



Quality Assurance Bulletin

September 18, 2014 No. 14-04

Program Support Bureau

County of Los Angeles - Department of Mental Health

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IBHIS ADDENDUM GUIDE TO SERVICE & PROCEDURE CODES

The IBHIS Addendum Guide to Service and Procedure Codes has been revised and placed online at: http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals. When a Provider is LIVE in IBHIS, the IBHIS Addendum Guide to Service and Procedure Codes (IBHIS Addendum) should be used in conjunction with the Guide to Procedure Codes to determine appropriate usage of Service/Procedure Codes in IBHIS. Once all Providers are up in IBHIS, the Guide to Procedure Codes will be phased out and all information currently contained in the Guide will be moved to either the Organizational Provider's Manual or the IBHIS Addendum. The IBHIS Addendum provides a list of all available Service/Procedure Codes in IBHIS and displays the following information:

- ✓ **Service Code:** Codes used by Directly-Operated Providers entering directly into IBHIS.
- ✓ **Procedure Code:** Codes used by Contract, Fee-For-Service, or Directly-Operated Providers NOT using IBHIS directly. For these Providers, Procedure Codes are submitted to IBHIS through the Avatar MSO module.
NOTE: Procedure Code is the term used for codes submitted on an 837 claim either into IBHIS or out of IBHIS to a payer source.
- ✓ **Roll-Up Code (Medi-Cal):** Codes submitted to the State Department of Health Care Services (DHCS) for Medi-Cal services. At this time, these are the only codes DHCS recognizes. See below for further information on Roll-Up Codes and Duplicate Override Codes.
- ✓ **Service Code Label/Descriptor:** Provides a brief description of the Service/Procedure Code. Due to limited characters and DMH-specific information, the description might be slightly different than the HIPAA CPT/HCPCS (national code sets) definitions. Contract Providers and Fee-For-Service Providers are responsible for being familiar with the national code sets and informing DMH if they have concerns about discrepancies between the DMH descriptors and the CPT/HCPCS definitions.
- ✓ **Type of Service:** Identifies if the Service/Procedure Code is an Individual (I) or Group (G) service.
- ✓ **Mode/SFC Code:** Identifies the Mode/Service Function Code (SFC) code. See the third tab of the worksheet for a list of the corresponding definitions for the Mode/SFC code.
- ✓ **Disciplines:** Identifies the allowable disciplines that may submit claims for the Service/Procedure Code. IBHIS will confirm that the practitioner on the service is allowed to use the Service/Procedure Code based on how the Practitioner is set up in IBHIS. See the second tab of the worksheet for a list of the corresponding definitions for the disciplines.
- ✓ **May be used by:** Used along with the Service Code and Procedure Code columns. Identifies whether the Service/Procedure Code is allowable for Directly-Operated, Contract or Fee-For-Service Providers.

Roll-Up Codes and Duplicate Override Codes

At this time, DHCS only accepts a limited set of Procedure Codes. Los Angeles County Department of Mental Health “rolls-up” the Service/Procedure Codes submitted by Providers to the more generic Procedure Codes allowable by DHCS/Medi-Cal.

When claims are submitted to DHCS using the “rolled-up” generic Procedure Codes, DHCS will deny any claim which appears to be a duplicate. A duplicate is identified based on identical values in each of the following fields:

- Medi-Cal Client Index Number (CIN)
- Program of Service (Provider Number)
- Date of Service
- Practitioner
- “Rolled-up” Procedure Code
- Total Duration

If the service is NOT a true duplicate, a duplicate override modifier must be added to the Service/Procedure Code to allow the claim to pass through when submitted to DHCS. There are two duplicate override modifiers which may be utilized: 76 and 59.

- The 76 modifier should be added to the Service/Procedure Code when the above conditions are met based on the **submitted** Service/Procedure Code.
- The 59 modifier should be added to the Service/Procedure Code when the above conditions are met based on the **rolled-up** Procedure Code.

For Directly-Operated Providers entering Service Codes directly into IBHIS, the Post-Posting Code Check report currently identifies services which may require the 76 modifier to be added. The report is being updated to identify services which may require the 59 modifier to be added. For Providers submitting claims to IBHIS (Contract, Fee-For-Service and Directly-Operated Providers not submitting claims directly into IBHIS), the 76 and 59 modifiers must be added to the Procedure Code prior to submission of the claim.

If you have any questions regarding this Bulletin, please contact your Service Area QA Liaison.

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