Visit definition for GPP – Traditional Services

(See further below for county mental health)

A visit is defined as a face-to-face encounter with a licensed professional (e.g., doctor, other mid-level practitioner) during which an ambulatory service provided when that **service is not incident to another service**. Multiple encounters that **cross** service types (i.e., OP ER, psych ER, urgent care, mental health, substance abuse, OP surgery, dental, primary/specialty) count as multiple visits. Multiple encounters with more than one practitioner within the same service type or with the same practitioner and which take place on the same day within the same location constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A location is defined as a separate campus or physical address (if not part of a campus). An additional encounter provided on the same day at a separate location is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (examples: x-ray; medication; laboratory test). Services which do not accompany a visit but are "incident to" that visit based upon the definition (lab, radiology, immunizations or other testing) are not separately reimbursed. Referred services that are "incident to" without having PCP visit within the county system do not count as a separate visit – instead these costs are reflected in the total cost/visit, resulting in a higher cost/visit to account for the value of referred ancillary services. The exception is renal dialysis, which counts as a separate visit, even when "incident to" a visit.

> Example 1: Uninsured individual sees a PCP and specialist at the hospital in the same day = 1 visit (same service type)
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> Example 2: Uninsured individual sees a PCP at an off-site clinic and specialist at the hospital in the same day = 2 visits
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> Example 3: Uninsured individual receives x-rays and lab test as referred services (Did not see a practitioner within the county) = 0 visits. These services are valued in the point value of a visit.

MH/SUD Services managed by county MH/SUD department

Due to the unique nature of Short-Doyle and Drug Medi-Cal cost reporting, a visit count is defined more granularly, but the differences are reflected in the lower cost/visit. Additionally, this method allows for a more accurate imputation of contracted/purchased behavioral health services, of which some counties may have a significant amount of.

A visit is defined as an encounter with a behavioral health provider where a behavioral service is provided by service function (or service function grouping for MH services in mode 15), by location, by day. Service function groupings are defined below:

Mode	Service function grouping	Description
15	1-9	Case management
15	10-57, 59	Mental health services
15	58	Therapeutic behavioral services
15	60-69	Medication management / support
15	70-79	Crisis intervention

> Example 1: Uninsured individual uses two services within mental health services (10-57,59) = 1 visit
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> Example 2: Uninsured individual uses case management, mental health services and medication management in the same day = 3 visits

Example 3: Uninsured individual uses pysch ER and case management = 2 visits