SAPC | Substance Abuse Prevention and Control

JUSTICE INVOLVED YOUTH BILLING GUIDE

OVERVIEW

This guide provides information for juvenile justice provider agencies on billing Fee-for-Service (FFS) Medi-Cal for substance use disorder (SUD) treatment delivered to justice involved (JI) youth. These guidelines apply only to youth who are currently incarcerated and receiving SUD treatment at a designated youth correctional facility/camp/hall. This guide does not apply to standard DMC-ODS services. This guide has been developed in accordance with Department of Health Care Services (DHCS) CalAIM JI policies and California Medicaid Management Information System (CA-MMIS) regulations.

JI youth billing mirrors DMC-ODS billing in most ways, but differs in several critical aspects.

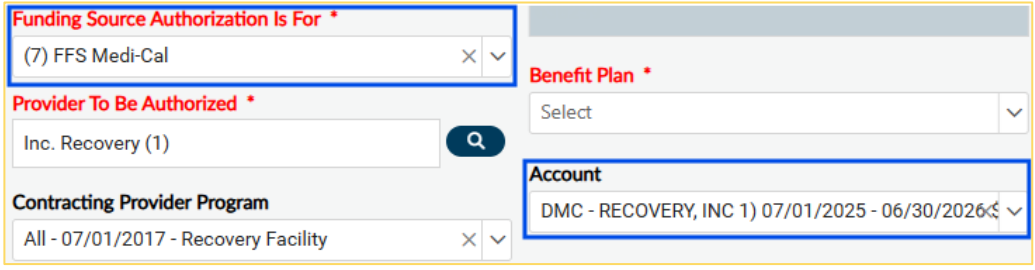
- **Same as DMC-ODS:** SUD diagnosis required as the primary diagnosis, billing in Sage (for Primary Sage Users)/837 billing (for Secondary Sage Users), Denial Codes and Crosswalk/Denial Troubleshooting, Clinical Documentation Standards, EOBs/835s and payment cycle.
- **Different for JI Youth:** Service Authorization funding source (FFS Medi-Cal), Guarantor (FFS Medi-Cal (7)), dedicated JI Rates Matrix, dedicated service code set, JI youth benefit plans for Service Authorizations, and indirect services billed by code instead of by invoice.

SERVICE AUTHORIZATIONS

In general, a Service Authorization Request form for a JI youth client is required to be completed in the same manner as a DMC-ODS client, with minor differences. When completing a Service Authorization Request for a JI youth client, the following fields have specific JI youth requirements:

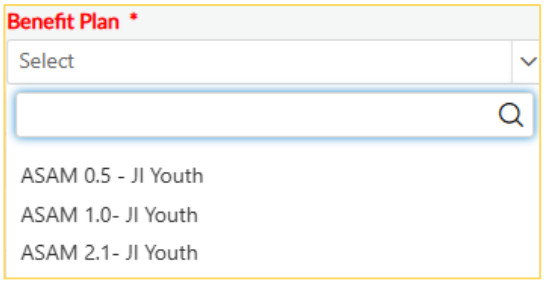
- **Funding Source Authorization is For** field: Regardless of the client's enrollment in Medi-Cal, the Funding Source selected must be **(7) FFS Medi-Cal**. Refer to Figure 1. Funding Source and Account for an example.
- **Account** field: Only the DMC account should be selected. Refer to Figure 1. Funding Source and Account for an example.
- **Benefit Plan** field: There are three (3) new benefit plans for JI youth: ASAM 0.5 - JI Youth, ASAM 1.0 - JI Youth, and ASAM 2.1 - JI Youth. Only one of these three plans should be selected. Refer to Figure 2. Benefit Plans for an example of the dropdown selections.

Figure 1. Funding Source and Account



County of Los Angeles Public Health

Figure 2. Benefit Plans



FINANCIAL ELIGIBILITY

All JI youth clients must have the new required guarantor - FFS Medi-Cal (7) – on the Financial Eligibility form (FE), with the Coverage Effective Date as the first date of treatment (including screening/assessment) while incarcerated, regardless of whether or not the client has Medi-Cal. Table 1. Youth FE Scenarios below provides example scenarios that may occur for clients who are incarcerated and receiving SUD treatment and how to set up their FE form for the JI pre-release program.

Table 1. JI Youth FE Scenarios

Scenario	Financial Eligibility Setup
Client received SUD treatment by the agency prior to incarceration and has an existing FE record for the agency's episode in Sage	1. Do not delete the existing DMC and/or Non DMC guarantor. 2. Enter the Coverage Expiration Date(s) as the day before the treatment start date for the DMC and/or Non DMC guarantor(s). 3. Add the FFS Medi-Cal guarantor with a Coverage Effective Date as the first date of treatment and complete all fields as required in the form.
Client has no prior SUD treatment by the agency prior to incarceration and is applying for Medi-Cal while incarcerated	1. Add the FFS Medi-Cal guarantor. a. Do not use the Applying for Medi-Cal guarantor. 2. Enter the placeholder CIN - 99999999X – in the Subscriber Client Index Number (CIN) field. 3. Enter the first day of treatment as the Coverage Effective Date. 4. Enter the client's application information in the FE Coverage Comments field. 5. Once the client is approved for Medi-Cal, update the Subscriber CIN field with the client's new Medi-Cal CIN. Do not update the Coverage Effective Date. 6. If the client is denied Medi-Cal coverage, leave the FE as setup and do not change the Subscriber CIN field.
Client is not eligible, no longer enrolled, and/or not interested in enrolling in Medi-Cal	1. If the client was an existing client of the agency and had the DMC and/or Non DMC guarantors on the FE, do not delete the existing DMC and/or Non DMC guarantor and enter the Coverage Expiration Date(s) as the day before the treatment start date. 2. Add the FFS Medi-Cal guarantor. a. Do not use the Non DMC guarantor.

	3. Enter the placeholder CIN - 99999999X – in the Subscriber Client Index Number (CIN) field. 4. Enter the first day of treatment as the Coverage Effective Date. 5. Enter a comment in the FE Coverage Comments field indicating that the client is not eligible or not interested in applying.

Post Release

Once the client is released, the FFS Medi-Cal guarantor should have the Coverage Expiration Date updated to the last day of the client's incarceration. If the client engages in SUD treatment post-release, the FE form should be updated per usual DMC-ODS standards and requirements. Do not delete the FFS Medi-Cal guarantor after the client leaves treatment and begins treatment at the provider agency post release.

If the client is receiving treatment after release by the same provider agency, and the client had existing DMC and/or Non DMC guarantors with Coverage Expiration Dates set to the day prior to treatment, remove the Coverage Expiration Date as needed to reactivate the DMC and Non DMC guarantor(s) per the client's current eligibility status.

RATES MATRIX & CODING

Rates Matrix

SAPC developed a dedicated service code set and a new JI FFS Rates Matrix for JI services, which can be found on the DPH-SAPC website. Use the dedicated rates matrix for allowable JI codes, rates, license types, and billing rules. Do not use the DMC-ODS rates matrix for the JI youth program as the codes, rates, and rules are different.

Rate Structure

JI youth services are generally reimbursed at a flat rate per 15 minutes of service. Some service codes represent a longer service duration than the usual 15 minutes per unit and the rate has been adjusted to accommodate the longer service duration. Service rates are the same across allowable license types. Only the specified types of practitioners indicated in the JI FFS Rates Matrix may deliver and bill JI Youth services.

Procedure Codes and Modifiers

The JI youth procedure code set includes treatment (direct) service codes and a new set of indirect service codes. All service codes have a "J" prefix to denote the JI youth program. Direct service codes are treatment codes that follow the standard CPT/HCPCS conventions, like the DMC-ODS service codes, but with several key differences, such as a limited set of allowable locations, modifiers, and allowable provider license types. All direct service codes must be submitted with a U8 modifier per DHCS guidelines for JI FFS billing, regardless of whether the patient is receiving 0.5, 1.0, or 2.1 levels of care. For in-person services, the QJ modifier is also required. Services rendered via telehealth must include the appropriate telehealth modifier (93 or 95 for CPT codes, or SC for HCPCS codes). Services billed without the QJ or a telehealth modifier will be denied.

Indirect service codes account for indirect service time, formerly reimbursed through invoicing, including activities that fall under the following categories: documentation, outreach and engagement, care delivery activities, and administrative coordination. Indirect service codes do not require modifiers. Refer to the Indirect Services section of this guide for further details.

Place of Service

The primary location of service for the JI Youth program is '09' (Prison/Correctional Facility) for all in-person treatment services, and '02' (Telehealth Provided Other than in Patient's Home) or '10' (Telehealth Provided in Patient's Home) for telehealth services. Verify that the appropriate place of service and service code modifier combination is used.

In-person treatment services must use the in-person modifier 'QJ' and place of service '09' and treatment services rendered via telehealth must use the appropriate telehealth modifier ('93' or '95' for CPT Codes, or 'SC' for HCPCS codes) and place of service code '02' or '10.' For indirect services, locations '09' (Prison/Correctional Facility) and '11' (Office) are allowable. Location '11' (Office) is for scenarios where indirect JI Youth services take place outside of the correctional facility (for example, at the provider agency office).

Indirect Services

Indirect services are activities that fall under categories such as documentation, outreach and engagement, care delivery activities, and administrative coordination. If the indirect service was related to the treatment for a particular client, bill the service under that client per the normal billing process. If the indirect service was not client-specific, use the stand-in client JI,INDIRECT as well as the appropriate service authorization to bill indirect service activities. SAPC will monitor billing on a per-staff member per-day basis to ensure indirect service billing does not exceed timesheet records. The time billed per clinician/staff per day must not exceed logged work hours.

BILLING, DENIALS, AND PAYMENTS

Billing Timeline

All JI youth services must be billed within **45 days** of the service date for both original and replacement claims. DHCS allows only a limited time to bill for full reimbursement, therefore, timely claim submission is critical to meet program compliance.

Pre-Billing Checklist

To ensure accurate billing and reduce denials, complete the following checks before submitting any JI Youth billing:

1. **Financial Eligibility:** ensure that the correct guarantor - FFS Medi-Cal, effective dates, CIN, and other required information is entered in the client's FE per the scenarios outlined in Table 1. JI Youth FE Scenarios.
2. **Service Authorization:** confirm there is an active authorization for the client under the FFS Medi-Cal funding source, appropriate JI youth benefit plan, and DMC account. Verify that the correct authorization number is entered on the claim.
3. **Diagnosis:** ensure the client has an SUD diagnosis as the primary diagnosis.
4. **Procedure Code and Location:** confirm that the correct JI service code and any required modifiers are listed on the service, and that the appropriate place of service is entered.
5. **Rate and units:** refer to the JI FFS Rates Matrix to verify that the correct rate is being billed per the units of service rendered and confirm that the units do not exceed the maximum allowable units per service.
6. **Practitioner:** verify that the practitioner listed on the service has an allowable license type per the JI FFS Rates Matrix.

Local Denials

The JI youth program uses the same denial codes as DMC-ODS billing, allowing provider agencies to use existing denial resolution tools and resources to help review and resolve local denials. For more details, refer to the Sage Claim Denial Reason and Resolution Crosswalk and Sage Guide to Claims Denial Resolution located in the Denial Troubleshooting subsection of the DPH-SAPC Sage Resources website. The 45-day timely claim submission window applies to original and replacement claims, therefore all denied claims are to be worked on immediately and resolved as soon as possible. For additional assistance with denials, provider agencies can complete the Request Billing Assistance form to create a Sage Help Desk ticket for SAPC to review.

Services denied by Medi-Cal will not be recouped by SAPC. As such, provider agencies will only receive local denials. However, SAPC Finance staff may reach out to provider agencies to assist in correcting client records in Sage or to confirm claim details in order to fix and resubmit services to DHCS for reimbursement.

Claim Processing and Payments

Processing of claims, EOBs, 835s, and payments at the local level follow standard DMC-ODS practices and timelines. Claims submitted by the 10th of the month will be issued payments by the 25th of the month. Provider agencies will receive all of the standard billing reports and files provided for treatment billing.

MONITORING AND AUDITING

SAPC will monitor JI services by reviewing and confirming that total billed units do not exceed 8 hours per staff member per day and that clients are receiving the appropriate number of service hours based on the level of care requirements. Services that exceed this limit, or that are not supported by required documentation, including clinical documentation and staff timesheets, will be disallowed. SAPC will also review all JI services to ensure compliance with DHCS JI policies and regulations.