.
- Acamprosate cannot be billed on the same day with Acamprosate, Disulfiram, or Vivitrol.
- Methadone cannot be billed on the same day with Methadone, Buprenorphine, Vivitrol, or Acamprosate.

Recovery Services

The components of recovery services are outpatient counseling services, recovery monitoring, substance abuse assistance, linkages to education and job skills training and services, linkages to family support education and services, linkages to support groups, and linkages ancillary services, such as housing assistance, transportation and case management.

¹⁰⁴ Cal. Dept of Health Care Services, “Frequently Asked Questions” , Medication Assisted Treatment
https://www.dhcs.ca.gov/provgovpart/Pages/FAQs_Fact_Sheets.aspx

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Recovery services may be billed for individual and group counseling, case management, and recovery monitoring/substance abuse assistance. Peer support can only be billed under the substance abuse assistance component.¹⁰⁵ One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service. Units of service for group counseling should be calculated using the same formula as described in outpatient services.

A site / facility offering recovery services must be a certified DMC provider. However, this does not mean that services must be provided at the certified site / facility. Alternatively, services may be provided in the community. If recovery services are provided in the community, the provider delivering the service must be linked with a physical site / facility that is DMC certified.

All claims must be submitted with a valid ICD-10 diagnosis code for remission, please refer to Information Notice 17-034.

Case Management

Case management is a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management services includes comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transition to a higher or lower level SUD of care; development and periodic revision of a beneficiary plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring the beneficiary's progress; patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services. One unit of service is equal to a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

Physician Consultation

Physician consultation services are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS Waiver beneficiaries. The DMC-ODS County will contract with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists as consultants. Physician consultation services can only be billed by and reimbursed to DMC providers. One unit of service is equal to

¹⁰⁵ Cal. Dept. of Health Care Services, "MHSUDS Information Notice 17-008"

https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/MHSUDS_Information_Notice_17-008_ODS_Peer_Support_Services.pdf

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a 15-minute increment. Claims may be submitted with either minutes or fractional units of service.

6.9 Additional Resources

Questions regarding DMC-ODS services should be emailed to:

DMCODSwaiver@dhcs.ca.gov.

DHCS DMC-ODS webpage:

<http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>

DHCS MHSUDS Information Notices:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx>

Introduction

This chapter provides an overview of DHCS claim forms, which may be found on the “Drug Medi-Cal Treatment Program Forms” page of the DHCS website.¹⁰⁶

- [DMC Claim Submission Certification – Direct Contract Provider Form \(DHCS 100185\)](#)
- [DMC Claim Submission Certification – County Contracted Provider Form \(DHCS 100186\)](#)
- [DMC Claim Submission Certification – County Operated Provider\(s\) Form \(DHCS 100187\)](#)
- [DMC Certification for Federal Reimbursement \(DHCS 100224A\)](#)
- [Multiple Billing Override Certification \(DHCS 6700\)](#)
- [Good Cause Certification \(DHCS 6065A or DHCS 6065B\)](#)

7.1 DMC Claim Submission Certification Direct Contract Provider Form (DHCS 100185)

Direct contract providers are required to submit a signed DMC Claim Submission Certification – Direct Contract Provider Form to DHCS for each EDI claim file submitted to DHCS. Payments for adjudicated claims will not be released until this form is received and approved by DHCS.

7.2 DMC Claim Submission Certification – County Contracted Provider Form (DHCS 100186)

County contracted providers are required to submit to the County a signed DMC Claim Submission Certification – County Contracted Provider Form for each DMC submission for processing.

7.3 DMC Claim Submission Certification – County Operated Provider(s) Form (DHCS 100187)

The County is required to complete and retain a DMC Claim Submission Certification – County Operated Provider(s) Form for each EDI file submitted for county operated

¹⁰⁶ Cal. Dept. of Health Care Services, “Drug Medi-Cal Treatment Program Forms,” <http://www.dhcs.ca.gov/formsandpubs/forms/Pages/DMC-Forms.aspx>

Forms

providers. Only one form has to be completed per EDI file certifying all claims within the file submitted for county operated providers.

7.4 DMC Certification for Federal Reimbursement (DHCS 100224A)

DHCS 100224A is used by the county to satisfy the Certified Public Expenditure (CPE) requirements for Federal Financial Participation (FFP) for DMC claims under the State-County contracts submitted for July 1, 2011 services and thereafter.

7.5 Multiple Billing Override Certification (DHCS 6700)

DHCS 6700 is used to certify that an additional, second unit of service for the same beneficiary was submitted for the same service date. DHCS 6700 documents that the additional service was medically necessary and was not a hardship for the beneficiary's return.

The DHCS 6700 must be signed by a person authorized to represent the provider to certify that the beneficiary record was reviewed, that the multiple service claim was valid per Section 51490.1 of Title 22,¹⁰⁷ and that the DHCS 6700 shall be prepared and retained in the beneficiary's patient record to be produced for monitoring and/or auditing purposes.

7.6 Good Cause Certification (DHCS 6065A and DHCS 6065B)

The DHCS 6065A form is used by the provider and/or county to document and support the reason a claim is being submitted outside of the required due date. A late claim is any claim submitted later than six months after the last date of the service year and month; i.e. a timely claim for July 2018 should be submitted to DHCS no later than January 31, 2019.

Delay Reason Codes are required to justify all late submissions. The reasons for justifying a late submission are defined in CCR Title 22, Section 51008.5.¹⁰⁸ The DHCS 6065A should be completed and signed by a person authorized to represent the county/direct provider certifying the validity of the billing. With exception of the Delay Reason code 4, 11, do not submit the forms to DHCS. The completed DHCS forms 6065A must be retained on site for monitoring purposes.

Use of Delay Reason code 4 or 11 must be pre-approved by DHCS. Once DHCS has issued pre-approval, DHCS 6065A must be prepared and submitted to DHCS for signature and final approval. After approval is granted, the claims will be adjudicated by the system and the signed DHCS 6065A will be faxed back to county/direct provider by DHCS and should be retained on site for monitoring purposes.

¹⁰⁷ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 6, §51490.1

¹⁰⁸ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5

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While use of Delay Reason code 8 does not require pre-approval by DHCS, DHCS 6065B must be prepared and submitted to DHCS and the original retained on site for monitoring purposes.

Good Cause for Late Submission and Delay Reason Codes

The county/direct provider must determine the appropriate Delay Reason code to use on the DHCS 6065A. DHCS cannot advise which Delay Reason code to use. Trading partners are not required to complete the Claim Supplemental Information Paperwork (PWK) segment of the 837P file for the submission of delay reason codes.

Providers must meet one of the seven situations below in order to qualify for delay reason cause exemption. For a late submission situation to be applicable for a Delay Reason, it must adhere to all time limits and documentation requirements. Most Delay Reason codes have a time limitation of one year from the date of service to submit the claim. DHCS has included a brief description of Delay Reason codes, but it is suggested that CCR Title 22, Section 51008.5 be reviewed for complete information and instructions.¹⁰⁹

Delay Reason Code 1 ¹¹⁰

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:
 - Medi-Cal ID card, Medi label or Proof of Eligibility (POE) label.
 - Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage by that carrier.
 - Photocopy of the Medi-Cal Beneficiary Card or Medi/POE labels.

¹⁰⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5

¹¹⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(1)

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Delay Reason Code 2 ¹¹¹

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.

Delay Reason Code 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.¹¹²

- 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:
 - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

Delay Reason Code 7 ¹¹³

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 date of notification that third party payment was denied.
- Provider and/or county must maintain documentation of the date of service and the notification of the denial of payment by the third party.

Delay Reason Code 8 ¹¹⁴

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 eligibility being determined or certified by the state or county. This also applies to retroactive Medi-Cal eligibility.

¹¹¹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(3)

¹¹² 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(4)(E)

¹¹³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(2)

¹¹⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(4)(A)

Forms

- 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 copy of beneficiary retroactive eligibility determination.

Delay Reason Code 10 (time limit: 60 days from resolution of circumstances causing delay)¹¹⁵

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.

Delay Reason Code 11

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:

- Damage to or destruction of the provider's business office or records by a natural disaster; includes fire, flood or earthquake,¹¹⁶ or
- Circumstances resulting from such a disaster have substantially interfered with processing bills in a timely manner;
- 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:¹¹⁷

- 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 delivery 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.

¹¹⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(b)(5)

¹¹⁶ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(a)(4)(B)

¹¹⁷ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 1.3, §51008.5(b)(1-4)

Forms

- Documentation of justification for request of Good Cause must be forwarded to DHCS by the county/direct contract provider, and must include:
 - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

Appendix A

Appendix A: Glossary and Acronyms

276	The Claim Status Request transaction used to obtain claim status information after claim submission.
277	The Claim Status Response transaction generated in response to the 276 Status Request transaction.
837I	Health Care Claim Transaction for Institutional Claims
837P	Health Care Claim Transaction for Professional Claims/Encounters.
835	The Health Care Claim Payment/Advice transaction (also known as a Remittance Advice or RA).
997	SDMC generates a 997 acknowledgement in response to each HIPAA-compliant transaction.
ADP	Department of Alcohol and Drug Programs
AEVS	Automated Eligibility Verification System
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
Beneficiary	A person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the <i>Diagnostic and Statistical Manual of Mental Disorders III Revised (DSM)</i> , DSM IV and/or DSM V criteria; and (d) meets the admission criteria to receive DMC covered services.
BIC	Benefits Identification Card
CalOMS	California Outcomes Measurement System. A statewide beneficiary-based data collection and outcomes measurement system.
CCR	California Code of Regulations
CFR	Code of Federal Regulations; also, County of Financial Responsibility
CIN	Beneficiary Index Number (first 9 digits of the BIC).
Beneficiary or Patient	Anyone who is receiving alcohol or drug services.
CPE	Certified Public Expenditure

Appendix A

CMS	Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services)
Covered Services	Those DMC services authorized by Title XIX of the Social Security Act; ¹¹⁸ Title 22 Section 51341.1; ¹¹⁹ Health and Safety Code Section 11758.46; ¹²⁰ and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug-free treatment, narcotic replacement therapy, intensive outpatient treatment and perinatal residential AOD treatment (excluding room and board).
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal. The state program wherein beneficiaries receive covered services from DMC-certified AOD treatment providers that are reimbursed for those services with a combination of federal Medicaid funds, State General Funds (SGF), and/or County Realignment funds.
DMC-ODS	Drug Medi-Cal Organized Delivery System
DP	Direct Provider. A DMC certified provider that contracts directly with DHCS for DMC reimbursement.
EDI	Electronic Data Interchange
EVC	Eligibility Verification Confirmation number. AEVS accesses the most current recipient information for a specific month of Medi-Cal eligibility and returns a 10-character EVC number if eligibility is confirmed. The EVC number may be entered in the remarks area of the claim, but it is not required. EVC information includes the beneficiary's eligible Aid Code(s).
Finalized Claim	A claim that is approved and paid, approved and payment deferred, or denied, as reported on an 835.
FFP	Federal Financial Participation. The share of federal Medicaid funds for reimbursement of DMC services. The FFP sharing ratio is determined on an annual basis and known as the Federal Medical Assistance Percentages (FMAP). ¹²¹

¹¹⁸ 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v

¹¹⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, part. 4, §51341.1

¹²⁰ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46

¹²¹ U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm>

Appendix A

FFS	Fee for Service
FMAS	Fiscal Management and Accountability Section
FMAP	Federal Medicaid Assistance Percentages
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System. A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
HIPAA	Health Insurance Portability and Accountability Act of 1996 ¹²²
IA	Interagency Agreement
Intergovernmental	
Agreement	The intergovernmental agreement is the managed care contract between DHCS and the county that is participating in the DMC-ODS.
ICD-9	International Classification of Diseases, 9 th Edition
ICD-10	International Classification of Diseases, 10 th Edition
IOT	Intensive Outpatient Treatment
ITWS	Information Technology Web Services
LAAM	Levoalphacetylmethadol (a narcotic replacement drug which is currently unavailable in the United States)
Medi-Cal	California's Medicaid program
Medical Necessity	AOD treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or in the case of EPSDT, services that meet the criteria specified in Title 22. ¹²³
MEDS	The DHCS Medi-Cal Eligibility Data System
Minor Consent	Those covered services that, pursuant to Family Code Section

¹²² Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., 2nd sess.

¹²³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51303

Appendix A

DMC Services	6929, may be provided to persons 12-20 years old upon their request without requiring parental consent or court consent. ¹²⁴
NAL	Naltrexone
NPI	National Provider Identifier
NTP	Narcotic Treatment Program. An outpatient clinic licensed to provide narcotic replacement therapy using methadone directed at stabilization and rehabilitation of persons who are opiate-addicted and have a SUD diagnosis.
ODF	Outpatient Drug Free
Perinatal DMC Services	Covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services. ¹²⁵
PHI	Patient Protected Health Information
PIN	Provider Identification Number
POE	Proof of Eligibility
POS	Point of Service
Postpartum	(As defined for DMC purposes) means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.
PSPP	Postservice Postpayment. The utilization review for program compliance and medical necessity conducted after service was rendered and the claim paid. State may recover prior payments if such review determines that the services did not comply with the applicable statutes, regulations, or standards.
Protected Population	(1) EPSDT-eligible Medi-Cal beneficiaries under age 21, and Medi-Cal-eligible pregnant and postpartum women.
Provider	A supplier of alcohol and drug treatment services in California.

¹²⁴ Cal. Family Code, div. 11, part 4, chap. 3, §6929

¹²⁵ 22 Cal. Code Regs., div 3, subdiv. 1, chap. 3, art. 4, §51341.1(c)4

Appendix A

Provider of DMC Services	Any person or entity that provides direct AOD treatment services and has been certified by State as meeting the certification requirements for participation in the DMC program set forth in the DMC Certification Standards for Substance Abuse Clinics, Document 2E and Standards for Drug Treatment Programs (October 21, 1981), Document 2F.
RA	Remittance Advice. The 835 Health Care Claim Payment/Advice transaction.
RES	Residential
SAEVS	Supplemental Automated Eligibility Verification System
SCO	State Controller's Office
SDMC	The Short-Doyle/Medi-Cal Act of 1957.
SDMC System	Short-Doyle/Medi-Cal system. The claims processing system operated by the Department of Health Services to process SDMC claims.
SGF	State General Funds
SMA	Statewide Maximum Allowances. The maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, intensive outpatient treatment, perinatal residential, and Naltrexone treatment services. Rates are subject to change annually.
SOC	Share of Cost
STC	Special Terms and Conditions of the Medi-Cal 2020 1115 Waiver
Subcontract	An agreement between the Contractor and its Subcontractors. A Subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.
Subcontractor	An individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a direct provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations.
SUD	Substance Use Disorder

Appendix A

SUDCD	Substance Use Disorder Compliance Division
Title IX	Portion of California Code of Regulations covering alcohol and drug services
Trading Partners	Counties and direct providers that contract with DHCS for DMC reimbursement.
TSC	Telephone Service Center
UOS	Unit of Service.
USC	United States Government Code
USDR	Uniform Statewide Daily Reimbursement Rate. The rate for NTP services based on a unit of service that is a daily treatment service provided.
Xerox	Xerox is the company that provides Medi-Cal telephone support and other related services.

Appendix B

Appendix B: ITWS Enrollment

DHCS's DMC trading partners must submit DMC claims through the ITWS secure portal at <https://itws.dhcs.ca.gov/>.

Trading partners must submit an Approver Form to request authorization for assigning/approving users for access to their organization's area of ITWS. Information and approver forms can be found under the "Support" menu on ITWS.

Trading partners must request that their authorized users enroll to obtain a username and password before logging onto ITWS to access the SDMC–DHCS system. User must enter their assigned username/password to submit claims and access claim status information.

To obtain a username/password go to the ITWS website, select the "Enroll" button and follow the instructions.

Appendix C

Appendix C: ITWS Claim Submission Instructions

Once ITWS enrollment is approved, DMC claims can be submitted via ITWS.

1. Open a browser and type the ITWS web address: <https://itws.dhcs.ca.gov/>.
2. Enter the username/password requested during enrollment under “ITWS Login.”
 - a. Logon can also be done using the “Login” button on the “Welcome” page.
 - b. Once logged on, the “Login” button in the top menu bar changes to “Logout.” Use this button when leaving ITWS.
 - c. The first page after logging on will be the “Home” page. Later you can use the “Home” button in the top menu bar to return to this page (menu buttons display on all ITWS pages).
3. Select the “Systems” button followed by “Short-Doyle/Medi-Cal Claims” under “ADP-Alcohol and Drug Program.”
4. The next page provides System Messages. Select “Transfer Files (Upload and Download)” from the “Functions” menu.
5. On the “Transfer Files” page select “SDMC-ADP Information” in the drop down menu labeled “Choose a System,” if not already selected.
6. Under “UPLOAD”, select the county or direct provider in the drop down menu. Select here to upload files for another county. The left side of the page lists any previously uploaded 837P or 837I files and the acknowledgement of 997 files.
7. To submit an 837P or 837I file, select the “Add” button. Use the dialog box to select the claim file to upload.
8. Once the file is located, select it and press “OK” in the dialog box.
9. The file displays in the “UPLOAD” section of the “Transfer Files” page. Click the “Upload” button below the file listing.
10. A message box displays to verify that a file is being uploaded. If the file is correct, click the “OK” button.
11. The “File Upload” page appears with the message on success of the upload and a link to the “Processing Status” page to view the tracking of the uploaded file.
12. To return to the “Transfer Files” page click the “Return to Transfer Page” button at bottom of dialog box.
13. The file that was just uploaded will be displayed on the left side.
14. E-mail acknowledgements from ITWS are generated with status messages.

Appendix D: Checking ITWS “Processing Status”

1. The “Processing Status” page can be checked for the status of a submitted claim. Log onto ITWS and select “Processing Status” from the “Functions” menu.
2. The “Processing Status” page displays. Select “SDMC-ADP” from the “Choose a system” drop down menu. The menu options in the “Show files within list box” can be used to limit the number of files submitted to be listed in the specified time.
3. The “Processing Status” page displays tracking messages posted for each file.

Appendix E: Downloading the 835 Remittance Advice

The SDMC adjudicated, approved and denied, 837P or 837I claim information will be reported in the HIPAA 835 transaction file. The 835 Healthcare Claim Remittance Advice (RA) is available for download from the ITWS “Transfer Files” page in the location where the submitted claim file and 997 acknowledgement files are posted.

The 835 RA can be used for reconciliation with claim information and as a basis for Replacement or Void claims when necessary.

- Trading partners must be enrolled on ITWS to access the SDMC–ADP system to download 835 RA files.
- The 835 RA files should be downloaded, extracted, and retained in a safe and secure location to protect the contents of the file from inappropriate access.
- To download the 835 RA, go to the ITWS website at and logon with the appropriate ITWS username and password; use either the “Logon” menu button or the “Username” and “Password” entry boxes in the “ITWS Login” area.
- Under “Systems” menu select “ADP–Alcohol and Drug Program,” then “Short-Doyle/Medi-Cal Claims”.
- Select “Transfer Files (Upload and Download)” on the option under the “Functions” menu button.
- The “Transfer Files” page lists any available electronic data interchange (EDI) HIPAA files.
- To download an 835 file, highlight and select.
- A “Download File” dialogue box will display; select the “Save” button. This will allow selection of a safe location for saving the file.
- The “Save As” (in the browser) should display allowing you to search for a folder or create a new folder in a secure area of the organization’s system.
- The compressed file can be opened using the county or direct provider’s password, and can be imported into the trading partner’s database, application or system in a text reader file.
- The format for the password can be viewed at the bottom of the ITWS “System Messages” page (a user ID and password are required to view the page).