ATTACHMENT A - California Short Doyle Medi-Cal Requirements

Medicaid (aka Medi-Cal in California) eligibility

Mental Health and Substance Use Disorder services for clients who have Medicaid (aka Medi-Cal in California) are carved out as a responsibility of the local counties Mental Health plan contract with DHCS. Services are provided by County clinics and contracted providers, but are the sole responsibility to be claimed by the county. In California, the claiming structure is controlled through DHCS following their Short Doyle Medi-Cal rules as described below.

Client Data Collection and Reporting

Specific client information is required to be collected at time of admission, discharge, at service entry and periodically/annually and reported for many unique client circumstances for both mental health and substance use disorder client treatments. State Department of Health Care Services (DHCS) categorizes these requirements differently for;

Mental Health = Client and Service Information (CSI)

Substance Use Disorder = California Outcomes Measurement System (CalOMS)

The unique client data for both categories above may identify the same or different items and collect different criteria such as;

- A number
- A date or a to/from date range
- A table of items to select from with one or multiple selections available and maybe associated with a unique timeframe
- Some data items are required to be updated periodically/annually based on different timeframes per client
- Some items may need a translation to a reportable code number

Monthly reporting of uniquely identified data based on DHCS guidelines, must be created and reported to DHCS via a secured portal, using a specific record layout, and filename format per the State Data Dictionary. Errors produced from the Counties submission must be corrected at the State and County level by individual or batch record correction for data synchronization.

Short Doyle Billing Structure

Mental Health

Short Doyle Medi-Cal billing guidelines are unique in the way the Department of Health Care Services (DHCS) structures State generated numbering schemes associated with each facility National Provider Identifier (NPI).

DHCS Short Doyle billing parameters include:

- Modes - Categories of service (such as 24 hr., day treatment, outpatient etc.)
- Service Function Codes - Types of service (such as Hospital Inpatient, Adult Residential, Crisis Stabilization, Case Management, Mental Health Service etc.)
- Translation of service billing codes, by Mode of Service and Service Function combination are cross walked to HCPC Level II ~~codes~~ Procedures and Procedure Modifier codes uniquely identified by DHCS.
- Service durations are claimed in various ways (per minute, per unit of time (15 minute), flat code, etc.) and may require a calculation for group services (number in group divided by total time of group).
- DHCS allows for the reporting/claiming of services not associated with a unique client, but as an INDIRECT service for Medi-Cal Administrative Activities (MAA), outreach or supportive services. Ability to create indirect service entry required.
- X-12 HIPAA compliant transaction type for electronic claiming to DHCS using specific coding format identified in the 835 & 837 I/P Technical Companion Guide and the DHCS Short-Doyle Medi-Cal Phase II Companion Guide and Companion Guide Appendix.
- Approved and Denied Claims are returned on an 835-transaction file that include approved claimed amount and FFP amount. Denied claims returned on an 835 transaction files with a unique State claim line identifier must be corrected and returned per DHCS guidelines using the 837 I/P HIPAA transaction which must include the State and County unique claim lines identifiers. This is the State Void/Replacement process.
- Special data values required at time of service entry and with claim submission.

<u>Substance Use Disorder (SUD)</u>

Short Doyle SUD Medi-Cal billing guidelines are unique in the way the Department of Health Care Services (DHCS) structures State generated numbering schemes associated with each facility National Provider Identifier (NPI).

DHCS Short Doyle billing parameters include:

- American Society of Addiction Medication (ASAM) Level of Care - Categories of service (such as; multiple levels of Residential, Outpatient, Intensive Outpatient, Opioid Treatment Program (OTP/NTP), etc.)
- Program Codes - Types of service (such as Perinatal “program 25” or a Non-Perinatal “program 20”)
- Translation of service billing codes are uniquely identified by ASAM levels, which produce HCPC Level II codes including unique State modifiers
- Service durations are claimed in various ways (per minute, units, fractional units, flat code, etc.). SUD claims require unit billing for specific service types. Units are 10- or 15-minute increments. Claims may be submitted with either minutes or fractional units of service. Unit segments requires a calculation for group services (number in group

divided by total group time (including travel time) plus each client(s) unique documentation time).

- X-12 HIPAA compliant transaction type for electronic claiming to DHCS using specific coding format identified in the 835 & 837 I/P Technical Companion Guide and the DHCS Short-Doyle Medi-Cal Phase II Companion Guide and Companion Guide Appendix.
- Approved and Denied Claims are returned on an 835 transaction file that include approved claimed amount and FFP amount. Denied claims returned on an 835 transaction files with a unique State claim line identifier must be corrected and returned per DHCS guidelines using the 837 I/P HIPAA transaction which must include the State and County unique claim lines identifiers. This is the State Void/Replacement process.
- Some Narcotic Treatment Program medication services require the reporting of a National Drug Code (NDC) number.
- Special data values required at time of service entry and with claim submission.