STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF MENTAL HEALTH
1600 - 9TH STREET
SACRAMENTO, CA 95814
(916) 654-2378

January 31, 1995

DMH LETTER NO.: 95-01

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
LOCAL MENTAL HEALTH DATA PROCESSING MANAGERS

SUBJECT: SHORT-DOYLE / MEDI-CAL CLAIMING CHANGES

The Department of Mental Health (DMH), Department of Health Services (DHS), Health Care Financing Administration (HCFA), and California Mental Health Director's Association (CMHDA) have agreed that, effective February 1, 1995, the practice of claiming simultaneously through Medicare, other coverage and Short-Doyle/Medi-Cal (SD/MC) for eligible beneficiaries (crossover clients) will be prohibited. The effective date of February 1, 1995 pertains to all SD/MC claims received at DMH on behalf of crossover clients starting February 1, 1995 regardless of the month when the services were provided. Case management services are not subject to the Medicare and other coverage crossover edits.

Claims to SD/MC for services provided to Medicare beneficiaries and paid in part by Medicare should be claimed after Medicare and other coverage reimbursement or denial documentation has been received. SD/MC claims should be made on a balance basis by SD/MC service function code; that is, gross charge less the Medicare and other coverage revenues received on a client specific basis. As indicated in DMH Letter No. 94-24, a Medicare/Medi-Cal worksheet or data must be retained by the county to document the SD/MC claim amount. Submission of the Medicare/Medi-Cal worksheet or data with the SD/MC claim will not be required. The Total Service Charge and Medicare Plus Other Health Coverage Amount Paid fields are <u>optional</u> but their reporting on the magnetic media claim transactions will facilitate evaluating service delivery and answering HCFA audit questions.

HCFA will require the application of the statewide maximum allowance (SMA) to all crossover claims except those where the claim correctly indicates that the beneficiary has Medicare coverage, Crossover Indicator value "X". Only valid SD/MC crossover claims with a Crossover Indicator value "X" will not be edited for SMA limits.

When submitting paper claims, the SD/MC Eligibility Worksheet (MH1980) will be coded to indicate if the claims are crossover. The code indicated on each MH1980 will apply to all claim lines on that document. The MH1980 will be coded "CROSSOVER INDICATOR___" (This must be typed or handwritten by the county at the top of each MH1980). Enter above the dash values as follows: "X" for Medicare coverage; "N" for Medicare coverage but either Medicare denied the claim or the claim is for services that Medicare does not cover; or "P" for other health coverage. These same codes will be used in position 119 of the magnetic media submissions. A variety of crossover claim

codes can be submitted within one batch. If there is no Medicare and/or other health coverage, do not add the "CROSSOVER INDICATOR___" header to the MH1980. DMH will not reprint the claim form to include the crossover indicator header.

The enclosed Crossover Billing Action Plan details the SD/MC data submission changes, Explanation of Balance (EOB) changes, Error Correction Report (ECR) changes, Edit Logic Tables used at DHS, SD/MC claim submittal file record layouts, SD/MC EOB file record layouts, and the Error Codes and Third Party Liability Indicator Crosswalk values that will be used in the EOB files.

If you have any questions regarding this matter, please call Ken McKinstry at (916) 654-2466 or Stan Johnson at (916) 654-3060.

William A. Arritt

LINDA A. POWELL for
Deputy Director
Administrative Services

Enclosure

cc: California Mental Health Planning Council
Chief, Technical Assistance and Training
Chiefs, Medi-Cal Oversight

CROSSOVER BILLING ACTION PLAN

originally presented to CMHDA Fiscal on November 30, 1994
revised January 20, 1995

PROBLEM: The Short-Doyle / Medi-Cal system (SD/MC) must be changed by January 1, 1995, to recognize claims related to crossover billing and apply the Schedule of Maximum Allowance (SMA) as required.

ACTION PLAN: Modify the state and county systems to flag medi-medi (Medicare - Medi-Cal) and other coverage claims received at the State DMH as of February 1, 1995, as crossover claims.

I. DATA SUBMISSION CHANGES:

A. What to submit using this method:

1. This method applies to crossover claims for people who are eligible for Medicare-Medi-Cal or other coverage that are sent to the state as of February 1, 1995. Only case management is excluded from the Medicare coverage edits presented.

2. If a person has Medicare and other coverage, indicate Medicare coverage on the claim transaction.

3. To resolve eligibility questions, county mental health needs to work with the county's health services and social services.

4. Share of cost will not be resolved in this change. It will be resolved in the long term with a vendor handling the claims processing.

B. Claim submission:

1. Magnetic media claim submission information:

   a. Magnetic media claims sent to the State as of February 1, 1995, will include fields for:

Claim record position	Field name	Attributes
119	Crossover flag	X(01)
120-127	Total Service Charge **(optional)**	9(6)V99
128-135	Medicare Plus Other Health Coverage Amount Paid **(optional)**	9(6)V99

The Total Service Charge and Medicare Plus Other Health Coverage Amount Paid fields are optional but their reporting on the claim transactions will facilitate evaluating service delivery and answering HCFA audit questions.

There is no room on the EOB File to send the Total Service Charge and the Medicare Plus Other Health Coverage Amount Paid data back to the counties.

A sample claim input record layout is attached.

b. Resubmitted and suspended claims with a receipt date prior to February 1, 1995, will be processed without consideration to crossover claiming logic.

c. Manual processes will be implemented in the counties to establish an amount to bill until automation can be implemented to document the billing amount.

d. The logic for crossover claiming will be:

See attachment Short-Doyle/Medi-Cal Mental Health Services Edit Logic Table

2. **Paper claim submission information:**

a. For submitting paper claims, the SD/MC Eligibility Worksheet (MH1980) will be coded to indicate if the claims are crossover or non-crossover. The code indicated will apply to all claim lines on that document. A sample MH1980 is attached.

b. There is no room on the paper claim format to enter the Total Charge and Medicare Paid Amount data but counties must maintain documentation locally for audits.

c. All other logic for claiming applies to paper claim submission.

II. EXPLANATION OF BALANCE (EOB) CHANGES:

The following fields will be added to the EOB files sent to the counties and to the Error Correction Reports:

EOB Positions	Field	attributes
188-189	Crossover Indicator error indicator See attachment for error code values.	X(02)
230	Crossover Indicator as submitted blank - no Medicare and other health coverage X - Medicare coverage N - Medicare coverage, however either Medicare denied the claim or the claim is for services that Medicare does not cover P - Other health coverage	X(01)
231	Third Party Liability (TPL) Indicator See attachment for TPL indicator values.	X(01)
232-243	Health Insurance Claim (HIC) Number	X(12)

An Explanation of Balances record layout is attached.

III. ERROR CORRECTION REPORT (ECR) CHANGES:

A. Error Correction Reports will be modified to reflect errors in Medicare and other coverage eligibility coding. New error codes will be established to reflect Medicare or other coverage eligibility coding problems.

B. The error correction process and instructions will remain the same. There will be new error codes on the EOB tape to help counties to correct the data. Counties can make corrections to the crossover code field on the ECR for errors in coding.

C. The Date of Service, Recipient Identifier, Total Billed Amount and Crossover Indicator data fields will be able to be changed to correct crossover errors.

D. The Third Party Liability (TPL, Type of Coverage) and HIC Number will be printed on the ECR to help resolve errors. Counties will not be able to change these fields.

E. ECR messages will be tailored to the type of error.

03 - Invalid Code (code not a blank, "X", "P" or "N")
10 - Conflicts with eligibility file
31 - Medicare coverage part _, HIC # _____
32 - Other coverage ind _

See attached MSD Error codes:

By: DMH - Ken McKinstry (916-654-2466) and Stan Johnson, and DHS - Kathy Sabel

SHORT DOYLE MEDI-CAL MENTAL HEALTH SERVICES EDIT LOGIC TABLE
FOR CROSSOVER BILLING EFFECTIVE FEBRUARY 1995

Date: 1/1995

COUNTY		STATE SYSTEM				
Recipient's Eligibility	Tape Xover Indicator	Recipient's MEDS Elig.	Action	Subject to SMA	EOB Xover Error Code	Error Correction Report Message
No Medicare	blank	No Medicare	Approve	Yes	--	---
No Medicare	blank	Medicare	Suspend	---	31	Medicare Part_, HIC#
Medicare	X	Medicare	Approve	No	--	---
Medicare	X	No Medicare	Approve	Yes	10	Conflicts with Elig.
Medicare	N	Medicare	Approve	Yes	--	---
Medicare	N	No Medicare	Approve	Yes	10	Conflicts with Elig.
No Other Cov	blank	No Other Cov	Approve	Yes	--	---
No Other Cov	blank	Other Cov.	Suspend	---	32	Other Coverage _
Other Cov	P	No Other Cov	Approve	Yes	10	Conflicts with Elig.
Other Cov	P	Other Cov.	Approve	Yes	--	---
Other Cov	P	Medicare	Suspend	---	31	Medicare Part_, HIC#
---	None Above	---	Suspend	---	03	Invalid Code

NOTES:

1. Error code "10" is a noncritical error. This error does NOT cause the claim to suspend. The error message for error code "10" will only appear on the Error Correction Report when a critical error occurs that causes the claim to suspend.

2. If a recipient has both Medicare and Other Health Coverage, the county must bill the claim as Medicare. System edits for other health coverage will NOT be performed if the recipient has Medicare coverage.

3. The State will deem the recipient covered by Medicare if on date of service:
   a. The claim service is Mode 07, 08, or 09 (inpatient) and MEDS Medicare status is either Part A only, or combination Part A and B.
   b. The claim service is NOT Mode 07, 08, or 09 (inpatient) and MEDS Medicare status is either Part B only, or combination Part A and B.

4. See "Medi-Cal Card Medicare Coding" Table for Medicare Part A/B determination.

5. The State will deem the recipient covered by Other Health Coverage if:
   a. The claim service is Mode 07, 08, or 09 (inpatient) and MEDS Other Health Coverage indicator is NOT "A", "M", "X", "Y", "Z", "N" or blank, and HIS displays Inpatient coverage during the date of service.
   b. The claim service is NOT Mode 07, 08, or 09 (inpatient) and MEDS Other Health Coverage indicator is NOT "A", "M", "X", "Y", "Z", "N" or blank, and HIS displays Outpatient or Medical coverage during the date of service.

6. Case Management services are not subject to Medicare and Other Health Coverage edits.

Abbreviations:

EOB=Explanation of Balances
MEDS=Medi-Cal Eligibility Determination System
HIS=Health Insurance System
SMA=State Maximum Allowable
XOVER=Crossover

Short Doyle Medi-Cal
Edits for Sequential Billing

The State Department of Health Services Data Systems Branch will use the following edits for processing Short-Doyle Medi-Cal claims.

Data Contained In Medi-Cal Tape Position 119	*Data Contained In Meds File*	*Processing Logic*
Crossover Patients		
1. Blank	No Medicare coverage	Process subject to SMA
2. Blank	Medicare coverage	Reject claim
3. "X"	Medicare coverage	Process not subject to SMA
4. "X"	No Medicare coverage	Process subject to SMA*
5. "N"	Medicare coverage	Process subject to SMA
6. "N"	No Medicare coverage	Process subject to SMA*
Medi-Cal Patient with Other Coverage		
7. Blank	No other coverage	Process subject to SMA
8. Blank	Other coverage	Reject claim
9. "P"	No other coverage	Process subject to SMA*
10. "P"	Other coverage	Process subject to SMA
11. "P"	Medicare coverage	Reject claim

* The system will need to report that these claims were processed as Medi-Cal without Medicare coverage and other coverage. They will be reported with an error code.

X= Patient is a Crossover (Medi-Medi). Patients with Medicare, Medi-Cal and other coverage are considered to be Crossovers.
N= Patient is a Crossover (Medi-Medi) but the service is not covered by Medicare. Claim is processed as straight Medi-Cal
P= Patient has other coverage.

PAGE: 1 OF 1
DATE: 01/11/95
REVISION:
REVIEWER: EFF. FEBRUARY 1995

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D L A Y O U T

FILE NAME: SHORT/DOYLE MEDI-CAL TAPE CLAIM SUBMITAL FILE

ORIGINATOR: KATHY SABEL
SYSTEM/PROJECT: MSD1001
SOURCE PROGRAM: MSD101

001	002	003	004	005	006	007	008	009	010	011	012	013	014	015	016	017	018	019	020	021	022	023	024	025	026	027	028	029	030	031	032	033	034	035	036	037	038	039	040	041	042	043	044	045	046	047	048	049	050
CLAIM ID														CLAIM FOR:																																			
TYPE	PROV CODE				SERIAL NUMBER					PROVIDER				YY		MM		PROGRAM		MODE SERV		PATIENT NAME																PATIENT RECORD #									BENEFICIARY ID				
																																													SSN				

051	052	053	054	055	056	057	058	059	060	061	062	063	064	065	066	067	068	069	070	071	072	073	074	075	076	077	078	079	080	081	082	083	084	085	086	087	088	089	090	091	092	093	094	095	096	097	098	099	100
BENEFICIARY ID OR										YYY BIRTH		SEX	RACE	DIAG CODE					SERV DATE				SERVICE DAY				DISCHARGE	SERV FUNCT		UNITS TIME				UNITS SERV		TOTAL BILLED AMOUNT									LATE O/R	DUP O/R	ADMIT DA		
SSN					BLANKS														YY		MM		FIRST		LAST												DOLLARS						CENTS				YY		MM	

101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150
ADMIT DA																			TOTAL SERVICE CHARGES								MEDICARE/TPL PAID AMOUN																							
MM	DD		COUNTY USE															XOVER IND	DOLLARS						CENTS		DOLLARS						CENTS		STATE USE															

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [X]
VARIABLE-V [ ]

RECORD LENGTH: 150
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MSD101

FIELD DESCRIPTIONS OF SHORT/DOYLE MEDI-CAL TAPE CLAIM SUBMITTAL FILE

ADP - Department of Alcohol and Drug Programs
DMH - Department of Mental Health

COLUMNS	FORMAT	DESCRIPTION
001 - 010	X(12)	Claim ID - 10 characters col. 1 - Claim type ADP - A or D : A - Disk or tape D - Paper DMH - H or M : H - Disk or tape M - Paper for disk/tape claims: col 1 : A or H cols 2 - 5 : provider code cols 6 - 10 : claim serial number; this is a 5 digit sequentially changing number within each provider code (each provider code has its own series)
011 - 014	X(04)	Provider code must be non-blank
015 - 018	X(04)	Date the claim is submitted for (YYMM) cols 15-16 : Year cols 17-18 : Month
019 - 020	X(02)	Program code 01 - DMH, Mental Health Services 05 - ADP, Drug Services (replaced by 20) 10 - ADP, Alcohol Services 20 - ADP, Drug Services (replaces 05) 25 - ADP, Perinatal Services
021 - 022	X(02)	Mode of service 05 - Psychiatric Health Facility 05 - Residential Rehabilitative Treatment 07 - Inpatient Hospital Services 08 - Psychiatric Hospital (Inpatient) - Under 21 09 - Psychiatric Hospital (Inpatient) - 65 or Over 12 - Outpatient Hospital Services 17 - Clinic Services 18 - Non-Residential Rehabilitative Treatment 50 - Case Management Services note: 05, 07, 08, 09, 18 & 50 are not used by ADP.
023 - 036	X(14)	Patient name
037 - 045	X(09)	Patient record number
046 - 059	X(14)	Beneficiary ID Formatted either: county, aid, case, FBU, person number or, SSN/MEDSID followed by 5 blanks.
060 - 062	X(03)	Year of Birth (format YYY, numeric)
063 - 063	X(01)	Sex code M - Male F - Female U - Unknown blank - Unknown

COLUMNS	FORMAT	DESCRIPTION
064 - 064	X(01)	Race/Ethnic code 1 - White 2 - Hispanic 3 - Black 4 - Asian/Pacific 5 - American Indian or Alaskan Native 7 - Filipino 8 - Other
065 - 069	X(05)	DSM III Diagnostic code must be non-blank; codes are defined in the American Psychiatric Diagnostic Service Manual III.
070 - 073	X(04)	Year/Month that service is provided must be non-blank & numeric (YYMM) cols 70-71 : Year cols 72-73 : Month
074 - 077	X(04)	Treatment (Service) dates cols 74-75 : First day 01 thru 31 cols 76-77 : Last day 01 thru 31
078 - 078	X(01)	Discharged code 1 or blank 1 - indicates that the patient has been formally discharged from inpatient services
079 - 080	X(02)	Service Function ADP - one of the following codes or blank 20 thru 29 - Outpatient Methadone Maintenance 30 thru 39 - Day Care Habilitative 40 thru 49 - Residential Care 50 thru 59 - Naltrexone Treatment 80 thru 89 - Outpatient Drug Free DMH - one of the following codes or blank 01 thru 09 - Case Management 10 thru 19 - Colateral/Case Management/Local Hospital 10-19 and 30-59 - Mental Health Services 20 thru 29 - Psychiatric Health Facility 20 thru 29 - Crisis Stabilization 20 thru 24 - Crisis Stabilization - Emergency Room 25 thru 29 - Crisis Stabilization - Urgent Care 30 thru 39 - Assessment 40 thru 49 - Individual Therapy/Adult Crisis Residential 50 thru 59 - Group Therapy 60 thru 69 - Medication 65 thru 79 - Adult Residential 70 thru 79 - Crisis Intervention 81 thru 89 - Day Care Intensive 81 thru 84 - Day Treatment Intensive, half day 85 thru 89 - Day Treatment Intensive, full day 91 thru 99 - Day Care Rehabilitation 91 thru 94 - Day Treatment Rehabilitative, half day 95 thru 99 - Day Treatment Rehabilitative, full day

COLUMNS	FORMAT	DESCRIPTION
081 - 084	9(04)	Units of Time ADP: units-of-time is not required, zero filled DMH: units-of-time must be numeric and, depending on the service, greater than or equal to zero, indicates either 15 minute periods, 4 hour periods, half day, full day, or one minute period.
085 - 087	9(03)	Units of Service must be numeric and, depending on the service, greater than or equal to zero
088 - 095	9(6)V99	Total Billed Amount must be numeric & greater than zero; represents total billed cost for the patient.
096 - 096	X(01)	Late billing override code A - Patient or legal representative's failure to present Medi-Cal identification. B - Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAMPUS. C - Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county. D - Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster and willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable. E - Special circumstances that cause a billing delay such as a court decision or fair hearing decision. F - Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC). blank - Do not override late billing
097 - 097	X(01)	Duplicate payment override code Y - Override duplicate billing edit blank - Do not override duplicate billing edit
098 - 103	X(06)	Admission Date (YYMMDD) cols 98-99 : Year cols 100-101 : Month cols 102-103 : Day 24 Hour Care claim use only
104 - 118	X(15)	County use field
** 119 - 119	X(01)	Crossover indicator blank - No Medicare and other health coverage N - Medicare covered recipient, however either Medicare denied the claim or the claim is for services that Medicare does not cover P - Other health coverage X - Medicare coverage
** 120 - 127	9(6)V99	Total Service Charge
** 128 - 135	9(6)V99	Medicare/other health coverage amount
136 - 150	X(15)	State use

** Indicates this field is either new or modified effective February 1995 Submittal

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DATE: 01/11/95
REVISION:
REVIEWER: EFF. FEBRUARY 1995

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D L A Y O U T

FILE NAME: SHORT/DOYLE MEDI-CAL EXPLANATION OF BALANCES

ORIGINATOR: KATHY SABEL
SYSTEM/PROJECT: MSD1001
SOURCE PROGRAM: ALL MSD PROGRAMS

001	002	003	004	005	006	007	008	009	010	011	012	013	014	015	016	017	018	019	020	021	022	023	024	025	026	027	028	029	030	031	032	033	034	035	036	037	038	039	040	041	042	043	044	045	046	047	048	049	050
CLAIM ID										PROVIDER				CLAIM FOR:				PROGRAM		MODE SERV		PATIENT NAME														PATIENT RECORD #									BENEFICIARY ID				
TYPE	CLAIM NUMBER													YY		MM																													CO		AID		9 OR M

051	052	053	054	055	056	057	058	059	060	061	062	063	064	065	066	067	068	069	070	071	072	073	074	075	076	077	078	079	080	081	082	083	084	085	086	087	088	089	090	091	092	093	094	095	096	097	098	099	100
BENEFICIARY ID OR									YYY BIRTH			SEX	RACE	DIAG CODE					SERV DATE				SERVICE DAY				DISCHARGE	SERV FUNCT		UNITS TIME				UNITS SERV		TOTAL BILLED AMOUNT									TOTAL ADJ. AMT				
SSN																			YY		MM		FIRST		LAST											DOLLARS								CENTS	DOLLARS				

101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150
TOTAL AD			DATE RECEIVED						TRANS	ELIG O/R	LATE O/R	DUP O/R	APPRV/SUSPND DATE						COUNTY		FED/NON	CLAIM ORIG	BATCH NUMBER												SSN									DUP MATCH ID				
DOLLARS	CENTS		YY		MM		DD						YY		MM		DD						CO		YYYY				MM		BT#		CR#																

151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200
DUP MATCH ID							COUNTY USE FIELD															MAXIMUM ALLOWABLE							ADMISSION DATE						FIELD INDICATORS													
																						DOLLARS				CENTS			YY		MM		DD		DUP		XOVER		BID		SEX		YOB		SERV YM		PROV		MODE

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [X]
VARIABLE-V [ ]

RECORD LENGTH: 275
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT ALL MSD PROGRAMS

PAGE: 2 OF 2
DATE: 01/11/95
REVISION:
REVIEWER: EFF. FEBRUARY 1995

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D L A Y O U T

FILE NAME: SHORT/DOYLE MEDI-CAL EXPLANATION OF BALANCES

ORIGINATOR: KATHY SABEL
SYSTEM/PROJECT: MSD1001
SOURCE PROGRAM: ALL MSD PROGRAMS

201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250
FIELD INDICATORS																									SORT KEY	DAYS SUSP			XOVER IND	TPL IND	HIC #													PC UNITS TIME					PC UN
MODE	PROGRAM	SRV FNC	UT TIME	UT SERV	TOT AMT	CLM FOR	NAME	ADM YMD	RACE	SRV DAY	DISCHRG	DIAG																															UNITS				SIGN	UNITS

251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300
PC UN		PC TOTAL AMOUNT										PC TOTAL ADJ. AMT										COUNTY	REC TYPE																										
UNITS	SIGN	DOLLARS						DECIMAL	CENTS		SIGN	DOLLARS						DECIMAL	CENTS		SIGN																													

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [X]
VARIABLE-V [ ]

RECORD LENGTH: 275
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT ALL MSD PROGRAMS

ADP - Department of Alcohol and Drug Programs
DMH - Department of Mental Health

COLUMNS	FORMAT	DESCRIPTION
001 - 010	X(10)	Claim ID - 10 characters col. 1 - Claim type ADP - A or D : A - Disk or tape D - Paper DMH - H or M : H - Disk or tape M - Paper for disk/tape claims: col 1 : A or H cols 2 - 5 : provider code cols 6 - 10 : claim serial number; this is a 5 digit sequentially changing number within each provider code (each provider code has its own series)
011 - 014	X(04)	Provider code must be non-blank
015 - 018	X(04)	Date the claim is submitted for (YYMM) cols 15-16 : Year cols 17-18 : Month
019 - 020	X(02)	Program code 01 - DMH, Mental Health Services 05 - ADP, Drug Services (replaced by 20) 10 - ADP, Alcohol Services 20 - ADP, Drug Services (replaces 05) 25 - ADP, Perinatal Services
021 - 022	X(02)	Mode of service 05 - Psychiatric Health Facility 05 - Residential Rehabilitative Treatment 07 - Inpatient Hospital Services 08 - Psychiatric Hospital (Inpatient) - Under 21 09 - Psychiatric Hospital (Inpatient) - 65 or Over 12 - Outpatient Hospital Services 17 - Clinic Services 18 - Non-Residential Rehabilitative Treatment 50 - Case Management Services note: 05, 07, 08, 09, 18 & 50 are not used by ADP.
023 - 036	X(14)	Patient name
037 - 045	X(09)	Patient record number
046 - 059	X(14)	Beneficiary ID Formatted either: county, aid, case, FBU, person number or, county, aid, '9' or 'M', SSN/MEDS-ID.
060 - 062	X(03)	Year of Birth (YYY) must be numeric or blank
063 - 063	X(01)	Sex code M - Male F - Female U - Unknown blank - Unknown

COLUMNS	FORMAT	DESCRIPTION
064 - 064	X(01)	Race/Ethnic code 1 - White 2 - Hispanic 3 - Black 4 - Asian/Pacific 5 - American Indian or Alaskan Native 7 - Filipino 8 - Other
065 - 069	X(05)	DSM III Diagnostic code must be non-blank; codes are defined in the American Psychiatric Diagnostic Service Manual III.
070 - 073	X(04)	Year/Month that service is provided must be non-blank & numeric (YYMM) cols 70-71 : Year cols 72-73 : Month
074 - 077	X(04)	Treatment (Service) dates cols 74-75 : first day 01 thru 31 cols 76-77 : last day 01 thru 31
078 - 078	X(01)	Discharged code 1 or blank 1 - indicates that the patient has been formally discharged from 24 care services
079 - 080	X(02)	Service Function ADP - one of the following codes or blank 20 thru 29 - Outpatient Methadone Maintenance 30 thru 39 - Day Care Habilitative 40 thru 49 - Residential Care 50 thru 59 - Naltrexone Treatment 80 thru 89 - Outpatient Drug Free DMH - one of the following codes 01 thru 09 - Case Management 10 thru 19 - Colateral/Case Management/Local Hospital 10-19 and 30-59 - Mental Health Services 20 thru 29 - Psychiatric Health Facility 20 thru 29 - Crisis Stabilization 20 thru 24 - Crisis Stabilization - Emergency Room 25 thru 29 - Crisis Stabilization - Urgent Care 30 thru 39 - Assessment 40 thru 49 - Individual Therapy/Adult Crisis Residential 50 thru 59 - Group Therapy 60 thru 69 - Medication 65 thru 79 - Adult Residential 70 thru 79 - Crisis Intervention 81 thru 89 - Day Care Intensive 81 thru 84 - Day Treatment Intensive, half day 85 thru 89 - Day Treatment Intensive, full day 91 thru 99 - Day Care Rehabilitation 91 thru 94 - Day Treatment Rehabilitative, half day 95 thru 99 - Day Treatment Rehabilitative, full day

COLUMNS	FORMAT	DESCRIPTION
081 - 084	S9(04)	Units of Time ADP: units-of-time is not required, zero filled DMH: units-of-time must be numeric and, depending on the service, greater than or equal to zero; indicates either 15 minute periods, 4 hour periods, half day, full day, or one minute period
085 - 087	S9(03)	Units of Service must be numeric and, depending on the service, greater than or equal to zero
088 - 095	S9(6)V99	Total billed amount must be numeric & greater than zero; represents total cost for the patient.
096 - 103	S9(6)V99	Total approved adjusted amount Indicates the amount approved for payment.
104 - 109	X(06)	Date claim received (YYMMDD)
110 - 110	X(01)	Transaction code (when Sort Key field='D', this code is used to indicate the denial reason) C - Unprocessable, invalid claim id D - Unprocessable, duplicate claim id N - Deny claim with non-Title XIX determination O - Unprocessable, invalid late billing override code R - Unprocessable, reciept date error S - Unprocessable, duplicate claim id on suspense T - Deny claim with tape submission error X - County requested denial of claim on suspense blank - Claim denied after 96 days on suspense
111 - 111	X(01)	Eligibility override code W - Override eligibility edit blank - Do not override eligibility edit
112 - 112	X(01)	Late billing override code A - Patient or legal representative's failure to present Medi-Cal identification. B - Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAMPUS. C - Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county. D - Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster and willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable. E - Special circumstances that cause a billing delay such as a court decision or fair hearing decision. F - Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC). blank - Do not override late billing

COLUMNS	FORMAT	DESCRIPTION
113 - 113	X(01)	Duplicate payment override code Y - Override duplicate billing edit blank - Do not override duplicate billing edit
114 - 119	X(06)	Date claim was approved, suspended or denied (YYMMDD) Approved and Denied claims use the process cutoff date. Suspended claims use the run date.
120 - 121	X(02)	County code Set to correct county (01-58, 65, 66 or 99) according to a county table in program MSD110.
122 - 122	X(01)	Federal/Non-Federal code Indicates whether or not the beneficiary is eligible for Federal Financial Participation. N - Non-Federal (Not Eligible) F - Federal (Eligible) blank - not determined
123 - 123	X(01)	Claim origin D - ADP M - DMH note: checks the program code first to set this field; otherwise it checks the claim type.
124 - 135	X(12)	Batch number (CCYYYYMMBBHH) Format: CC County code YYYY Year of claim MM Month of claim BB Batch sequence HH Health management organization
136 - 144	X(09)	SSN/MEDS-ID
145 - 157	X(13)	Duplicate Match ID Contains either the beneficiary ID less the units of aid or the SSN/MEDS-ID followed by four spaces.
158 - 172	X(15)	County use field
173 - 179	S9(5)V99	Maximum allowed amount
180 - 185	X(06)	Admission Date (YYMMDD) col 180-181 : Year col 182-183 : Month col 184-185 : Day 24 hour care claim use only
186 - 225	X(02)	ERROR FIELD INDICATORS
(occurs 20 times)		(See Attachment for error code values)
186 - 187		Duplicate error indicator
** 188 - 189		Crossover indicator error indicator
190 - 191		Welfare ID error indicator (error indicator for either SSN or Beneficiary ID)
192 - 193		Sex error indicator
194 - 195		Year of Birth error indicator
196 - 197		Service YYMM error indicator
198 - 199		Provider error indicator
200 - 201		Mode of service error indicator
202 - 203		Program code error indicator
204 - 205		Service function code error indicator
206 - 207		Units of time error indicator

	COLUMNS	FORMAT	DESCRIPTION
			ERROR FIELD INDICATORS Continued
	208 - 209		Units of service error indicator
	210 - 211		Total billed amount error indicator
	212 - 213		Claim for error indicator
	214 - 215		Name error indicator
	216 - 217		Admission Date error indicator (redefined from patient record #)
	218 - 219		Race error indicator
	220 - 221		Treatment (Service) date error indicator
	222 - 223		Discharge code error indicator
	224 - 225		Diagnosis code error indicator
	226 - 226	X(01)	Sort key A - Approved claim D - Denied claim G - Aged suspended claim S - Suspended claim
	227 - 229	9(03)	Days on suspense
**	230 - 230	X(01)	Crossover indicator blank - No Medicare and other health coverage N - Medicare covered recipient, however either Medicare denied the claim or the claim is for services that Medicare does not cover P - Other health coverage X - Medicare coverage
**	231 - 231	X(01)	Third Party Liability (TPL) Indicator (See Attachment for TPL indicator values)
**	232 - 243	X(12)	Health Insurance Claim Number
	244 - 248	9(04)S	PC Units of time
	249 - 252	9(03)S	PC Units of service
	253 - 262	9(6).99S	PC Total Billed Amount
	263 - 272	9(6).99S	PC Total Approved Adjusted Amount
	273 - 274	X(02)	EOB County (same as County field)
	275 - 275	X(01)	EOB Record Type (same as Sort Key field)

** Indicates this field is either new or modified effective February 1995 EOB tape.

MSD ERROR CODES

ERROR CODE	ERROR MESSAGE	FLAGGED IN PROGRAM
01	BLANK	MSD110
02	NOT VALID DATE	MSD110
03	INVALID CODE	MSD110
04	LATE SUBMISSION	MSD110
05	NOT VALID DAY	MSD110
06	NOT NUMERIC	MSD110
07	ZERO CLAIMED	MSD110
08	MODE NOT AUTHORIZED	MSD110
09	INELIGIBLE IN MO/YR	MSD120/MSD125
10	CONFLICTS WITH ELIGIBILITY FILE	MSD120/MSD125
11	NOT ON ELIGIBILITY FILE	MSD120/MSD125
12	NOT ON PROVIDER FILE	MSD110
13	PROGRAM NOT AUTHORIZED	MSD110
14	MODE NOT AUTHORIZED IN MO/YR	MSD110
15	NO SECONDARY MATCH	MSD120/MSD125
16	MO/YR OF SERVICE GREATER THAN RECEIPT DATE	MSD110
17	CLAIM TOO OLD FOR ELIGIBILITY CHECK BY WELFARE-ID	MSD120
18	CLAIM TOO OLD FOR ELIGIBILITY CHECK BY SSN	MSD125
19	INVALID SERVICE FUNCTION CODE	MSD110
20	UNITS/SERVICE IS NOT <= UNITS/TIME	MSD110
21	INVALID DRUG CODE	MSD110
22	DATE RANGE NOT ALLOWED	MSD110
23	UNITS > ALLOWED	MSD110/MSD170
24	TO DAY > FROM DAY	MSD110
25	UNITS NOT EQUAL TO DAYS	MSD110

MSD ERROR CODES

ERROR CODE	ERROR MESSAGE	FLAGGED IN PROGRAM
26	DUPLICATE SERVICE - NO OVERRIDE	MSD170
27	MULTIPLE SERVICE - OVERRIDE OK	MSD170
28	GREATER THAN TWO OUTPATIENT SERVICES	MSD170
29	SERVICE FUNCTION NOT AUTHORIZED	MSD110
30	SERVICE FUNCTION NOT AUTHORIZED IN MO/YR	MSD110
31	MEDICARE COVERAGE PART __, HIC # _____	MSD120/MSD125
32	OTHER COVERAGE IND _	MSD120/MSD125

FILE:HDMDCAL1:MSD ERRCODES (REVISED 1/95)

THIRD PARTY LIABILITY INDICATOR CROSSWALK

Indicator	Coverage/Carrier
blank	NO MEDICARE AND OTHER HEALTH COVERAGE
MEDICARE	
*	PART A ONLY
#	PART B ONLY
$	PART A AND PART B
PAY AND CHASE	
A	ANY SINGLE CARRIER
M	TWO OR MORE
X	BLUE SHIELD
Y	BLUE CROSS NORTH
Z	BLUE CROSS SOUTH
COST AVOIDANCE	
B	BLUE CROSS
C	CHAMPUS
D	PRUDENTIAL
E	AETNA
F	FIRST FARWEST
G	AMERICAN GENERAL
H	MUTUAL OF OMAHA
I	METROPOLITAN LIFE
J	JOHN HANCOCK MUTUAL LIFE
K	KAISER
L	DENTAL COST AVOIDANCE
N	NONE
P	PHP/HMO'S
Q	EQUICOR/EQUITABLE
R	ROSS LOOS
S	BLUE SHIELD
T	TRAVELERS
U	CONNECTICUT GENERAL
V	VARIABLE
W	GREAT WEST LIFE
2	PROVIDENT LIFE & ACCIDENT
3	PRINCIPAL FINANCIAL GROUP
4	PACIFIC MUTUAL LIFE
5	ALTA HEALTH STRATEGIES
6	AARP
7	ALLSTATE LIFE
8	NEW YORK LIFE
9	CROWN LIFE
O	OVERRIDE

HDMDCAL1:TPL XWALK (01/1995)

CROSSOVER INDICATOR __

State of California—Health and Welfare Agency

SHORT-DOYLE/MEDI-CAL ELIGIBILITY WORKSHEET

MH-1980 (REV. 5/93)

Department of Mental Health

M № 000001

"CONFIDENTIAL PATIENT INFORMATION: SEE W & I CODE, SECTION 5328"

PROVIDER: | PROV. CODE | CLAIM FOR: MO. YR | PROG. CODE 01 | MODE OF SERVICE: | PAGE ____ OF ____

LINE	PATIENT NAME	PATIENT RECORD NUMBER	WELFARE IDENTIFICATION NO. (OR MEDS I.D. IN FIRST NINE) CO	AID	CASE NUMBER	FBU	PER NO.	YEAR OF BIRTH	SEX	RACE/ETH.	DSM III-R DIAGNOSTIC CODE	MO/YR OF SERVICE	TREATMENT DATE FIRST	LAST	24-HR CARE ADMIT DATE (MM/DD/YY)	DISCHARGED	SVC FUNC CODE	UNITS OF SVC.	UNITS OF TIME	TOTAL AMOUNT	GOOD CAUSE	DUP. O'RIDE
01																						
02																						
03																						
04																						
05																						
06																						
07																						
08																						
09																						
10																						
11																						
12																						
13																						
14																						
15																						
																	TOTALS					
																		TOTAL REVENUE RECEIVED				

I HEREBY CERTIFY THAT A REVIEW OF ALL PATIENTS HAS BEEN CONDUCTED WITHIN 30 DAYS AFTER ADMISSION (OR DATE OF FIRST SERVICE) TO DETERMINE ELIGIBILITY FOR THE CALIFORNIA MEDICAL ASSISTANCE PROGRAM IN ACCORDANCE WITH SECTION 5719 OF THE WELFARE AND INSTITUTIONS CODE. THE PATIENTS LISTED HERE ARE THOSE WHO HAVE BEEN DETERMINED ELIGIBLE. I FURTHER CERTIFY TO COMPLIANCE WITH THE STATEMENT ON THE REVERSE OF THIS FORM.

SIGNATURE: _____ PHONE: _____ DATE: _____