AGREEMENT BETWEEN COUNTY OF LAKE AND TRADITIONS BEHAVIORAL HEALTH FOR SPECIALTY MENTAL HEALTH SERVICES FOR FISCAL YEAR 2026-2027

This Agreement is made and entered into by and between the County of Lake, hereinafter referred to as "County," and Traditions Behavioral Health, hereinafter referred to as "Contractor," collectively referred to as the "parties."

RECITALS

WHEREAS, the Lake County Behavioral Health Services Department provides mental health services to the residents of Lake County; and

WHEREAS, the Board of Supervisors of the County has determined that its mental health program requires specialized mental health services for the residents of Lake County; and

WHEREAS, County issued a Request for Proposals for Specialty Mental Health Services, including locum tenens and telepsychiatry psychiatric services, and Contractor was selected for negotiation and award; and

WHEREAS, Contractor has the appropriate experience, staffing, qualifications, licenses, certifications, and/or credentials necessary to provide such specialized mental health services and desires to enter into this Agreement with County upon the terms and conditions set forth herein.

NOW, THEREFORE, based on the foregoing recitals, the parties hereto agree as follows:

1. SERVICES. Subject to the terms and conditions set forth in this Agreement, Contractor shall provide to County the services described in the Scope of Services attached hereto and incorporated herein as **Exhibit A** at the time and place and in the manner specified therein. In the event of a conflict in or inconsistency between the terms of this Agreement and **Exhibits A/B/C/D**, the Agreement shall prevail.

2. TERM. This Agreement shall commence on July 1, 2026, and shall terminate on June 30, 2027, unless earlier terminated as hereinafter provided. In the event County desires to temporarily continue services after the expiration of this Agreement, such continuation shall be deemed on a month-to-month basis, subject to the same terms, covenants, and conditions contained herein, unless otherwise amended in writing.

3. COMPENSATION. Contractor has been selected by County to provide the services described hereunder in Exhibit A, titled "Scope of Services," attached hereto and incorporated herein. Compensation to Contractor shall not exceed **Five Million Four Hundred Thousand Dollars ($5,400,000.00)**

The County shall compensate Contractor pursuant to the applicable compensation structure, rate table, budget, or payment schedule contained in Exhibit B – Fiscal Provisions, which is incorporated herein by this reference.

The rates set forth therein shall apply to all covered services provided under this Agreement and shall constitute full compensation for all costs associated with service delivery.

This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this

Agreement. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement. In the event of delayed reimbursement from the State or Federal government, County may delay payment to Contractor until funds are received. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Contractor to discuss renegotiating the services required by this Agreement.

4. TERMINATION.

Notwithstanding any other provision in this Agreement, this Agreement may be terminated by mutual consent of the parties or by County upon 30 days written notice to Contractor. In the event of non-appropriation of funds for the services provided under this Agreement, County may terminate this Agreement, without termination charge or other liability.

In addition to any other remedies available under this Agreement or applicable law, County may, at its sole discretion, take one or more of the following actions in response to Contractor's noncompliance with or breach of this Agreement or applicable DHCS requirements:
a. Require Contractor to submit and implement a corrective action plan (CAP);
b. Require additional training, supervision, or technical assistance;
c. Suspend referrals or authorization of services;
d. Withhold, delay, or deny payment for services;
e. Disallow costs and recoup funds previously paid to Contractor and not used for services specifically outlined in Exhibit A of this Agreement; and/or
f. Terminate this Agreement upon fifteen (15) days written notice to Contractor.

The exercise of any of the above remedies shall not preclude County from exercising any other rights or remedies available under this Agreement or at law.

Upon termination, Contractor shall be paid a prorated amount for the services provided up to the date of termination. Within thirty (30) days of the effective date of termination, Contractor shall:

a. Submit all financial documents for the effective period of this Agreement, including but not limited to, invoices, canceled checked, bookkeeping records, financial ledgers, and bank records;
b. Return any payments received that are above and beyond said prorated amount based on the results of an audit by County of said financial documents.

5. MODIFICATION. This Agreement may only be modified by a written amendment hereto, executed by both parties; however, matters concerning scope of services which do not affect the compensation may be modified by mutual written consent of Contractor and County executed by the Lake County Behavioral Health Services Director.

6. NOTICES. All notices that are required to be given by one party to the other under this Agreement shall be in writing and shall be deemed to have been given if delivered personally or enclosed in a properly addressed envelope and deposited with the United States Post Office for delivery by registered or certified mail addressed to the parties at the following addresses, unless such addresses are changed by notice, in writing, to the other party.

County of Lake
Lake County Behavioral Health Services
PO Box 1024

6302 Thirteenth Avenue
Lucerne, CA 95458-1024
Attn: Elise Jones, MA
Director

Contractor:
Traditions Behavioral Health
900 Larkspur Landing Circle
Suite 285
Larkspur, CA 94939

Attn: Cassandra Eslami
Senior Vice President, Clinical Operations

7. EXHIBITS. The Agreement Exhibits, as listed below, are incorporated herein by reference:
Exhibit A - Scope of Services
Exhibit B - Fiscal Provisions
Exhibit C - Compliance Provisions
Exhibit D – Business Associate Agreement

8. TERMS AND CONDITIONS. Contractor warrants and agrees that it shall comply with all terms and conditions of this Agreement including **Exhibit A**, **Exhibit B**, and **Exhibit C**, titled, "**Compliance Provisions,**" attached hereto and incorporated herein in addition to all other applicable federal, state and local laws, regulations and policies.

9. DHCS COMPLIANCE AND SUPREMACY CLAUSE. Contractor shall comply with all applicable federal, state, and local laws, regulations, and guidance, including but not limited to all requirements imposed by the California Department of Health Care Services (DHCS), including Behavioral Health Information Notices (BHINs), and all provisions of County's agreement with DHCS, as may be amended from time to time.

In the event of any conflict between applicable requirements, the following order of precedence shall apply:
(1) Federal law, including but not limited to requirements issued by the Centers for Medicare & Medicaid Services (CMS);
(2) State law and guidance, including but not limited to California statutes, regulations, and California Department of Health Care Services (DHCS) requirements, including Behavioral Health Information Notices (BHINs);
(3) The County's contract with DHCS, including all applicable terms, conditions, and Special Terms and Conditions;
(4) This Agreement; and
(5) All exhibits, attachments, and incorporated documents.
Contractor shall comply with the highest-ranking applicable authority.

Contractor acknowledges that County relies on Contractor's compliance with this Agreement to meet its obligations under its agreement with DHCS. Contractor further acknowledges that failure to comply may result in financial disallowances, penalties, or other liabilities to County, for which Contractor may be held responsible.

10. INTEGRATION. This Agreement, including attachments, constitutes the entire agreement between the parties regarding its subject matter and supersedes all prior Agreements, related proposals, oral and written, and all negotiations, conversations or discussions heretofore and between the parties.

County and Contractor have executed this Agreement on the day and year first written above.

COUNTY OF LAKE

_____
Chair
Board of Supervisors
Date: _____

CONTRACTOR

_____
Name: David Spacarelli
Title: CEO
Date: 8/26/2024

APPROVED AS TO FORM:
LLOYD GUINTIVANO
County Counsel

By: _____

Date: August 24, 2026

ATTEST:
SUSAN PARKER
Clerk to the Board of Supervisors

By: _____

Date: _____

EXHIBIT A – SCOPE OF SERVICES

1. DEFINITIONS

1.1 BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and contractors of changes in policy or procedures at the federal or state levels. These were previously referred to as Mental Health and Substance Use Disorder Services Information Notices (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.
1.2 BENEFICIARY OR CLIENT: "Beneficiary" or "client" mean the individual(s) receiving services.
1.3 DHCS: "DHCS" means the California Department of Health Care Services.
1.4 DIRECTOR: "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.
1.5 DOWNSTREAM ENTITY: "Downstream Entity" means any subcontractor, vendor, consultant, staffing agency, independent contractor, delegated entity, affiliate, facility, provider group, management company, billing company, technology vendor, data vendor, telehealth vendor, or other person or entity used by Contractor to perform, support, arrange, document, bill, authorize, manage, or otherwise carry out any function under this Agreement. Downstream Entity includes any downstream subcontractor, sub-vendor, agent, or other person or entity acting on behalf of Contractor or another Downstream Entity.

2. CONTRACTOR'S RESPONSIBILITIES. Contractor agrees to comply with all applicable Medi-Cal laws, regulations, including 1915(b) Waiver and any Special Terms and Conditions.

2.1 Contractor shall possess and maintain, and shall ensure that its employees, agents, subcontractors, providers, and Downstream Entities possess and maintain, all necessary licenses, permits, certificates, approvals, enrollments, supervision, and credentials required by the laws of the United States, the State of California, County of Lake, and all other appropriate governmental agencies, including any certification and credentials required by County, as applicable to the services or functions performed under this Agreement. Failure to maintain required licenses, permits, certificates, approvals, enrollments, supervision, and credentials shall be deemed a breach of this Agreement and constitutes grounds for termination of this Agreement by County. Contractor shall ensure compliance with California Code of Regulations, Title 9, Section 1810.435, in the selection of providers and shall review for continued compliance with standards at least every three (3) years.

2.2 The Contractor shall maintain written policies and procedures on advance directive in compliance with the requirements of 42, Code of Federal Regulations (CFR), Section 422.128 and 438.6. Any written materials prepared by the Contractor for beneficiaries shall be updated to reflect changes in state laws governing advance directives as soon as possible, but not later than 90 days after the effective date of the change. For purposes of this contract, advance directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated as defined in 42 C.F.R 489.100.

2.3 Contractor will observe and comply with all applicable Federal, State and local laws, ordinances and codes which relate to the services to be provided pursuant to this Agreement, including but not

limited to the Deficit Reduction Act (DRA) of 2005, the Federal and State False Claims Acts, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005 (HITECH Act); and the HIPAA Omnibus Final Rule.

2.4 Contractor acknowledges that this Agreement is funded in whole or in part through agreements between County and the California Department of Health Care Services (DHCS), including but not limited to County Performance Contracts.
Contractor agrees to comply with all applicable requirements imposed on County under such agreements, including but not limited to all applicable federal and state laws, regulations, DHCS guidance, Behavioral Health Information Notices (BHINs), policy manuals, and program requirements, as may be amended from time to time. To the extent that any requirement applicable to County is delegated to Contractor through this Agreement, Contractor shall be responsible for full compliance with such requirements.

2.5 Contractor shall comply with all applicable DHCS guidance, including but not limited to Behavioral Health Information Notices (BHINs), plan letters, and policy manuals, as issued and updated by DHCS. Contractor acknowledges that such guidance may be updated periodically and agrees to comply with all updates without the need for formal amendment to this Agreement.

2.6 All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

2.7 Contractor shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.

2.8 **NOABD, Grievance, Appeal, and State Hearing Responsibilities.** County retains ultimate responsibility for compliance with federal and state grievance, appeal, State Hearing, and Notice of Adverse Benefit Determination ("NOABD") requirements. County expressly delegates to Contractor, and Contractor shall expressly delegate to approved Downstream Entities when applicable, the responsibility to prepare, issue, track, report, and retain NOABDs for adverse benefit determinations made, recommended, implemented, or communicated by Contractor or such Downstream Entities under this Agreement.
Contractor and each applicable Downstream Entity shall issue NOABDs only in accordance with County policy, County-approved templates, applicable DHCS guidance, and 42 C.F.R. Part 438, Subpart F. Contractor and Downstream Entities shall provide reasonable assistance to clients in completing forms and taking procedural steps related to grievances, appeals, expedited appeals, and State Hearings, including auxiliary aids, interpreter services, and assistance required by applicable law.
Contractor and each applicable Downstream Entity shall provide County same-day notice and copies of any NOABD issued, maintain a NOABD log in the format required by County, and make all NOABD, grievance, appeal, expedited appeal, State Hearing, and aid-paid-pending records available to County upon request.
Contractor shall not, and shall ensure that Downstream Entities do not, discourage the filing of grievances or appeals. Clients shall not be required to use the term "grievance," "appeal," or "NOABD"

for the matter to be recognized, processed, tracked, and reported in accordance with applicable requirements.
County may require correction, reissuance, additional notice, corrective action, training, suspension of delegated authority, payment withholding, recoupment, suspension of referrals, or termination for failure to comply with NOABD, grievance, appeal, or State Hearing requirements.

2.9 Procedures and timeframes for responding to grievances, issuing and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).

2.10 Contractor must provide clients any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.

2.11 Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2.12 Contractor shall follow County's continuity of care policy in accordance with applicable state and federal laws, regulations, 42 C.F.R. § 438.62, and current or superseding DHCS guidance related to continuity of care and parity in mental health and substance use disorder benefits.

2.13 Client's rights shall be assured pursuant to California law and regulation, including but not limited to Welfare and Institutions Code 5325, Title 9, CCR, Sections 860 through 868 and Title 42, CFR, Section 438.100(b)(1) and, (b)(2). Included in these rights is the right of beneficiaries to participate in decisions regarding his or her health care, including the right to refuse potential treatment services.

2.14 Contractor agrees to extend to County or its designee, the right to review and monitor all records, programs or procedures, at any time in regards to clients, as well as the overall operation of Contractor's programs in order to ensure compliance with the terms and conditions of this Agreement.

2.15 Upon discovery of a reportable breach by Contractor, the Contractor must notify County within 24 hours of the breach by submitting an incident report to the Behavioral Health Compliance Officer/Privacy Officer, and fulfill the mandated reporting requirements. Contractor will make his/her best efforts to preserve data integrity and the confidentiality of protected health information.

2.16 Upon termination of the Agreement all Protected Health Information provided by Lake County Behavioral Health to Contractor, or created or received by Contractor on behalf of County, is destroyed or returned to County, or if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

2.17 Contractor shall comply with the provision of the County's Cultural Competency Plan by maintaining 100% compliance with National Culturally and Linguistically Appropriate Services (CLAS) standards. Contractor shall provide proof, no less than annually or upon County's request, evidence of compliance including but not limited to attendance and training agendas, or other such documentation which reasonably evidences compliance.

2.18 Contractor shall ensure that the logo for Lake County Behavioral Health Services (LCBHS) is included on flyers, handouts, and any advertising materials for any projects or events that LCBHS contributes to via funding from this Agreement.

2.19 Contractor will notify the County about any change that may affect Contractor's eligibility and ability to provide services including, but not limited to, changes in licensing, certification, ownership and address.

3. REPORTING REQUIREMENTS. Contractor agrees to provide County with any reports which may be required by County, DHCS, state or federal agencies, or applicable funding sources for compliance with this Agreement.

3.1 Contractor shall submit monthly, quarterly, annual, and/or other reports as required by County, DHCS, or applicable funding source, in a format approved by County. Failure to provide required reports in a timely manner may constitute a material breach of this Agreement.

3.2 Contractor shall submit a year-end program summary in a format to be provided by County, if requested by County.

4. RECORDS RETENTION.

4.1 Contractor shall prepare, maintain and/or make available to County upon request, all records and documentation pertaining to this Agreement, including financial, statistical, property, recipient and service records and supporting documentation for a period of ten (10) years from the date of final payment of this Agreement. If at the end of the retention period, there is ongoing litigation or an outstanding audit involving the records, Contractor shall retain the records until resolution of litigation or audit. After the retention period has expired, Contractor assures that confidential records shall be shredded and disposed of appropriately.

4.2 Contractor shall maintain the legal clinical record for each client served under this Agreement in accordance with applicable law, licensing requirements, and this Agreement. County shall have the right to access, inspect, copy, audit, and obtain records related to County clients and services provided under this Agreement, subject to applicable confidentiality laws. Clinical records shall be kept at least ten (10) years following discharge. Clinical records of un-emancipated minors shall be kept at least one (1) year after such minor has reached the age of eighteen (18) years or ten (10) years past the last date of treatment, whichever is longer. Records of minors who have been treated by a licensed psychologist must be retained until the minor has reached age twenty-five (25). All information and records obtained in the course of providing services under this Agreement shall be confidential and Contractor shall comply with State and Federal requirements regarding confidentiality of patient information, including but not limited to Welfare and Institutions Code section 5328 and Title 45, Code of Federal Regulations, section 205.50 for Medi-Cal-eligible clients. All applicable regulations and statutes relating to clients' rights shall be adhered to. This provision shall survive the termination, expiration, or cancellation of this Agreement. Clinical records shall contain sufficient detail to make possible an evaluation by County's Behavioral Health Director or designee, or DHCS, and shall be maintained in accordance with applicable laws, regulations, and DHCS requirements.

5. DATA SHARING AND INTEROPERABILITY

5.1 Contractor shall comply with all applicable federal and state requirements related to data sharing, interoperability, and patient access to health information, including but not limited to requirements issued by the California Department of Health Care Services (DHCS), including Behavioral Health Information Notice (BHIN) 26-013, as may be amended from time to time.
Contractor shall ensure compliance with all applicable privacy and security laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (45 C.F.R. Parts 160 and 164), and 42 C.F.R. Part 2, where applicable.

5.2 Contractor shall provide timely, complete, and accurate data to County in formats and within timeframes specified by County, DHCS, or other applicable regulatory authorities. Contractor shall cooperate with County in implementing data exchange, reporting, and interoperability requirements, including participation in any required health information exchange (HIE), electronic health record (EHR) integration, or data-sharing initiatives required by County or DHCS.

5.3 Contractor shall provide data in a County-approved format, including County-approved templates, EHR exports, or secure electronic exchange, as directed by County. Contractor shall notify County of client admissions, discharges, and other status changes within one business day, as applicable to the services provided under this Agreement; submit required data and utilization information; participate in care coordination meetings or case conferences upon County request; cooperate with County and DHCS data sharing and interoperability requirements; and correct incomplete or inaccurate data within timeframes specified by County.

5.4 Data Systems and Downstream Entity Access**.** Contractor shall ensure that all systems, platforms, applications, electronic health records, billing systems, care coordination systems, telehealth systems, data warehouses, and other technology used by Contractor or any Downstream Entity in connection with this Agreement comply with applicable privacy, security, confidentiality, interoperability, audit, data-sharing, and record-retention requirements.

Contractor shall not permit any Downstream Entity to create, receive, maintain, transmit, access, store, process, or exchange County client information, PHI, PII, claims data, clinical records, authorization data, NOABD data, grievance or appeal data, or network adequacy data unless Contractor has obtained all required agreements, assurances, privacy/security controls, and County approvals.
Contractor shall ensure that County has access, upon request, to data and records maintained in any Contractor or Downstream Entity system to the extent necessary for payment validation, audit, monitoring, care coordination, quality improvement, grievance and appeal processing, NOABD oversight, network adequacy monitoring, timely access monitoring, reporting, investigation, or compliance with County, DHCS, CMS, or other oversight requirements.

6. DESCRIPTION OF SERVICES.

6.1 Contractor shall provide Specialty Mental Health Services and related services as described in this Exhibit A and as authorized by County. Services shall be provided in accordance with applicable federal and state laws, DHCS requirements, County policies, and the terms of this Agreement.

6.2 Contract-Specific Scope of Services. Contractor shall provide locum tenens, telepsychiatry, and related outpatient Specialty Mental Health Services staffing support for Lake County Behavioral Health Services as authorized by County. Services include the following:

• Outpatient psychiatric evaluation, psychiatric consultation, medication support, medication management, and related covered Specialty Mental Health Services within the scope of practice of County-approved psychiatrists/physicians and County-approved psychiatric nurse practitioners or other prescribers only if expressly authorized by County in writing.
• County-authorized LPHA, Registered Nurse, Licensed Vocational Nurse, Licensed Psychiatric Technician, and Medical Assistant services within each rendering provider type's scope of practice and covered code set. These service lines are included in the scope of this Agreement so the parties may negotiate rates and operational expectations; however, Contractor shall not render or bill these services until County approves the provider type, staffing model, compensation rate, and implementation expectations in writing.
• Services may be delivered by telehealth and/or in person, as authorized by County and clinically appropriate, at County clinics, County-approved field-based locations, County-approved facility locations, and other County-approved service locations.
• Adult psychiatry coverage and child/youth psychiatry coverage based on County programmatic need, caseload, productivity, timely access requirements, no-show patterns, and County-approved staffing levels. The solicitation identified a potential need for approximately six adult psychiatry FTE and one child/youth psychiatry FTE; actual staffing shall be determined collaboratively and shall require County approval.
• Participation in multidisciplinary team meetings, care coordination, treatment planning, quality/compliance meetings, and consultation with County clinical teams, including BHSA-required evidence-based practice teams such as ACT, FACT, and ICM, when applicable.
• Authorized psychiatric on-call coverage after hours, on weekends, County holidays, and County break periods, available across County programs including the mobile response team, only when scheduled and approved in advance by County.
• Recruitment and presentation of qualified candidate packets within 24-72 hours after Contractor verification when candidates are available, with phased staffing ramp-up targeted within 90 days after execution of the Agreement, subject to credentialing, enrollment, County approval, and County operational readiness.
• Priority recruitment of bilingual Spanish-speaking staff and staff able to meet Lake County cultural and linguistic accessibility needs.
• Quarterly performance review with County, including review of productivity, timely access, caseload, no-shows, documentation timeliness, claim acceptance/denial patterns, client access needs, quality concerns, staffing stability, and any corrective action needs.

6.3 Covered Procedure Codes by Provider Type. Contractor may provide and claim only the covered procedure codes listed below for the identified provider types, and only when the service is within the rendering provider's scope of practice, authorized by County, medically necessary, properly documented, allowable under applicable DHCS and Medi-Cal requirements, and accepted by County. Inclusion of a code in this table does not guarantee payment, does not authorize services outside the scope of this Agreement, and does not override County authorization, credentialing, documentation, timely access, medical necessity, program integrity, or negotiated-rate requirements.
The provider types included in this covered-code appendix are Licensed Physician, Nurse Practitioner, LPHA - LCSW, LPHA - MFT/LPCC, Registered Nurse, Licensed Vocational Nurse, Licensed Psychiatric Technician, and Medical Assistant. If the parties later add another provider type, including but not limited to Psychologist, Mental Health Rehabilitation Specialist, Peer, Community Health Worker, or Medical Director services, the provider type must be added through a written amendment or

other County-approved written authorization that identifies the covered codes, rate structure, deliverables, staffing expectations, and compliance requirements.

Covered Procedure Codes - Licensed Physician

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
90791		Assessment	Psychiatric diagnostic evaluation, 60 minutes
90792		Assessment	Psychiatric diagnostic evaluation with medical services, 60 minutes
90832	22	Therapy	Psychotherapy, 30 minutes with patient
90832		Therapy	Psychotherapy, 30 minutes with patient
90833	22	Therapy	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90833		Therapy	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90834	22	Therapy	Psychotherapy, 45 minutes with patient
90834		Therapy	Psychotherapy, 45 minutes with patient
90836	22	Therapy	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90836		Therapy	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837	22	Therapy	Psychotherapy, 60 minutes with patient
90837		Therapy	Psychotherapy, 60 minutes with patient
90838	22	Therapy	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
90838		Therapy	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
90839		Crisis	Psychotherapy for crisis; first hour
90840		Crisis	Psychotherapy for crisis; each additional 30 minutes
90845		Therapy	Psychoanalysis, 45 minutes
90847	22	Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90847		Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90849		Therapy	Multiple-family group psychotherapy, 84 minutes

Procedure Code	Modifier	Type of Service	Service Description
90853		Therapy	Group psychotherapy (other than of a multiple-family group), 50 minutes
90865		Medication Support	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview), 90 minutes
90867		Therapy	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management (Report only once per course of treatment), 60 minutes
90868		Therapy	Subsequent delivery and management of TMS, per session, 15 minutes
90869		Therapy	TMS treatment subsequent motor threshold re-determination with delivery and management, 45 minutes
90870		Therapy	Electroconvulsive therapy (includes necessary monitoring), 20 minutes
90880		Therapy	Hypnotherapy, 60 minutes
90885		Assessment	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, 60 minutes
90887		Supplemental	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes
96105		Assessment	Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report), per hour
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring

Procedure Code	Modifier	Type of Service	Service Description
			and documentation, per standardized instrument), 60 minutes
96112		Assessment	Developmental Testing Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, first hour
96113		Assessment	Developmental Testing Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, each additional 30 minutes
96116		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, each additional hour
96125		Assessment	Standardized Cognitive Performance Testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional’s time, both face-to-face

Procedure Code	Modifier	Type of Service	Service Description
			time administering tests to the patient and time interpreting these test results and preparing the report
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96130		Assessment	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour
96131		Assessment	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour
96132		Assessment	Neuropsychological Testing Evaluation Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour
96133		Assessment	Neuropsychological Testing Evaluation Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision

Procedure Code	Modifier	Type of Service	Service Description
			making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour
96136		Assessment	Psychological or Neuropsychological Testing Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137		Assessment	Psychological or Neuropsychological Testing Psychological or neuropsychological test administration and scoring by a physician or other qualified health care professional, two or more tests, any method, each additional 30 minutes
96146		Assessment	Psychological Neuropsychological Test (Automated) Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only: Via electronic platform & formulates an electronic result. Interpretation and report, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes

Procedure Code	Modifier	Type of Service	Service Description
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
96365		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour
96366		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, each additional hour
96367		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, additional sequential infusion of a new drug/ substance, up to 1 hour
96368		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes
96373		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
96374		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375		Medication Support	Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes
96376		Medication Support	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug
96377		Medication Support	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving,

Procedure Code	Modifier	Type of Service	Service Description
			safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
99202		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99212		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99213		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99221		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99223		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99233		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99234		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99235		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238		Discharge	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter
99239		Discharge	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99242		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99244		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99252		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99253		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99255		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of

Procedure Code	Modifier	Type of Service	Service Description
			medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
99304		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99307		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99309		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99341		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99342		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of

Procedure Code	Modifier	Type of Service	Service Description
			medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99367		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99415		Therapy	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the

Procedure Code	Modifier	Type of Service	Service Description
			office or outpatient setting, direct patient contact with physician supervision; first hour
99416		Therapy	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes
99417		Therapy	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time
99418		Therapy	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time
99441		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Procedure Code	Modifier	Type of Service	Service Description
99443		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99451		Referral & Linkage	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time (5-30 minutes)
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0316		Therapy	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or

Procedure Code	Modifier	Type of Service	Service Description
			qualified healthcare professional, with or without direct patient contact
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0033		Medication Support	Medication administration, direct observation, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H0036		Functional Family Therapy	A family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2021	22	Therapy	Therapy substitute, 15 minutes
T2021	HQ	Therapy	Therapy substitute, 15 minutes
T2021		Therapy	Therapy substitute, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

Covered Procedure Codes - Nurse Practitioner

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
90791		Assessment	Psychiatric diagnostic evaluation, 60 minutes
90792		Assessment	Psychiatric diagnostic evaluation with medical services, 60 minutes
90832	22	Therapy	Psychotherapy, 30 minutes with patient
90832		Therapy	Psychotherapy, 30 minutes with patient
90833	22	Therapy	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service

Procedure Code	Modifier	Type of Service	Service Description
90833		Therapy	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service
90834	22	Therapy	Psychotherapy, 45 minutes with patient
90834		Therapy	Psychotherapy, 45 minutes with patient
90836	22	Therapy	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90836		Therapy	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service
90837	22	Therapy	Psychotherapy, 60 minutes with patient
90837		Therapy	Psychotherapy, 60 minutes with patient
90838	22	Therapy	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
90838		Therapy	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service
90839		Crisis	Psychotherapy for crisis; first hour
90840		Crisis	Psychotherapy for crisis; each additional 30 minutes
90845		Therapy	Psychoanalysis, 45 minutes
90847	22	Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90847		Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90849		Therapy	Multiple-family group psychotherapy, 84 minutes
90853		Therapy	Group psychotherapy (other than of a multiple-family group), 50 minutes
90865		Medication Support	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview), 90 minutes
90867		Therapy	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management (Report only once per course of treatment), 60 minutes
90868		Therapy	Subsequent delivery and management of TMS, per session, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
90869		Therapy	TMS treatment subsequent motor threshold re-determination with delivery and management, 45 minutes
90870		Therapy	Electroconvulsive therapy (includes necessary monitoring), 20 minutes
90880		Therapy	Hypnotherapy, 60 minutes
90885		Assessment	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, 60 minutes
90887		Supplemental	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes
96105		Assessment	Assessment of Aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report), per hour
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument), 60 minutes
96112		Assessment	Developmental Testing Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, first hour
96113		Assessment	Developmental Testing Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or

Procedure Code	Modifier	Type of Service	Service Description
			executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, each additional 30 minutes
96116		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, each additional hour
96125		Assessment	Standardized Cognitive Performance Testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96130		Assessment	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report,

Procedure Code	Modifier	Type of Service	Service Description
			and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour
96131		Assessment	Psychological Testing Evaluation Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour
96132		Assessment	Neuropsychological Testing Evaluation Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour
96133		Assessment	Neuropsychological Testing Evaluation Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed, each additional hour
96136		Assessment	Psychological or Neuropsychological Testing Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137		Assessment	Psychological or Neuropsychological Testing Psychological or neuropsychological test administration and scoring by a physician or other qualified health care

Procedure Code	Modifier	Type of Service	Service Description
			professional, two or more tests, any method, each additional 30 minutes
96146		Assessment	Psychological Neuropsychological Test (Automated) Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only: Via electronic platform & formulates an electronic result. Interpretation and report, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
96365		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour
96366		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, each additional hour

Procedure Code	Modifier	Type of Service	Service Description
96367		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, additional sequential infusion of a new drug/ substance, up to 1 hour
96368		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes
96373		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes
96374		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375		Medication Support	Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes
96376		Medication Support	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug

Procedure Code	Modifier	Type of Service	Service Description
96377		Medication Support	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
98966		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Procedure Code	Modifier	Type of Service	Service Description
98967		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
99202		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99204		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time

Procedure Code	Modifier	Type of Service	Service Description
			on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205		Medication Support	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99212		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99213		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215		Medication Support	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99221		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99222		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99223		Therapy	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99231		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99232		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the

Procedure Code	Modifier	Type of Service	Service Description
			encounter for code selection, 35 minutes must be met or exceeded.
99233		Therapy	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99234		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99235		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded.
99236		Assessment	Hospital inpatient or observation care, for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded.
99238		Discharge	Hospital inpatient or observation discharge day management; 30 minutes or less on the date of the encounter

Procedure Code	Modifier	Type of Service	Service Description
99239		Discharge	Hospital inpatient or observation discharge day management; more than 30 minutes on the date of the encounter
99242		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99244		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245		Therapy	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
99252		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99253		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99254		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99255		Therapy	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.
99304		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.
99305		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.
99306		Therapy	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of

Procedure Code	Modifier	Type of Service	Service Description
			medical decision making. When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded.
99307		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99308		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99309		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99310		Therapy	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99341		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

Procedure Code	Modifier	Type of Service	Service Description
99342		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99344		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99345		Medication Support	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
99347		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99348		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99349		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and

Procedure Code	Modifier	Type of Service	Service Description
			moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99350		Medication Support	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99366		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99368		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99415		Therapy	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
99416		Therapy	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes
99417		Therapy	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

Procedure Code	Modifier	Type of Service	Service Description
99418		Therapy	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time
99441		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443		Assessment	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following

Procedure Code	Modifier	Type of Service	Service Description
			required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0316		Therapy	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes

Procedure Code	Modifier	Type of Service	Service Description
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H0036		Functional Family Therapy	A family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1001		Assessment	Nursing assessment/ evaluation, 15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2021	22	Therapy	Therapy substitute, 15 minutes
T2021	HQ	Therapy	Therapy substitute, 15 minutes
T2021		Therapy	Therapy substitute, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

Covered Procedure Codes - LPHA - LCSW (Licensed, Waivered or Registered)

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
90791		Assessment	Psychiatric diagnostic evaluation, 60 minutes
90832	22	Therapy	Psychotherapy, 30 minutes with patient
90832		Therapy	Psychotherapy, 30 minutes with patient
90834	22	Therapy	Psychotherapy, 45 minutes with patient
90834		Therapy	Psychotherapy, 45 minutes with patient
90837	22	Therapy	Psychotherapy, 60 minutes with patient
90837		Therapy	Psychotherapy, 60 minutes with patient
90839		Crisis	Psychotherapy for crisis; first hour
90840		Crisis	Psychotherapy for crisis; each additional 30 minutes
90845		Therapy	Psychoanalysis, 45 minutes
90847	22	Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90847		Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90849		Therapy	Multiple-family group psychotherapy, 84 minutes
90853		Therapy	Group psychotherapy (other than of a multiple-family group), 50 minutes
90880		Therapy	Hypnotherapy, 60 minutes
90885		Assessment	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests,

Procedure Code	Modifier	Type of Service	Service Description
			and other accumulated data for medical diagnostic purposes, 60 minutes
90887		Supplemental	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument), 60 minutes
96116		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, each additional hour
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs],

Procedure Code	Modifier	Type of Service	Service Description
			instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
98966		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
99366		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

Procedure Code	Modifier	Type of Service	Service Description
99368		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0323		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, or marriage and family therapist time, per calendar month.
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0036		Functional Family Therapy	A family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2021	22	Therapy	Therapy substitute, 15 minutes
T2021	HQ	Therapy	Therapy substitute, 15 minutes
T2021		Therapy	Therapy substitute, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

Covered Procedure Codes - LPHA - MFT/LPCC (Licensed, Waivered or Registered)

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
90791		Assessment	Psychiatric diagnostic evaluation, 60 minutes
90832	22	Therapy	Psychotherapy, 30 minutes with patient
90832		Therapy	Psychotherapy, 30 minutes with patient
90834	22	Therapy	Psychotherapy, 45 minutes with patient
90834		Therapy	Psychotherapy, 45 minutes with patient
90837	22	Therapy	Psychotherapy, 60 minutes with patient
90837		Therapy	Psychotherapy, 60 minutes with patient
90839		Crisis	Psychotherapy for crisis; first hour
90840		Crisis	Psychotherapy for crisis; each additional 30 minutes
90845		Therapy	Psychoanalysis, 45 minutes
90847	22	Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90847		Therapy	Family psychotherapy [conjoint psychotherapy] (with patient present), 50 minutes
90849		Therapy	Multiple-family group psychotherapy, 84 minutes
90853		Therapy	Group psychotherapy (other than of a multiple-family group), 50 minutes
90880		Therapy	Hypnotherapy, 60 minutes

Procedure Code	Modifier	Type of Service	Service Description
90885		Assessment	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes, 60 minutes
90887		Supplemental	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument), 60 minutes
96116		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour
96121		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, each additional hour
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with

Procedure Code	Modifier	Type of Service	Service Description
			scoring and documentation, per standardized instrument, 15 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
98966		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968		Assessment	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
99366		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or

Procedure Code	Modifier	Type of Service	Service Description
			family, 30 minutes or more, participation by nonphysician qualified health care professional
99368		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0323		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist, clinical social worker, mental health counselor, or marriage and family therapist time, per calendar month.
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional

Procedure Code	Modifier	Type of Service	Service Description
			(without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0036		Functional Family Therapy	A family-based prevention and intervention program for high-risk youth that addresses complex and multidimensional problems with a flexibly structured and culturally responsive practice.
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2021	22	Therapy	Therapy substitute, 15 minutes
T2021	HQ	Therapy	Therapy substitute, 15 minutes
T2021		Therapy	Therapy substitute, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

Covered Procedure Codes - Registered Nurse

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
90887		Supplemental	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient, 50 minutes
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument), 60 minutes
96116		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-

Procedure Code	Modifier	Type of Service	Service Description
			face time with the patient and time interpreting test results and preparing the report, first hour
96121		Assessment	Neurobehavioral Status Exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities) by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, each additional hour
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple

Procedure Code	Modifier	Type of Service	Service Description
			sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
96365		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour
96366		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, each additional hour
96367		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, additional sequential infusion of a new drug/ substance, up to 1 hour
96368		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes
96373		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes
96374		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375		Medication Support	Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
96376		Medication Support	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug
96377		Medication Support	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
99366		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

Procedure Code	Modifier	Type of Service	Service Description
99368		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer

Procedure Code	Modifier	Type of Service	Service Description
			formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1001		Assessment	Nursing assessment/ evaluation, 15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

Covered Procedure Codes - Licensed Vocational Nurse

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
96365		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour
96366		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, each additional hour
96367		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, additional sequential infusion of a new drug/ substance, up to 1 hour

Procedure Code	Modifier	Type of Service	Service Description
96368		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes
96373		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes
96374		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375		Medication Support	Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes
96376		Medication Support	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug
96377		Medication Support	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or

Procedure Code	Modifier	Type of Service	Service Description
			community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.

Procedure Code	Modifier	Type of Service	Service Description
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1001		Assessment	Nursing assessment/ evaluation, 15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes

Covered Procedure Codes - Licensed Psychiatric Technician

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
96138		Assessment	Psychological or Neuropsychological (2 or more) Tests Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; In person (Administration) & Scoring, first 30 minutes
96139		Assessment	Psychological or Neuropsychological (2 or more) Tests Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; In person (Administration) & Scoring, each additional 30 minutes
96202		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by

Procedure Code	Modifier	Type of Service	Service Description
			physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes
96203		Collateral	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes
96365		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hour
96366		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, each additional hour
96367		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, additional sequential infusion of a new drug/ substance, up to 1 hour
96368		Medication Support	Intravenous infusion, for therapy, prophylaxis, or diagnosis, concurrent infusion, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes
96373		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intra-arterial, 1 - 15 minutes
96374		Medication Support	Therapeutic, prophylactic, or diagnostic injection, intravenous push, single or initial substance/drug, 15 minutes
96375		Medication Support	Therapeutic, prophylactic, or diagnostic injection, each additional sequential intravenous push of a new substance/drug, 15 minutes
96376		Medication Support	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility; 15 minutes; has to be more than 30 minutes after a reported push of the same drug
96377		Medication Support	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection, 1 - 15 minutes
97550		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes
97551		Collateral	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
97552		Collateral	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers. Need to clarify time.
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
G0539		Collateral	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540		Collateral	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or

Procedure Code	Modifier	Type of Service	Service Description
			illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
G0542		Collateral	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes
G0543		Collateral	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
H0031		Assessment	Mental health assessment by nonphysician, 15 minutes
H0032		Treatment Planning	Mental health service plan development by non-physicians, 15 minutes
H0033		Medication Support	Medication administration, direct observation, 15 minutes
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2011		Crisis	Crisis intervention service, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1001		Assessment	Nursing assessment/ evaluation, 15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
T1017		Referral & Linkage	Targeted case management, 15 minutes

Covered Procedure Codes - Medical Assistant

Procedure Code	Modifier	Type of Service	Service Description
90785		Supplemental	Interactive complexity. This code is claimed in addition to the code for the primary procedure. There is no assigned time for this code.
96110		Assessment	Developmental Screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument), 60 minutes
96127		Assessment	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation per standardized instrument, 60 minutes
96161		Supplemental	Caregiver Assessment Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument, 15 minutes
96369		Medication Support	Subcutaneous infusion for therapy or prophylaxis, initial, including pump set-up and establishment of subcutaneous infusion site(s), 16-60 minutes (For infusions of 15 minutes or less, use 96372)
96370		Medication Support	Subcutaneous infusion for therapy or prophylaxis, including pump set-up and establishment or subcutaneous infusion site(s), each additional hour
96371		Medication Support	Subcutaneous infusion for therapy or prophylaxis, additional pump set-up with establishment of new subcutaneous infusion site(s), 15 minutes
96372		Medication Support	Therapeutic, prophylactic, or diagnostic injection, subcutaneous or intramuscular, 1 - 15 minutes

Procedure Code	Modifier	Type of Service	Service Description
99366		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99368		Treatment Planning	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99484		Treatment Planning	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.
H0034	HQ	Medication Support	Medication training and support, 15 minutes
H0034		Medication Support	Medication training and support, 15 minutes
H2000		Assessment	Comprehensive multidisciplinary evaluation, 15 minutes
H2017	HQ	Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2017		Rehabilitation	Psychosocial rehabilitation, 15 minutes
H2019		Therapeutic Behavioral Services	Therapeutic behavioral services, 15 minutes
H2021		Rehabilitation	Community-based wrap-around services (coordination with other programs),15 minutes
T1013		Supplemental	Sign language or oral interpretive services, 15 minutes
T1017		Referral & Linkage	Targeted case management, 15 minutes
T2024		Assessment	Assessment substitute, 15 minutes

6.4 Implementation and Readiness. Contractor shall not begin rendering billable services until County confirms clinical, operational, credentialing, enrollment, privacy/security, SmartCare access, and quality readiness. Contractor shall cooperate with County in onboarding, EHR access, provider enrollment, credentialing, scheduling, documentation training, claims validation, and quality review before services begin.

6.5 County Approval of Providers. No Contractor provider may render, document, supervise, prescribe, consult, or bill under this Agreement until County has approved the provider in writing and County has verified all credentialing, licensing, enrollment, exclusion screening, insurance, training, and system access requirements. County may require removal or replacement of a provider for compliance, quality, access, documentation, productivity, or operational reasons.

6.6 No Guarantee of Volume. County does not guarantee any minimum referrals, minimum caseload, minimum hours, minimum FTE, minimum revenue, or minimum payment for standard weekday services. Staffing levels shall be adjusted based on actual County need, timely access requirements, productivity, caseload, no-show rates, and available funding.

6.7 Authorized Services Only. Contractor shall provide only those services, activities, placements, supplemental services, and/or other costs expressly authorized in advance by County, except where emergency circumstances require immediate action and County provides written retroactive authorization.

7. AUTHORIZATIONS.

7.1 Contractor, in a competent and professional manner, shall provide specialized services to Lake County clients who meet applicable criteria and whose services have been authorized by County in accordance with County policy, DHCS guidance, and applicable federal and state requirements.

7.2 County shall not be financially responsible for any service, activity, placement, supplemental service, or other cost unless expressly authorized in advance by County, except where emergency circumstances require immediate action and County provides written retroactive authorization.

7.3 County authorization requirements do not delay assessment, crisis/timely access, or covered SMHS during assessment.

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EXHIBIT B – FISCAL PROVISIONS

1. **CONTRACTOR'S FINANCIAL RECORDS**.
Contractor shall keep and maintain all financial records for funds received hereunder, separate from any other funds administered by Contractor, and maintained in accordance with Generally Accepted Accounting Principles and Procedures and the Office of Management and Budget's Cost Principles. **Contractor shall produce said financial records within fifteen (15) days upon receipt of a written request by the County.**

2. **FISCAL DEFINITIONS**

2.1 "Delayed Reimbursement" means a delay in payment to County from federal or state funding sources, including but not limited to Medi-Cal, that is unrelated to the allowability or validity of Contractor's claim. Delayed reimbursement does not constitute a denial or disallowance of services and does not obligate County to advance payment prior to receipt of funds.

2.2 "Denied Claim" means a claim for services that is rejected for payment by County, DHCS, or CMS due to failure to meet billing, coding, authorization, eligibility, timeliness, or documentation requirements. Denied Claims are not payable unless and until corrected and resubmitted within applicable timelines and accepted for payment.

2.3 "Disallowed Claim" means a claim for which payment has been determined to be unallowable, in whole or in part, as a result of audit, review, investigation, or other compliance determination by County, DHCS, CMS, or other authorized entity. Disallowed Claims are not eligible for reimbursement and are subject to recoupment.

2.4 "Overpayment" means any funds paid to Contractor to which Contractor is not entitled, including but not limited to payments associated with Denied Claims, Disallowed Claims, duplicate payments, billing errors, or services that do not meet applicable medical necessity, documentation, or program requirements. Contractor shall report and return any identified Overpayment in accordance with timelines established by County and applicable law.

2.5 "Recoupment" means the recovery by County of Overpayments or amounts associated with Disallowed Claims, whether by direct repayment from Contractor or by offset against current or future amounts due to Contractor under this Agreement or any other agreement between the parties.

3. Offset and Recovery

County reserves the right to recover any Overpayment or Disallowed Claim through Recoupment, including by offsetting such amounts against any current or future payments due to Contractor under this Agreement or any other agreement between the parties, without the need for additional consent from Contractor.

3.1 Payment Conditions; Recoupment for Compliance Failures. County may withhold payment, deny claims, suspend referrals, require replacement of staff or subcontractors, require corrective action, revoke delegated authority, recoup payments, offset amounts due, or terminate this Agreement if Contractor or any Downstream Entity fails to maintain required credentialing, enrollment, exclusion

screening, disclosure, conflict-of-interest, network adequacy, timely access, provider directory, documentation, NOABD, grievance, appeal, audit-access, privacy, security, or record-retention requirements.
Services rendered, arranged, documented, authorized, or billed by an uncredentialed, unenrolled, excluded, unauthorized, unlicensed, uncertified, improperly supervised, or otherwise ineligible provider or Downstream Entity shall be nonpayable and subject to recoupment unless County determines in writing that payment is required by law or necessary to protect continuity of care.
Failure to issue a required NOABD, failure to timely issue a required NOABD, failure to use County-approved NOABD templates, failure to provide same-day notice to County, failure to maintain a NOABD log, or failure to provide NOABD-related records upon request may result in corrective action, reissuance, payment withholding, recoupment, suspension of referrals, revocation of delegated authority, or termination.

4. INVOICES.

4.1 Contractor's invoices shall be submitted in arrears on a monthly basis, or such other time that is mutually agreed upon in writing and shall be itemized and formatted to the satisfaction of the County.

4.2 Contractor's invoices shall be submitted electronically through County's secure file-transfer portal at: **https://filetransfer.co.lake.ca.us/filedrop/BHFiscalInvoicing**

4.3 Contractor's invoices shall be submitted in arrears no later than the 15th working day of the following month for which services are being billed, or such other time that is mutually agreed upon in writing, and shall be itemized and formatted to the satisfaction of the County.

4.4 All billing forms and supporting documentation shall clearly reflect client names or identifiers, dates of service, service type, billing category, applicable authorization, corresponding rates, rendering provider information, NPI numbers, service location/modality, appointment status, and any other information required by County for claim validation, payment validation, audit, utilization review, network adequacy, and compliance monitoring. Supporting documentation shall include sufficient information to validate the service, date of service, authorization, rate, billing category, rendering provider, claim status, and payment calculation. County may require progress notes, assessments, medication support documentation, treatment plans, or other clinical documentation when necessary for payment validation, audit, utilization review, or compliance monitoring.

4.5 County shall make payment to Contractor within thirty (30) business days after County receives applicable state, federal, or other reimbursement for the services billed, provided the invoice is undisputed, allowable, properly documented, and accepted by County. County shall have no obligation to advance payment to Contractor prior to receipt of applicable reimbursement from the State, Federal government, or other funding source. Payment shall be limited to services that are authorized, medically necessary, properly documented, eligible for reimbursement, and not otherwise denied, disallowed, or subject to recoupment. Payment on partial deliverables or partially reimbursed claims may be made when amounts due so warrant or when requested by Contractor and approved by County. Any disputed, denied, disallowed, unsupported, or non-reimbursed amounts may be withheld, denied, offset, or recouped as provided in this Agreement.

4.6 County shall not be obligated to pay Contractor for services provided which are the subject of any bill if Contractor submits such bill to County more than ninety (90) days after the date Contractor provides the services, or more than sixty (60) days after this Agreement terminates, whichever is earlier; provided that the foregoing deadlines shall not apply to the extent Contractor's submission is delayed due to Contractor not having received information reasonably necessary to prepare and submit the bill.

4.7 Monthly payment may vary based on actual services billed.

4.9 County clients who are able to pay for services from other public or private resources are not billable under this Agreement.

4.10 Contractor and County shall each appoint one responsible representative for the purpose of resolving any billing questions, questioned costs, denied claims, disallowed amounts, unsupported charges, or other billing disputes that may arise during the term of this Agreement. If such issues arise, County shall remain obligated to pay Contractor for any undisputed, allowable, properly documented, accepted, and reimbursed amounts in accordance with Section 4.5 of this Agreement. County shall not be required to pay disputed, denied, disallowed, unsupported, or non-reimbursed amounts unless and until the matter is resolved, the amount is determined to be allowable and payable, and County has received applicable state, federal, or other reimbursement for the services billed. Once a questioned or disputed amount is resolved by the designated representatives, any allowable and payable amount shall be paid to Contractor in accordance with Section 4.5.

5. AUDIT REQUIREMENTS AND AUDIT EXCEPTIONS.

5.1 Contractor warrants that it shall comply with all audit requirements established by County and will provide a copy of Contractor’s Annual Independent Audit Report, if applicable.

5.2 County may conduct periodic audits of Contractor’s financial records, notifying Contractor no less than 48 hours prior to scheduled audit. Said notice shall include a detailed listing of the records required for review. Contractor shall allow County, or other appropriate entities designated by County, access to all financial records pertinent to this Agreement.

5.3 If DHCS, CMS, or HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or HHS Inspector General may inspect, evaluate, and audit Contractor or subcontractor at any time pursuant to 42 C.F.R. § 438.230.

5.4 DHCS, CMS, HHS Inspector General, Comptroller General or their designees have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the contractor or subcontractor that pertain to any aspects of services and activities performed on Medi-Cal beneficiaries per 42 CFR 438.230(i).

5.5 Contractor shall reimburse County for audit exceptions within 30 days of written demand or shall make other repayment arrangements subject to the approval of County.

5.6 The contracting parties shall be subject to the examination and audit of the Department of Health Care Services (DHCS) or Auditor General for any contract in excess of $10,000 which utilizes state funds

for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later per 42 CFR 438.230(iii).

5.7 If DHCS or County determines Contractor has not performed satisfactorily, the Contract shall still be subject to examination and audit for the period of ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

5.8 County shall provide Contractor with access to the County's Electronic Health Record system (SmartCare) only for County-approved Contractor staff who require access to perform services under this Agreement. Contractor shall ensure that each user completes all County-required training, confidentiality acknowledgments, access forms, and security requirements before access is granted. County may charge Contractor for user access costs beyond the number or scope approved by County. Contractor shall immediately notify County when any user no longer requires access or when access should be modified or terminated.

5.9 Credentialing, Delegation, and Downstream Audit Rights. Contractor shall maintain complete and current records sufficient to demonstrate compliance with credentialing, recredentialing, enrollment, exclusion screening, ownership/control disclosure, conflict-of-interest, network adequacy, timely access, provider directory, subcontracting, delegation oversight, billing, documentation, and compliance requirements.
Such records shall include, as applicable, credentialing files, recredentialing files, primary-source verification, licensure/registration/certification verification, NPI information, PAVE/ORP enrollment documentation, provider attestations, malpractice and disciplinary history, exclusion-screening logs, Death Master File checks, ownership/control disclosures, conflict disclosures, subcontractor and Downstream Entity rosters, subcontract terms, delegation agreements, corrective action plans, monitoring reports, appointment availability data, provider directory data, timely access data, and network adequacy submissions.
Contractor shall make such records available to County, DHCS, CMS, HHS Office of Inspector General, the Comptroller General, and their designees upon request. Contractor shall ensure that all Downstream Entities are contractually required to make such records, systems, contracts, premises, staff, and documentation available for inspection, audit, evaluation, and copying by County and all authorized state and federal oversight entities.
Contractor shall not assert subcontractor, vendor, proprietary, confidentiality, business associate, trade secret, or other restrictions as a basis to deny or delay County's access to records necessary to determine compliance with this Agreement or applicable law.

6. PAYMENT TERMS. County shall reimburse Contractor for covered services provided under this Agreement in accordance with the compensation structure, rate schedule, budget, or payment terms set forth below, subject to the terms and conditions of this Agreement and applicable DHCS requirements.

6.1 RATE SCHEDULE / PAYMENT STRUCTURE. Contractor shall be compensated only for covered, authorized, medically necessary, properly documented, allowable services actually rendered by County-approved rendering providers, and for County-authorized on-call coverage, subject to the following payment structure and all other terms of this Agreement:

A. Negotiated Standard Psychiatric Service Payment Structure. For County-authorized outpatient psychiatric services performed by County-approved rendering providers, Contractor shall be paid the

applicable percentage below of the County-recognized payable amount for the applicable covered service, as determined by County in accordance with the applicable DHCS Medi-Cal Behavioral Health Fee Schedule and County claiming rules. The applicable percentage shall be determined by the client population served, provider specialty, and modality actually used for the service. The percentage is fully loaded and includes all Contractor administrative, recruitment, supervision, credentialing, scheduling, payroll, malpractice, technology, telehealth, travel, overhead, and other costs unless expressly authorized elsewhere in this Agreement.

Scenario	Modality	Contractor Payment
Adult Telepsychiatry	Telehealth	35.0%
Child Telepsychiatry	Telehealth	40.0%
Adult In-Person Locum Tenens	In-person / Facility	45%
Child In-Person Locum Tenens	In-person / Facility	50%
LPHA telehealth services	Telehealth	45%
LPHA in-person / field-based services	In-person / Facility	50%
RN in-person services	In-person / Facility	50%
LVN in-person services	In-person / Facility	50%
Licensed Psychiatric Technician in-person services	In-person / Facility	50%
Medical Assistant in-person services	In-person / Facility	50%

B. Payment Limitation. Contractor shall not be paid more than the applicable percentage of the County-recognized payable amount, and no payment shall be due for services that are denied, disallowed, unsupported, unauthorized, duplicative, non-covered, non-reimbursed, or otherwise not payable under County, DHCS, state, or federal requirements.

C. Payment Not Based on Gross Charges. Contractor shall not be paid based on billed charges, scheduled appointments, unrendered services, no-shows, cancelled appointments, blocked provider time, administrative time, recruitment time, onboarding time, travel time, chart correction time, or any service that is not payable under this Agreement, unless County has expressly authorized payment in writing.

D. On-Call and After-Hours Coverage. Contractor may provide psychiatric physician on-call support during County-authorized evening, weekend, County holiday, and County break periods. Authorized on-call coverage shall be paid at fifty dollars ($50.00) per hour for each hour of County-approved scheduled coverage from 5:00 p.m. to 8:00 a.m., or other written schedule approved by County. On-call coverage must be approved in advance by County and documented with Contractor's invoice, and supported by schedules/call logs sufficient to validate coverage and any services rendered. The on-call coverage arrangement shall be reevaluated after the first three months of operations and may be modified only by written amendment or written County authorization consistent with this Agreement.

E. Services Rendered During On-Call Periods. If a covered, billable psychiatric service is actually rendered during an on-call period, payment for the rendered service shall be made only if the service is authorized, clinically appropriate, properly documented, allowable, and accepted for payment under this Agreement. County and Contractor shall avoid duplicate payment for the same unit of time or service. County may offset or recoup any duplicate, unsupported, denied, or disallowed payment.

F. Required Invoice Detail. Contractor invoices must include, at minimum, the client identifier, date of service, rendering provider name and NPI, provider type, service code, modifier if applicable, service modality/location, minutes or units, County authorization if applicable, gross DHCS fee schedule amount or County-recognized payable amount, Contractor percentage/rate, calculated Contractor payment, claim status if known, and supporting documentation required by County. On-call invoices must include approved schedule, hours covered, provider assigned, call log/coverage validation, and any associated rendered services.

G. Claim Denials, Disallowances, and Adjustments. Contractor shall cooperate with County to correct claim issues within applicable claiming timelines. Contractor is not entitled to payment for denied, disallowed, unsupported, untimely, duplicate, unallowable, or non-reimbursed claims unless County determines in writing that payment is required under this Agreement. Any later denial, disallowance, audit exception, overpayment, or correction may result in offset or recoupment.

H. Provider Placement Fee. If, during the term of this Agreement or within twelve (12) months following its expiration or termination, County directly or indirectly employs, contracts with, engages, or retains any physician, nurse practitioner, psychologist, or other clinical professional first introduced to County through Contractor, County shall pay Contractor a placement fee of thirty-five thousand dollars ($35,000) per provider. The parties acknowledge that this amount represents a reasonable estimate of Contractor's recruitment, credentialing, onboarding, and administrative costs and is not intended as a penalty.

EXHIBIT C – COMPLIANCE PROVISIONS

1. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

1.1 Contractor shall provide services in conformance with all applicable state and federal statutes, regulations and sub regulatory guidance, as from time to time amended, including but not limited to:

1) California Code of Regulations, Title 9;
2) California Code of Regulations, Title 22;
3) California Welfare and Institutions Code, Division 5;
4) United States Code of Federal Regulations, Title 42, including but not limited to Parts 438 and 455;
5) United States Code of Federal Regulations, Title 45;
6) United States Code, Title 42 (The Public Health and Welfare), as applicable;
7) Balanced Budget Act of 1997;
8) Health Insurance Portability and Accountability Act (HIPAA); and
9) Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's, state or federal contracts governing client services.

1.2 In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

2. SERVICES AND ACCESS PROVISIONS

2.1 CERTIFICATION OF ELIGIBILITY

Contractor will, in cooperation with County, comply with Section 14705.5 of California Welfare and Institutions Code to obtain a certification of a client's eligibility for SMHS under Medi-Cal.

2.2 ACCESS TO SPECIALTY MENTAL HEALTH SERVICES

A. General Access Criteria. In collaboration with County, Contractor shall ensure that individuals to whom Contractor provides Specialty Mental Health Services (SMHS) meet applicable access criteria in accordance with Welfare and Institutions Code section 14184.402, DHCS guidance, including but not limited to BHIN 26-002, and any subsequent or superseding DHCS guidance. Contractor shall ensure that the clinical record for each client, taken as a whole, contains sufficient information demonstrating that the client's presentation, condition, and service needs are consistent with the access criteria applicable to the client's age at the time services are provided.

B. Clients Age 21 and Older. For clients age 21 or older, Contractor shall provide medically necessary SMHS to clients who meet the applicable adult access criteria. The clinical record, taken as a whole, shall demonstrate that the client has one or both of the following:

1. A significant impairment in an important area of life functioning; or
2. A reasonable probability of significant deterioration in an important area of life functioning;

and that the client's condition is due to one of the following:

1. A diagnosed mental health disorder, according to the criteria in the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases and Related Health Problems (ICD); or
2. A suspected mental health disorder that has not yet been diagnosed.

C. Clients Under Age 21. For clients under age 21, Contractor shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to clients under age 21 who meet either of the following criteria:

1. The client has a condition placing them at high risk for a mental health disorder due to experience of trauma, evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by DHCS, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness; or
2. The client has at least one of the following:
   a. A significant impairment;
   b. A reasonable probability of significant deterioration in an important area of life functioning;
   c. A reasonable probability of not progressing developmentally as appropriate; or
   d. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan is required to provide;
   and the client's condition is due to one of the following:

1. A diagnosed mental health disorder, according to the criteria in the current editions of the DSM and ICD;
2. A suspected mental health disorder that has not yet been diagnosed; or
3. Significant trauma placing the client at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

2.3 ADDITIONAL CLARIFICATIONS

A. A clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service listed within this Agreement may be provided and submitted to County for reimbursement under any of the following circumstances:

1. The service was provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process;
2. The service was not included in an individual treatment plan, unless a treatment plan is specifically required by applicable law, regulation, DHCS guidance, or County policy; or
3. The client has a co-occurring substance use disorder.

B. In accordance with BHIN 26-002 and any subsequent or superseding DHCS guidance, the absence of a formal mental health diagnosis shall not preclude a beneficiary from accessing covered SMHS when access criteria are otherwise met. Notwithstanding the foregoing, all Medi-Cal claims submitted for reimbursement, including SMHS claims, shall include a current ICD diagnosis code approved by the Centers for Medicare & Medicaid Services (CMS), consistent with applicable federal and state claiming requirements.

2.4 MEDICAL NECESSITY

A. Contractor shall ensure that services provided pursuant to this Agreement meet applicable standards for medical necessity and clinical appropriateness in accordance with Welfare and Institutions Code section 14184.402, BHIN 26-002, and any subsequent or superseding DHCS guidance. The client record, considered in its entirety, shall contain sufficient documentation to demonstrate the medical necessity of services provided in accordance with the client's age, presenting condition, service needs, and applicable state and federal requirements at the time of service delivery.

B. For clients age 21 or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, as set forth in Welfare and Institutions Code section 14059.5.

C. For clients under age 21, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, including services necessary to correct or ameliorate mental health conditions, consistent with applicable federal and state requirements and DHCS guidance.

2.5 COORDINATION OF CARE

A. Contractor shall ensure that all care, treatment and services provided pursuant to this Agreement are coordinated among all providers who are serving the client, including all other SMHS providers, as well as providers of Non-Specialty Mental Health Services (NSMHS), substance use disorder treatment services, physical health services, dental services, regional center services and all other services as applicable to ensure a client-centered and whole-person approach to services.
B. Contractor shall ensure that care coordination activities support the monitoring and treatment of comorbid substance use disorder and/or health conditions.
C. Contractor shall include in care coordination activities efforts to connect, refer and link clients to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
D. Contractor shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
E. To facilitate care coordination, Contractor will request a HIPAA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state and federal privacy laws and regulations.

2.6 CO-OCCURRING TREATMENT AND NO WRONG DOOR

A. Per BHIN 22-011, Specialty and Non-Specialty Mental Health Services can be provided concurrently, if those services are clinically appropriate, coordinated, and not duplicative. When a client meets criteria for both NSMHS and SMHS, the client should receive services based on individual clinical need and established therapeutic relationships. Clinically appropriate and covered SMHS can also be provided when the client has a co-occurring mental health condition and substance use disorder.
B. Under this Agreement, Contractor will ensure that clients receive timely mental health services without delay. Services are reimbursable to Contractor by County even when:
    I. Services are provided prior to determination of a diagnosis, during the assessment or prior to determination of whether SMHS access criteria are met, even if the assessment ultimately indicates the client does not meet criteria for SMHS.
    II. If Contractor is serving a client receiving both SMHS and NSMHS, Contractor holds responsibility for documenting coordination of care and ensuring that services are non-duplicative.

3. PROGRAM INTEGRITY

3.1 GENERAL PROVISIONS

As a condition of receiving payment under a Medi-Cal managed care program, the Contractor shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. § 438.600(b)).

3.2 CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS

A. Contractor must follow the uniform process for credentialing and recredentialing of service providers established by County, including disciplinary actions such as reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
B. Upon request, the Contractor must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.
C. Contractor must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. See relevant section below regarding specific requirements for exclusion monitoring.
D. Contractor shall ensure that all of their network providers delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
    I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
    II. A history of loss of license or felony convictions;
    III. A history of loss or limitation of privileges or disciplinary activity;
    IV. A lack of present illegal drug use; and
    V. The application's accuracy and completeness.
E. Contractor must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
F. Contractor is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
G. Contractor is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.
H. Credentialing, Recredentialing, and Downstream Entity Oversight. Contractor shall ensure that all employees, individual contractors, subcontractors, Downstream Entities, and rendering providers who deliver, arrange, supervise, document, authorize, bill for, or materially affect Specialty Mental Health Services under this Agreement are credentialed, recredentialed, screened, enrolled, supervised, and monitored in accordance with County policy, DHCS requirements, 42 C.F.R. Parts 438 and 455, and this Agreement.

    Contractor shall not allow any employee, individual contractor, subcontractor, Downstream Entity, or rendering provider to furnish, arrange, document, authorize, or bill for covered services until all County-required credentialing, recredentialing, enrollment, exclusion-screening,

disclosure, conflict-of-interest, training, and approval requirements have been satisfied, unless County provides prior written authorization for a limited exception.

Contractor shall maintain complete and current credentialing and recredentialing files for all applicable persons and entities. Such files shall include, as applicable, primary-source verification, licensure, registration, certification, waiver status, National Provider Identifier information, PAVE/ORP enrollment documentation, education and training, work history, malpractice history, disciplinary history, criminal background check information where required, provider attestations, exclusion-screening documentation, ownership/control disclosures, conflict disclosures, and any other documentation required by County, DHCS, CMS, or applicable law.

Contractor shall verify and document, at least every three years or more frequently if required by County or applicable law, that each applicable provider and Downstream Entity continues to meet all credentialing, enrollment, licensing, certification, exclusion-screening, disclosure, and eligibility requirements. Contractor shall immediately notify County of any change that may affect a provider's or Downstream Entity's eligibility, qualifications, licensure, certification, enrollment, exclusion status, capacity, or ability to provide services under this Agreement.

Contractor shall remain fully responsible for the performance, acts, omissions, qualifications, compliance, billing, documentation, confidentiality, data security, and service delivery of all employees, individual contractors, subcontractors, Downstream Entities, and rendering providers used in connection with this Agreement.

3.3 SCREENING AND ENROLLMENT REQUIREMENTS

A. County shall ensure that all Contractor providers are enrolled with the State as Medi-Cal providers consistent with the provider's disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. § 438.608(b))

B. County may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of Contractor of up to 120 days but shall terminate this Agreement immediately upon determination that Contractor cannot be enrolled, or the expiration of one 120-day period without enrollment of the Contractor, and notify affected clients. (42 C.F.R. § 438.602(b)(2))

C. Contractor shall ensure that all Providers and/or subcontracted Providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a). Contractor shall provide evidence of completed consent when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

3.4 COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS

A. Contractor shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608(a)(1), that must include:
    I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements.
    II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the

requirements of this Agreement and who reports directly to the CEO and the Board of Directors.

III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.

IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.

V. Effective lines of communication between the Compliance Officer and the organization's employees.

VI. Enforcement of standards through well-publicized disciplinary guidelines.

VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence and ongoing compliance with the requirements under the Contract.

B. The requirement for prompt reporting and repayment of any overpayments identified.

C. Contractor must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Contractor must report fraud and abuse information to the County including but not limited to:

I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),

II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42 C.F.R. § 438.608(a), (a)(2),

III. Information about changes in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).

IV. Information about a change in the Contractor's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Contractor as per 42 C.F.R. § 438.608(a)(6).

D. Contractor shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

E. Contractor shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.

F. County may suspend payments to Contractor if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. §455.23. (42 C.F.R. §438.608 (a)(8)).

G. Contractor shall report to County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

3.5 INTEGRITY DISCLOSURES

A. Contractor shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Contractor. (42 C.F.R. §§ 455.104, 455.105, and 455.106.)

B. Upon the execution of this Contract, Contractor shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. § 455.104.)

C. Contractor must disclose the following information as requested in the Provider Disclosure Statement:

D. Disclosure of 5% or More Ownership Interest:

   I. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security number must be disclosed.

   II. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.

   III. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.

   IV. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Contract. (42 C.F.R. § 455.434)

E. Disclosures Related to Business Transactions:

   I. The ownership of any subcontractor with whom Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

   II. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

F. Disclosures Related to Persons Convicted of Crimes:

   I. The identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)

G. County shall terminate the enrollment of Contractor if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

H. Contractor must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Contractor ownership or upon request of County. County may refuse to enter into an agreement or terminate an existing agreement with Contractor if Contractor fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if Contractor did not fully and accurately make the disclosure as required.

I. Contractor must provide the County with written disclosure of any prohibited affiliations under 42 C.F.R. § 438.610. Contractor must not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610.

J. Conflicts of Interest; Related-Party Transactions. Contractor shall disclose to County, prior to execution of this Agreement, annually thereafter, upon request, and within ten business days of discovery or change, any actual, potential, or perceived conflict of interest involving Contractor, its owners, officers, directors, board members, managing employees, key personnel, rendering providers, subcontractors, Downstream Entities, referral sources, vendors, facilities, or related parties that may affect performance under this Agreement, client choice, authorization decisions, placement decisions, admission decisions, discharge decisions, service reductions, service terminations, billing, documentation, quality of care, network adequacy, timely access, or program integrity.

K. Disclosures shall include ownership interests, control interests, familial relationships, compensation arrangements, referral arrangements, management agreements, leases, loans, gifts, incentives, shared employees, exclusive arrangements, business transactions, subcontractor relationships, facility relationships, and other financial or governance relationships involving Contractor or any Downstream Entity.

L. Contractor shall require all Downstream Entities to make equivalent disclosures to Contractor and County. Contractor shall update such disclosures within ten business days of any change.

M. County may require mitigation, recusal, corrective action, additional monitoring, subcontract modification, suspension of referrals, payment withholding, repayment, removal of a provider or Downstream Entity, revocation of delegated authority, or termination if County determines that a conflict or related-party arrangement creates compliance, quality, fiscal, program integrity, client-protection, or network adequacy risk.

3.6 CERTIFICATION OF NON-EXCLUSION OR SUSPENSION FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM

A. Prior to the effective date of this Contract, the Contractor must certify that it is not excluded from participation in Federal Health Care Programs under either Section 1128 or 1128A of the Social Security Act. Failure to so certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Contract.

B. Contractor shall certify, prior to the execution of the Contract, that the Contractor does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. Contractor shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
   I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
   II. www.sam.gov/portal/SAM - GSA Exclusions Extract
   III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
   IV. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
   V. any other database required by DHCS or DHHS.

C. Contractor shall certify, prior to the execution of the Contract, that Contractor does not employ staff or individual contractors/vendors that are on the Social Security Administration's Death Master File. Contractor shall check the following database prior to employing staff or individual contractors/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS. https://www.ssdmf.com/ - Social Security Death Master File
D. Contractor is required to notify County immediately if Contractor becomes aware of any information that may indicate their (including employees/staff and individual contractors/vendors) potential placement on an exclusions list.
E. Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
F. Contractor must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
G. If Contractor finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). The Contractor shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.
H. Exclusion Screening of Downstream Entities. Contractor shall perform and document exclusion screening before engagement and monthly thereafter for Contractor, all rendering providers, employees, individual contractors, subcontractors, Downstream Entities, and any person with an ownership or control interest, agent, managing employee, or person with authority over services, billing, claims, referrals, client records, or delegated functions under this Agreement.
I. Screening shall include all databases required by County, DHCS, CMS, or applicable law, including but not limited to the OIG List of Excluded Individuals/Entities, SAM, Medi-Cal Suspended and Ineligible Provider List, NPPES, the Social Security Administration Death Master File where applicable, and any other required state or federal database.
J. Contractor shall require each Downstream Entity to perform equivalent screening of its own workforce, owners, managing employees, agents, providers, subcontractors, and downstream contractors, and to provide evidence to Contractor and County upon request.
K. Contractor shall immediately notify County if Contractor identifies or receives information indicating that any person or entity involved in services under this Agreement is excluded,

suspended, debarred, deceased, ineligible, unlicensed, uncertified, unenrolled, or otherwise prohibited from participation. Contractor shall not submit claims for, pay, employ, contract with, or use any such person or entity in connection with Medi-Cal-funded services.

3.7 QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION

A. Contractor shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.

B. Contractor shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Contractor shall measure, monitor, and annually report to the County its performance.

C. Contractor shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Contractor shall assess client/family satisfaction by:
    I. Surveying client/family satisfaction with the Contractor's services at least annually.
    II. Evaluating client grievances, appeals and State Hearings at least annually.
    III. Evaluating requests to change persons providing services at least annually.
    IV. Informing the County and clients of the results of client/family satisfaction activities.

D. Contractor, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.

E. Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually and shared with the County.

F. Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

G. Contractor shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.

H. Contractor shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs,

institute needed QI actions, and ensure follow-up of QI processes. Contractor shall ensure that there is active participation by the Contractor's practitioners and providers in the QIC.

I. Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

J. Contractor shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

3.8 NETWORK ADEQUACY

A. The Contractor shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a), (c)).
B. Contractor shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to the County, utilizing a provided template or other designated format.
C. Contractor shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services.
D. To the extent possible and appropriately consistent with CCR, Title 9, §1830.225 and 42 C.F.R. §438.3 (l), the Contractor shall provide a client the ability to choose the person providing services to them.

3.9 TIMELY ACCESS

A. Contractor shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of need for services. The County shall monitor Contractor to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
B. Timely access standards include:
    I. Contractor must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the provider offers services to non-Medi-Cal clients. If the Contractor's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Agreement or another County.
    II. Appointments data, including wait times for requested services, must be recorded and tracked by Contractor, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management Department or other designated persons.
    III. Urgent care appointments for services that do not require prior authorization must be provided to clients within 48 hours of a request. Urgent appointments for services that do require prior authorization must be provided to clients within 96 hours of request.
    IV. Non-urgent non-psychiatry mental health services, including, but not limited to Assessment, Targeted Case Management, and Individual and Group Therapy

appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 10 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service. Non-urgent psychiatry appointments (for both adult and children/youth) must be made available to Medi-Cal clients within 15 business days from the date the client or a provider acting on behalf of the client, requests an appointment for a medically necessary service.

C. Applicable appointment time standards may be extended if the referring or treating provider has determined and noted in the client's record that a longer waiting period will not have a detrimental impact on the health of the client.
D. Periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.
E. Network Adequacy, Capacity, and Provider Roster Requirements. Contractor shall maintain and submit to County, in the form and frequency required by County, a complete, accurate, and current network and capacity roster identifying all rendering providers, subcontractors, Downstream Entities, service locations, service modalities, languages, cultural and clinical specialties, license/registration/certification type, National Provider Identifier, PAVE/ORP enrollment status where applicable, hours of operation, appointment availability, panel status, caseload capacity, telehealth availability, in-person availability, ADA accessibility, age groups served, populations served, and covered services available.
F. Contractor shall notify County within five business days, or sooner if required by County, of any change that may affect network adequacy, timely access, provider directory accuracy, service capacity, appointment availability, client choice, or continuity of care. Such changes include, but are not limited to, provider resignation, leave, suspension, termination, discipline, exclusion, licensure restriction, site closure, panel closure, material reduction in hours, interruption in service availability, change in service location, loss of a subcontractor or Downstream Entity, or inability to meet timely access standards.
G. Contractor shall not materially reduce capacity, close a panel, discontinue a covered service, terminate a key subcontractor or Downstream Entity, close a service location, or materially modify service availability without prior notice to County and a County-approved transition plan, except in emergency circumstances.
H. Contractor shall submit network adequacy, provider directory, appointment availability, and timely access data in the format and timeframe required by County. Contractor shall certify the accuracy and completeness of such data upon request.
I. Failure to provide complete, accurate, and timely network adequacy, appointment availability, provider directory, or timely access data may result in corrective action, suspension of referrals, payment withholding, recoupment, revocation of delegated authority, or termination.
J. Timely Access Tracking and Reporting. Contractor shall track, monitor, and report appointment availability, appointment requests, offered appointment dates, accepted appointment dates, wait times, urgent requests, non-urgent requests, psychiatry requests, non-psychiatry service requests, missed appointments, rescheduled appointments, client preferences, provider availability, and any exceptions to timely access standards.

Contractor shall submit timely access data to County in the format and frequency required by County. Contractor shall ensure that all Downstream Entities collect and submit timely access

data sufficient to allow County to monitor compliance with applicable federal and state timely access requirements.

Contractor shall immediately notify County if Contractor or any Downstream Entity is unable to meet applicable timely access standards or experiences a capacity issue that may delay access to services. Contractor shall cooperate with County in implementing corrective action, alternative access arrangements, continuity-of-care protections, and client notices where required.

3.11 PRACTICE GUIDELINES

A. Contractor shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements:
   I. They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;
   II. They consider the needs of the clients;
   III. They are adopted in consultation with contracting health care professionals; and
   IV. They are reviewed and updated periodically as appropriate (42 C.F.R.§ 438.236(b) and CCR, Title 9, Section 1810.326).
B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients (42 C.F.R. § 438.236(c)).

3.12 PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

A. Contractor shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal clients on behalf of Contractor, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to BHIN 20-071 requirements, the 21st Century Cures Act and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.
B. SMHS licensed individuals required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e. PAVE application package) available through the DHCS PED Pave Portal, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor (LPCC), Psychologist, Licensed Educational Psychologist, Physician (MD and DO), Physician Assistant, Registered Pharmacist/Pharmacist, Certified Pediatric/Family Nurse Practitioner, Nurse Practitioner, Occupational Therapist, and Speech-Language Pathologist. Interns, trainees, and associates are not eligible for enrollment.

3.13 REPORTING UNUSUAL OCCURRENCES

A. Contractor shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.
B. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
   I. Complete written description of event including outcome;
   II. Written report of Contractor's investigation and conclusions;
   III. List of persons directly involved and/or with direct knowledge of the event.

County and DHCS retain the right to independently investigate unusual occurrences and Contractor will cooperate in the conduct of such independent investigations.

4. CLIENT INFORMING MATERIALS

A. NON-DISCRIMINATION

I. Contractor shall not discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet medical necessity criteria for SMHS in the provision of SMHS because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 25-042, State Law, and any superseding DHCS guidance.

II. Contractor shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.

B. PHYSICAL ACCESSIBILITY

In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Contractor must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities.

C. APPLICABLE FEES

I. Contractor shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, Contractor shall use the uniform billing and collection guidelines prescribed by DHCS.

II. Contractor will perform eligibility and financial determinations, in accordance DHCS' Uniform Method of Determining Ability to Pay (UMDAP), for all clients unless directed otherwise by the Director.

III. Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any specialty mental health or related administrative services provided under this Contract, except to collect other health insurance coverage, share of cost, and co-payments (Cal. Code Regs., tit. 9, §1810.365(c).

IV. The Contractor must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

D. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Contractor must participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients, including those with limited English

proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

5. DATA, PRIVACY, AND SECURITY REQUIREMENTS

5.1 CONFIDENTIALITY AND SECURE COMMUNICATIONS

A. Contractor shall comply with all applicable federal and state laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records and all relevant County policies and procedures.

B. Contractor will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.

C. Contractor shall have all employees acknowledge an Oath of Confidentiality mirroring that of the County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.

D. Contractor shall not use or disclose PHI or PII other than as permitted or required by law.

5.2 ELECTRONIC PRIVACY AND SECURITY

A. Contractor shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Contractor's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.

B. Contractor shall institute compliant password management policies and procedures, which shall include but not be limited to procedures for creating, changing, and safeguarding passwords. Contractor shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.

C. Any Electronic Health Records (EHRs) maintained by Contractor that contain PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Contractors that utilize an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.

D. Contractor entering data into any county electronic systems shall ensure that staff are trained to enter and maintain data within this system.

5.3 BUSINESS ASSOCIATE AGREEMENT (BAA)

A. Contractor may perform or assist County in the performance of certain health care administrative duties that involve the use and/or disclosure of client identifying information as defined by HIPAA. For these duties, the Contractor shall be a Business Associate of the County and shall comply with the applicable provisions set forth in the HIPAA BAA, which must be signed and attached as an exhibit to this agreement.

B. Contractor shall follow all requirements listed within the BAA and shall comply with all applicable County policies, state laws and regulations and federal laws pertaining to breaches of confidentiality. Contractor agrees to hold the County harmless for any breaches or violations.

6. RIGHT TO MONITOR

6.1 County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Contractor in the delivery of services provided under this Contract. Full cooperation shall be given by the Contractor in any auditing or monitoring conducted, according to this agreement.

6.2 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Contract, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least ten years from the final date of the Agreement period or in the event the Contractor has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR §438.230(c)(3)(i)-(ii)).

6.3 The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Contractor at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Contractor's place of business, premises, or physical facilities (42 CFR §438.230(c)(3)(iv)).

6.4 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall cooperate with County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by County. Should County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, County may audit, monitor, and/or request information from Contractor to ensure compliance with laws, regulations, and requirements, as applicable.

6.5 County reserves the right to place Contractor on probationary status, as referenced in the Probationary Status Article, should Contractor fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Contractor may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.

6.6 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall retain all records and documents originated or prepared pursuant to Contractor's performance under this Contract, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and

electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.

6.7 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but not be limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

6.8 All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
Contractor shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.

6.9 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.

6.10 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall agree to maintain and retain all appropriate service and financial records for a period of at least ten years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.

6.11 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

6.12 In the event the Agreement is terminated, ends its designated term or Contractor ceases operation of its business, Contractor shall deliver or make available to County all financial records that may have been accumulated by Contractor or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.

6.13 Contractor, employees, agents, subcontractors, providers, and Downstream Entities shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Contractor.

6.14 County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Contractor has not performed satisfactorily.

7. SITE INSPECTION

7.1 Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Contractor shall permit authorized County, state, and/or federal agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

8. CLIENT RIGHTS. Contractor shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code Sections 5325 et seq; Title 9 California Code of Regulations (CCR), Sections 862, 883, 884; Title 22 CCR, Sections 72453 and 72527; and 42 C.F.R. § 438.100.

9. NON-DISCRIMINATION. Contractor shall not unlawfully discriminate against any qualified worker or recipient of services because of race, religious creed, color, sex, sexual orientation, national origin, ancestry, physical disability, mental disability, medical condition, marital status or age.

10. AGREEMENTS IN EXCESS OF $150,000 – CLEAN AIR ACT AND FEDERAL WATER POLLUTION CONTROL ACT

10.1 Contractor shall comply with all applicable standards, orders, and regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401–7671q, as amended.

10.2 Contractor shall comply with all applicable standards, orders, and regulations issued pursuant to the Federal Water Pollution Control Act, 33 U.S.C. 1251–1387, as amended.

10.3 Contractor shall report any violations to the County, the Federal awarding agency, and the Regional Office of the Environmental Protection Agency, as applicable.

11. INDEMNIFICATION AND HOLD HARMLESS. Contractor shall indemnify and defend County and its officers, employees, and agents against and hold them harmless from any and all claims, losses, damages, and liability for damages, including attorney's fees and other costs of defense incurred by County, whether for damage to or loss of property, or injury to or death of person, including properties of County and injury to or death of County officials, employees or agents, arising out of, or connected with Contractor's operations hereunder or the performance of the work described herein, unless such damages, loss, injury or death is caused solely by the negligence of County.

12. INTEREST OF CONTRACTOR. Contractor assures that neither it nor its employees has any interest, and that it shall not acquire any interest in the future, direct or indirect, which would conflict in any manner or degree with the performance of services hereunder.

13. DUE PERFORMANCE – DEFAULT. Each party agrees to fully perform all aspects of this agreement. If a default to this agreement occurs then the party in default shall be given written notice of said default by the other party. If the party in default does not fully correct (cure) the default within 30 days of the date of that notice (i.e. the time to cure) then such party shall be in default. The time period for corrective action of the party in default may be extended in writing executed by both parties, which must include the reason(s) for the extension and the date the extension expires.

Notice given under this provision shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable time period. No such notice shall be deemed a termination of this Agreement, unless the party giving notice so elects in that notice, or so elects in a subsequent written notice after the time to cure has expired.

14. INSURANCE

14.1 Workers' Compensation Insurance. Contractor shall procure and maintain Workers' Compensation Insurance as required by the State of California for all employees performing services under this Agreement. Contractor shall also maintain Employers' Liability Insurance in amounts required by applicable law.

14.2 Commercial General Liability Insurance. Contractor shall procure and maintain Commercial General Liability Insurance covering bodily injury, personal injury, and property damage arising from Contractor's operations under this Agreement. Coverage shall include premises and operations, products and completed operations, contractual liability, and independent contractors' liability, with limits of not less than one million dollars ($1,000,000) per occurrence.

14.3 Automobile Liability Insurance. Contractor shall procure and maintain Automobile Liability Insurance covering bodily injury and property damage arising from owned, hired, leased, and non-owned vehicles used in connection with the performance of this Agreement, with limits of not less than one million dollars ($1,000,000) combined single limit per occurrence.

14.4 Professional Liability Insurance. Contractor shall procure and maintain Professional Liability Insurance covering claims arising from errors, omissions, malpractice, or other professional acts associated with the performance of services under this Agreement, with limits of not less than one million dollars ($1,000,000) per claim or occurrence.

14.5 Evidence of Coverage Required Before Commencement of Work. Contractor shall not commence work or permit any employee, provider, subcontractor, or Downstream Entity to perform services under this Agreement until Contractor has obtained all insurance required by this Section and delivered to County:

a. Certificates of insurance demonstrating the required coverage and limits;

b. The additional insured endorsements required by this Section; and

c. Any other endorsements or evidence of coverage reasonably required by County.

County's receipt or acceptance of a certificate of insurance or endorsement that does not comply with this Agreement shall not waive Contractor's obligation to maintain the required coverage.

14.6 Additional Insured; Primary and Noncontributory Coverage. Contractor's Commercial General Liability and Automobile Liability policies shall name the County of Lake and its officers, officials, employees, agents, and volunteers as additional insureds with respect to claims arising from or related to Contractor's performance under this Agreement.

Such coverage shall be primary and noncontributory with respect to the County and its officers, officials, employees, agents, and volunteers. Any insurance or self-insurance maintained by the County shall be excess of Contractor's coverage and shall not contribute with it.

Additional insured status shall be provided by endorsement acceptable to County, including ISO Form CG 20 10 11 85 or an equivalent form providing coverage acceptable to County.

14.7 Subcontractors and Downstream Entities. Contractor shall require every subcontractor and Downstream Entity performing services under this Agreement to maintain insurance appropriate to the services and risks associated with its work and, unless otherwise approved in writing by County, the same types and minimum amounts of coverage required of Contractor under this Section.

Contractor shall obtain and maintain certificates of insurance and required endorsements for its subcontractors and Downstream Entities and shall provide them to County upon request. Contractor shall not permit a subcontractor or Downstream Entity to commence work until the required insurance has been obtained and verified.

Contractor remains fully responsible for the acts, omissions, performance, and insurance compliance of its subcontractors and Downstream Entities.

14.8 Insurer Qualifications. All insurance required under this Agreement shall be issued by insurers authorized to transact insurance business in the State of California and having a current A.M. Best rating of not less than A:VII, unless County approves otherwise in writing.

14.9 Continuous Coverage and Renewal Documentation. Contractor shall maintain all required insurance continuously throughout the term of this Agreement and for any additional period required by applicable law or the terms of the applicable policy.

Contractor shall provide County with updated certificates of insurance and required endorsements before the expiration, cancellation, lapse, reduction, or material modification of any required coverage. Contractor shall promptly notify County upon learning of any actual or anticipated cancellation, lapse, reduction, or material modification of coverage.

14.10 No Limitation of Liability. The insurance requirements and minimum limits established by this Section shall not be construed to limit Contractor's liability or obligations under this Agreement. The required coverage shall not preclude County from pursuing any remedy available under this Agreement or applicable law.

County's failure to review, object to, or enforce any insurance requirement at any particular time shall not waive Contractor's obligation to comply with this Section or County's right to enforce the requirement at a later date.

14.11 Material Breach. Contractor's failure to obtain, maintain, or provide evidence of any insurance required by this Section shall constitute a material breach of this Agreement. In addition to any other remedies available under this Agreement, County may suspend the commencement or continued performance of services until Contractor has fully satisfied the insurance requirements.

15. ATTORNEY'S FEES AND COSTS. If any action at law or in equity is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements in addition to any other relief to which such party may be entitled.

16. ASSIGNMENT. Contractor shall not assign any interest in this Agreement and shall not transfer any interest in the same without the prior written consent of County except that claims for money due or to become due Contractor from County under this Agreement may be assigned by Contractor to a bank, trust company, or other financial institution without such approval. Written notice of any such transfer shall be furnished promptly to County. Any attempt at assignment of rights under this Agreement except for those specifically consented to by both parties or as stated above shall be void.

17. INDEPENDENT CONTRACTOR. It is specifically understood and agreed that, in the making and performance of this Agreement, Contractor is an independent contractor and is not an employee, agent or servant of County. Contractor is not entitled to any employee benefits. County agrees that Contractor shall have the right to control the manner and means of accomplishing the result agreed for herein.

Contractor is solely responsible for the payment of all federal, state and local taxes, charges, fees, or contributions required with respect to Contractor and Contractor's officers, employees, and agents who are engaged in the performance of this Agreement (including without limitation, unemployment insurance, social security and payroll tax withholding.)

18. SUBCONTRACTS

SUBCONTRACTS AND DOWNSTREAM ENTITY FLOW-DOWN. Contractor shall not subcontract, delegate, assign, or otherwise transfer any obligation, function, service, or activity under this Agreement without prior written approval from County. County approval may be withheld, conditioned, suspended, or revoked at County's discretion based on compliance, quality, fiscal, program integrity, network adequacy, data security, or client-protection concerns.
Each subcontract or written arrangement with a Downstream Entity shall be in writing and shall:
(a) identify the specific delegated activities, obligations, reporting responsibilities, performance standards, and deliverables;
(b) require compliance with all applicable provisions of this Agreement, County policy, DHCS guidance, and federal and state law;
(c) require credentialing, recredentialing, enrollment, exclusion screening, integrity disclosures, conflict disclosures, privacy/security compliance, documentation, billing, reporting, network adequacy, timely access, provider directory, NOABD, grievance, appeal, record-retention, and audit compliance, as

applicable;
(d) grant County, DHCS, CMS, HHS Office of Inspector General, the Comptroller General, and their designees the right to inspect, audit, evaluate, and copy records, systems, contracts, and premises related to services or activities under this Agreement;
(e) require prompt reporting of compliance issues, overpayments, suspected fraud, waste, or abuse, adverse events, unusual occurrences, service interruptions, provider changes, capacity changes, data incidents, privacy incidents, security incidents, breaches, and any event affecting client access or continuity of care;
(f) require the Downstream Entity to prepare, issue, track, report, and retain NOABDs when required by County policy, County-approved templates, applicable DHCS guidance, 42 C.F.R. Part 438, Subpart F, and this Agreement;
(g) permit County to require corrective action, suspension, revocation of delegated activities, removal of a provider or Downstream Entity, termination of the subcontracted arrangement, or other remedies permitted by this Agreement or applicable law; and
(h) prohibit further subcontracting or delegation without prior written County approval.
Contractor shall remain fully responsible for the performance, acts, omissions, compliance, billing, documentation, confidentiality, data security, credentialing, network adequacy, timely access, NOABD issuance, grievances, appeals, and service delivery of all Downstream Entities.
Required NOABD Flow-Down. Each subcontract or written arrangement with a Downstream Entity that performs or supports service authorization, utilization management, placement, admission, continued-stay review, discharge, service reduction, service termination, denial, suspension, delay, modification, or other function that may result in an adverse benefit determination shall expressly require the Downstream Entity to prepare, issue, track, report, and retain NOABDs in accordance with County policy, County-approved templates, applicable DHCS guidance, 42 C.F.R. Part 438, Subpart F, and this Agreement.
Contractor shall not enter into or maintain any such subcontract unless the subcontract contains these NOABD obligations and County audit, monitoring, corrective action, reissuance, suspension, and revocation rights.

19. OWNERSHIP OF DOCUMENTS. All non-proprietary reports, drawings, renderings, or other documents or materials prepared by Contractor hereunder are the property of County. In the event of the termination of this Agreement for any reason whatsoever, Contractor shall promptly turn over all said reports, drawings, renderings, information, and/or other documents or materials to County without exception or reservation.

20. SEVERABILITY. If any provision of this Agreement is held to be unenforceable, the remainder of this Agreement shall be severable and not affected thereby.

21. ADHERENCE TO APPLICABLE DISABILITY LAW. Contractor shall be responsible for knowing and adhering to the requirements of Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, (42 U.S.C. Sections 12101, et seq.). California Government Code Sections 12920 et seq., and all related state and local laws.

22. SAFETY RESPONSIBILITIES. Contractor will adhere to all applicable Cal OSHA requirements in performing work pursuant to this Agreement. Contractor agrees that in the performance of work under this Agreement, Contractor will provide for the safety needs of its employees and will be responsible for maintaining the standards necessary to minimize health and safety hazards.

23. JURISDICTION AND VENUE. This Agreement shall be construed in accordance with the laws of the State of California and the parties hereto agree that venue of any action or proceeding regarding this Agreement or performance thereof shall be in Lake County, California. Contractor waives any right of removal it might have under California Code of Civil Procedure Section 394.

24. RESIDENCY. All independent contractors providing services to County for compensation must file a State of California Form 590, certifying California residency or, in the case of a corporation, certifying that they have a permanent place of business in California.

25. NO THIRD-PARTY BENEFICIARIES. Nothing contained in this Agreement shall be construed to create, and the parties do not intend to create, any rights in or for the benefit of third parties.

26. OVERSIGHT. Lake County Behavioral Health Services shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this Agreement, and applicable federal and state law and regulations, in accordance with Welfare & Institutions Code 14712(c)(3) and CCR, Title 9, Section 1810.380 and 1810.385. Remedies in instances where the State Department of Health Care Services or the County Mental Health Plan determine the subcontractor has not performed satisfactorily and right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

County may revoke, suspend, limit, or condition any delegated function or authority granted to Contractor or any Downstream Entity if County determines that Contractor or the Downstream Entity has failed to perform satisfactorily, failed to comply with this Agreement or applicable law, created risk to client access or quality of care, failed to meet network adequacy or timely access standards, failed to issue or properly manage NOABDs, failed to maintain required records, failed to cooperate with audits or monitoring, or created fiscal, privacy, security, program integrity, or client-protection risk.
Upon notice from County, Contractor shall immediately cease or modify the delegated function as directed by County and shall cooperate with County to transition affected clients, records, services, authorizations, NOABD responsibilities, grievances, appeals, and related activities in a manner that protects continuity of care and client rights.

27. NON-APPROPRIATION. In the event County is unable to obtain funding at the end of each fiscal year for specialty mental health services required during the next fiscal year, County shall have the right to terminate this Agreement, without incurring any damages or penalties, and shall not be obligated to continue performance under this Agreement. To the extent any remedy in this Agreement may conflict with Article XVI of the California Constitution or any other debt limitation provision of California law applicable to County, Contractor hereby expressly and irrevocably waives its right to such remedy.

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EXHIBIT D - BUSINESS ASSOCIATE AGREEMENT

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into effective as of the effective date of the Agreement (the "Effective Date"), by and between Traditions Behavioral Health ("Business Associate") and the County of Lake ("Covered Entity").

Business Associate and Covered Entity have a business relationship (the "Relationship" or the "Agreement") in which Business Associate may perform functions or activities on behalf of Covered Entity involving the use and/or disclosure of protected health information received from, or created or received by, Business Associate on behalf of Covered Entity. ("PHI"). Therefore, if Business Associate is functioning as a business associate to Covered Entity, Business Associate agrees to the following terms and conditions set forth in this HIPAA Business Associate Agreement.

1. **Definitions.** For purposes of this Agreement, the terms used herein, unless otherwise defined, shallhave the same meanings as used in the Health Insurance Portability and Accountability Act of 1996,and any amendments or implementing regulations ("HIPAA"), or the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American Recovery and Reinvestment Act of 2009), and any amendments or implementing regulations ("HITECH"). Additionally, for this agreement, Protected Health Information (PHI) includes electronic Protected Health Information (ePHI); Personally Identifiable Information (PII); and Personal Information (PI).
2. **Compliance with Applicable Law.** The parties acknowledge and agree that, beginning with the relevant effective dates, Business Associate shall comply with its obligations under this Agreement and with all obligations of a business associate under HIPAA, HITECH and other related laws, as they exist at the time this Agreement is executed and as they are amended, for so long as this Agreement is in place.
3. **Permissible Use and Disclosure of Protected Health Information.** Business Associate may use anddisclose PHI to carry out its duties to Covered Entity pursuant to the terms of the Relationship. Business Associate may also use and disclose PHI (i) for its own proper management and administration, and (ii) to carry out its legal responsibilities. If Business Associate discloses Protected Health Information to a third party for either above reason, prior to making any such disclosure, Business Associate must obtain: (i) reasonable assurances from the receiving party that such PHI will be held confidential and be disclosed only as required by law or for the purposes for which it was disclosed to such receiving party; and (ii) an agreement from such receiving party to immediately notify Business Associate of any known breaches of the confidentiality of the PHI.
4. **Limitations on Uses and Disclosures of PHI.** Business Associate shall not, and shall ensure that its directors, officers, employees, and agents do not, use or disclose PHI in any manner that is notpermitted or required by the Relationship, this Agreement, or required by law. All uses and disclosures of, and requests by Business Associate, for PHI are subject to the minimum necessary rule of the Privacy Standards and shall be limited to the information contained in a limited data set, to the extent practical, unless additional information is needed to accomplish the intended purpose, or as otherwise permitted in accordance with Section 13405(b) of

HITECH and any implementing regulations.

5. **Required Safeguards To Protect PHI.** Business Associate agrees that it will implement appropriate safeguards in accordance with the Privacy Standards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement.

6. **Reporting of Improper Use and Disclosures of PHI.** Business Associate shall report within 24 hours to Covered Entity a use or disclosure of PHI not provided for in this Agreement by Business Associate, its officers, directors, employees, or agents, or by a third party to whom Business Associate disclosed PHI. Business Associate shall also report within 24 hours to Covered Entity a breach of unsecured PHI, in accordance with 45 C.F.R. §§ 164.400-414, and any security incident of which it becomes aware. Report should be made to:

Compliance Officer
Lake County Behavioral Health Services
1-877-610-2355

7. **Mitigation of Harmful Effects.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement, including, but not limited to, compliance with any state law or contractual data breach requirements. Business Associate shall cooperate with Covered Entity's breach notification and mitigation activities and shall be responsible for all costs incurred by Covered Entity for those activities.

8. **Agreements by Third Parties.** Business Associate shall enter into an agreement with any agent or subcontractor of Business Associate that will have access to PHI. Pursuant to such agreement, the agent or subcontractor shall agree to be bound by the same restrictions, terms, and conditions that apply to Business Associate under this Agreement with respect to such PHI.

9. **Access to Information.** Within five (5) days of a request by Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to Covered Entity such PHI for so long as such information is maintained by Business Associate in theDesignated Record Set, as required by 45 C.F.R. § 164.524. In the event any individual delivers directly to Business Associate a request for access to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

10. **Availability of PHI for Amendment.** Within five (5) days of receipt of a request from Covered Entity for the amendment of an individual's PHI or a record regarding an individual contained in a Designated Record Set (for so long as the PHI is maintained in the Designated Record Set), Business Associate shall provide such information to Covered Entity for amendment and incorporate any such amendments in the PHI as required by45 C.F.R. § 164.526. In the event any individual delivers directly to Business Associate a request for amendment to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

11. **Documentation of Disclosures.** Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond

to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

12. **Accounting of Disclosures.** Within five (5) days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual during the six (6) years prior to the date on which the accounting was requested, Business Associate shall make available to Covered Entity information to permit Covered Entity to respond to the request for an accounting of disclosures of PHI, as required by 45 C.F.R. § 164.528. In the case of an electronic health record maintained or hosted by Business Associate on behalf of Covered Entity, the accounting period shall be three (3) years and the accounting shall include disclosures for treatment, payment and healthcare operations, in accordance with the applicable effective date of Section 13402(a) of HITECH. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within two (2) days forward such request to Covered Entity.
13. **Electronic PHI.** To the extent that Business Associate creates, receives, maintains or transmits electronic PHI on behalf of Covered Entity, Business Associate shall:

(a) Comply with 45 C.F.R. §§164.308, 312, and 316 in the same manner as such sections apply to Covered Entity, pursuant to Section 13401(a) of HITECH, and otherwise implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI;

(b) Ensure that any agent to whom Business Associate provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect it; and

(c) Report to Covered Entity any security incident of which Business Associate becomes aware.

14. **Judicial and Administrative Proceedings.** In the event Business Associate receives a subpoena, court or administrative order or other discovery request or mandate for release of PHI, Covered Entity shall have the right to control Business Associate's response to such request. Business Associate shall notify Covered Entity of the request as soon as reasonably practicable, but in any event within two (2) days of receipt of such request.
15. **Availability of Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure and privacy protection of PHI received from Covered Entity, or created, maintained or received by Business Associate on behalf of the Covered Entity, available to the Covered Entity, the State of California, and the Secretary of the Department of Health and Human Services, in the time and manner designated by the Covered Entity, State or Secretary, for purposes of determining Covered Entity's compliance with the Privacy Standards. Business Associate shall notify the Covered Entity upon receipt of such a request for access by

the State or Secretary and shall provide the Covered Entity with a copy of the request as well as a copy of all materials disclosed.

16. **Breach of Contract by Business Associate.** In addition to any other rights Covered Entity may havein the Relationship, this Agreement or by operation of law or in equity, Covered Entity may i) immediately terminate the Relationship if Covered Entity determines that Business Associate has violated a material term of this Agreement, or ii) at Covered Entity's option, permit Business Associate to cure or end any such violation within the time specified by Covered Entity. Covered Entity's option to have cured a breach of this Agreement shall not be construed as a waiver of any other rights Covered Entity has in the Relationship, this Agreement or by operation of law or in equity.
17. **Effect of Termination of Relationship.** Upon the termination of the Relationship or this Agreementfor any reason, Business Associate shall return to Covered Entity or, at Covered Entity's direction, destroy all PHI received from Covered Entity that Business Associate maintains in any form, recorded on any medium, or stored in any storage system, unless said information has been de-identified and is no longer PHI. This provision shall apply to PHI that is in the possession of Business Associates or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall remain bound by the provisions of this Agreement, even after termination of the Relationship or the Agreement, until such time as all PHI has been returned, de-identified or otherwise destroyed as provided in this Section.
18. **Injunctive Relief.** Business Associate stipulates that its unauthorized use or disclosure of PHI while performing services pursuant to this Agreement would cause irreparable harm to Covered Entity, and in such event, Covered Entity shall be entitled to institute proceedings in any court of competent jurisdiction to obtain damages and injunctive relief.
19. **Indemnification.** Business Associate shall indemnify and hold harmless Covered Entity and its officers, trustees, employees, and agents from any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Covered Entity arising from a violation by Business Associate of its obligations under this Agreement.
20. **Exclusion from Limitation of Liability.** To the extent that Business Associate has limited its liability under the terms of the Relationship, whether with a maximum recovery for direct damages or a disclaimer against any consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any damages to Covered Entity arising from Business Associate's breach of its obligations relating to the use and disclosure of PHI.
21. **Owner of PHI.** Under no circumstances shall Business Associate be deemed in any respect to be the owner of any PHI used or disclosed by or to Business Associate by Covered Entity.
22. **Third Party Rights.** The terms of this Agreement do not grant any rights to any parties other than Business Associate and Covered Entity.
23. **Independent Contractor Status.** For the purposed of this Agreement, Business Associate is an independent contractor of Covered Entity, and shall not be considered an agent of Covered Entity.

24. **Changes in the Law.** The parties shall amend this Agreement to conform to any new or revisedlegislation, rules and regulations to which Covered Entity is subject now or in the future including, without limitation, HIPAA, HITECH, the Privacy Standards, Security Standards or Transactions Standards.