

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

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**ADP BULLETIN**

Title

Fiscal Year 1999-00 Drug Medi-Cal Claiming Procedures and Miscellaneous Claiming Information

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PURPOSE

The purpose of this bulletin is to provide processing procedures for Fiscal Year (FY) 1999-00 Drug Medi-Cal (DMC) claims. These procedures will clarify and reiterate the DMC claiming and reporting requirements.

DISCUSSION

The following procedures apply to both counties and direct contract providers.

1. Monthly Claim for DMC Reimbursement and Monthly Provider Service and Revenue

Summary (ADP 1592)

The Monthly Claim for DMC Reimbursement and Monthly Provider Service and Revenue Summary (hereafter referred to as a ADP 1592 or Invoice [Exhibit A]), has been revised to incorporate check boxes for media types that include paper, tape/disk (non-paradox), paradox disk, internet-paradox, and internet e-mail and submission types that include original, supplemental, and CalWORKs. You may create a facsimile of this form for your use. Signature Card on File is also a new feature. The county/direct provider must have a completed Signature Card on file at the Department of Alcohol and Drug Programs (ADP) signed by the appropriate personnel in order to use this feature. (See **Signature Cards for Monthly Claims** section for further details).

If a county/direct provider does not have a current Signature Card on file at ADP, please submit **one** original ADP 1592 **with original signatures** plus **three** copies with each

DMC claim. The preparer of the ADP 1592 must sign in the Fiscal Representative signature box. If a county is submitting the ADP 1592, the county representative must sign the County Certification section. If a direct provider is submitting the claim, the Direct Contractor Certification section must be signed. Both counties and direct contract providers must sign the last section for "...Auditor-Controller, Finance Officer."

If the county/direct provider has a valid Signature Card on file with ADP, the ADP 1592 may be either faxed to (916) 323-0653 or e-mailed to DMCINV@ADP.CA.GOV.state.ca.us.

To avoid unnecessary delays, all items must be completed on the ADP 1592. Please complete the following items:

Heading

- a. Check the Media Type: Paper, Tape/Disk (non-paradox), Paradox Disk, Internet-Paradox, Internet-Email.
- b. Check the Submission Type: Original, Supplemental, and/or CalWORKs.
- c. Enter the Date of Submission.
- d. Enter the County Name and Code.
- e. Enter Claim for MO/YR.
- f. Enter the **Contract number**.
- g. Check the appropriate Program Code of 20 or 25.
- h. Enter the appropriate Fiscal Year.

Columns

- i. Enter the provider name and DMC provider number by service function code (each service function code must be on a separate line).
- j. Enter Total amount(s).
- k. Enter any Adjustments To Gross Claim.
- l. Enter Net Claim amount(s).
- m. Obtain signatures from appropriate personnel.
- n. Check the Signature Card on File box if applicable.

Please use the ADP 1592 with a revised date of 7/99 for submitting future claims (Exhibit A).

2. **Signature Cards for Monthly Claims**

Original signatures are not required on ADP 1592 if you have submitted a completed Signature Card for Monthly Claim, FY 1999-00 (Exhibit B) to ADP. The Signature Card will be valid through the end of the fiscal year. This will enable you to submit an ADP 1592 form without original signatures as long as the Signature Card on File box is marked on the ADP 1592. If you would like to use the Signature Card, please complete the enclosed Signature Card form with the signatures of the appropriate personnel and return it to ADP as soon as possible. New Signature Cards must be completed and returned to ADP at the beginning of each fiscal year for this provision to remain in effect.

3. **Drug Medi-Cal Eligibility Worksheet (ADP 1584, Revised 6/99)**

A copy of the revised Drug Medi-Cal Eligibility Worksheet (ADP 1584) is enclosed (Exhibit C). Hardcopy (paper) claims must be submitted on the NCR form ADP 1584 or an ADP approved facsimile. Counties/direct providers must use the revised ADP 1584 starting with July 1999 claims. Original signatures are required on each page. The revision adds a column for Counselor Indicator/Identifier.

Please be sure to group **each service function code** separately whether on ADP 1584, tape, diskette or e-mail submission. This also applies to narcotic treatment program providers.

Transcribing Social Security Numbers. Do **Not** use the 10th digit from the clients eligibility swipe card. Do **Not** use dashes, typhens or spaces when transcribing social security numbers. Doing so generates and perpetuates error reports and delays reimbursement for client services.

4. **Submitting a “Revised” ADP 1592**

When replacing an ADP 1592 with another, please write the words “**Revised**” in large letters on the Invoice face to avoid accounting errors. The Fiscal Management Branch (FMB) analyst normally requests a revised Invoice when the claim amount is more than is reflected on the original ADP 1592 submitted by the county or direct provider.

5. Claim Definitions

a. Original DMC Claim Submission

The original claim is the first claim ADP receives for a particular month and year of service. The original claim must be submitted within 30 days after the end of the month of service. Claims received thereafter are considered late.

b. Supplemental DMC Claim Submission

A supplemental claim is any claim submitted after the original submission for that particular month and year of service.

A supplemental claim can include new clients or additional services not claimed on the original submission. A supplemental claim is not an original submission and must be clearly identified by checking the Supplemental box on the ADP 1592.

a. **Late Submission**

If an original or supplemental claim for the same month is not submitted within the 30-day time period, it is considered to be a late submission. A good cause code is required for late submissions and must be entered on the DMC claim form. Also required is a Good Cause Certification form (ADP 6065), completed and signed by a person authorized to represent the county/direct provider, certifying the validity of the billing. **This form should remain at the provider site for ADP monitor review or audit.** See ADP Bulletin 98-39 for a list of Good Cause Reason Codes, and a Good Cause Certification form.

b. **Resubmission Claim**

This is a claim that is being resubmitted because the unit(s) have been denied, adjusted (disallowed), or deleted. A copy of the **Denied Claims Report** or the Error Correction Report showing that the units being resubmitted have been denied or deleted or an adjustment form ADP 5035C **must accompany the resubmission document.** If there is no proof that the units were denied the claim will **Not** be processed and the resubmission will be returned to the county/direct provider.

A disk, tape, Information Network Project (INP), or paper resubmission **does NOT require an ADP 1592 invoice.** The form "Drug Medi-Cal Resubmission Form" (Exhibit K) must accompany any resubmissions (non-INP) that are submitted to ADP.

A separate form "Drug Medi-Cal Information Network Project (INP)" (Exhibit L) was designed for resubmissions of INP claims. This form must accompany any INP resubmission.

If **additional units of service (UOS)** are claimed, they **must be submitted separately as a Supplemental Claim with an ADP 1592** that includes those additional units.

Do not include resubmission units with supplemental units on the same claim. These are two different processes and they **cannot** be combined.

Before resubmitting the claim:

- Do** compare the denied report to the approved report*
- Do** check the reason code for the denial
- Do** determine if the denial reason is correctable
- Do** check error messages where applicable
- Do** make corrections as appropriate
- Do** send in the denial report with the resubmission
- Do** send in resubmissions separate from supplemental claims
- Do** send in resubmissions separated by batch number
- Do** send the Drug Medi-Cal Resubmission Form or the

Drug Medi-Cal INP Rejected/Resubmission Form

*In some cases the units have been previously approved.

Please apply these suggestions and save valuable time and effort.

6. **CalWORKs (California Work Opportunity and Responsibility to Kids)**

Please continue to submit CalWORKs claims separately from other DMC Claims (i.e. on whatever media type you normally submit your claims). A separate ADP 1592 must accompany the claim. Please check the CalWORKs box on the ADP 1592 and the media and submission type appropriate to the CalWORKs claim.

7. **Rejected Submissions**

A claim can be rejected by the Short-Doyle Automated Billing System (Department of Health Services Automated System). This occurs when the claim total dollars and total records on the disk/tape label do not match the total dollar amount and total records contained on the disk or tape claim. When this occurs, the disk or tape is returned, with a cover letter, to the county/direct provider for corrections. The cover letter has a cut off form on the bottom portion of the letter describing the information on the rejected disk/tape being returned. Once the corrections are made the claim must be returned to ADP and processed through the DHS automated billing system in order to receive payment. The cut off portion of the cover letter must accompany the rejected claim replacement tape or disk (Exhibit M).

Rejected INP claims must be returned through the e-mail process with the Drug Medi-Cal INP Rejected/Resubmission Form (Exhibit L).

8. **Counselor Indicators/Identifiers**

Counselor indicators/identifiers will be required on DMC claims (ADP 1584) for outpatient drug free and narcotic treatment program counseling services beginning with July 1999 DMC claims. The counselor indicator/identifier code is required on all media types of DMC submissions: hardcopy (paper), paradox disk, tape, diskette and INP claims.

DMC claims for reimbursement of outpatient drug free and narcotic treatment programs counseling services shall include either the three-alpha character initials or a provider assigned unique five-digit numeric code of the counselor providing the individual or group counseling session. For electronic media claims the counselor indicator must be placed on the claim form in fields 136, 137, 138, 139, and 140 of the record layout. When using alpha characters, a minimum of three letter characters is required in this field which should be the counselor's first, middle and last initial of their name. For example, Jane Q. Doe would be indicated as JQD. If the counselor has no middle initial a dash (-) should be used (J-D). The alpha characters should be left justified and the last two fields should be left blank. The five-digit numeric code is assigned by each provider and must be unique to the counselor. It is the provider's responsibility to keep a listing of the numeric code assigned to each counselor on the site where the services were provided. In addition, the list must be provided to ADP staff upon request.

Counties and providers have the option of including the counselor indicator on their claim form for reimbursement of Day Care Habilitative, Naltrexone and Perinatal Residential services.

Please review ADP Bulletin 99-21 for more information.

9. **Correcting Edit and Duplicate Error Correction Reports (ECR)**

Error Correction Reports (ECR) inform counties/direct providers of ADP 1584 claim lines which are suspended because the claim was not submitted accurately and allows providers to make corrections. Edit ECRs contain miscellaneous errors made on claims. Duplicate ECRs contain two claims for the same service for the same client on the same day.

Please review the ECR before you make corrections. **Read the error message and make sure that the correction you make is correcting the error identified on the ECR.**

A review of ECRs returned to ADP by counties/direct providers has revealed that override codes are used improperly. If an ECR has improper corrections, the automated billing system will not accept the corrections. Improper corrections will result in records remaining on suspense for the maximum time (97 days from the rundate). At the end of the 97-day period the claim will be denied. ECR processing instructions and error messages are enclosed (Exhibit D).

In general, the following appropriate override codes that may be used are:

- a. **Override Codes** that may be used on an **Edit ECR** are:
 1. **“W”** Override Code plus the **county code** and the **aid code overrides a client eligibility** error. The aid code can be obtained from the client’s proof of eligibility. The county code and aid code is **mandatory** in the first four boxes of the correction field. Please leave remaining fields for that claim blank; otherwise the override codes will **not** work.
 2. **“X”** is used to **delete** the entry.
 3. **“A”** through **“F”** Good Cause Codes are used for late DMC submission(s). A Good Cause Certification form ADP 6065 (See ADP Bulletin 98-39) must be completed and retained at the provider site for audit or monitoring purposes.

Note: NO OTHER OVERRIDE CODES ARE ALLOWED.

- b. **Override Codes** that may be used on a **Duplicate ECR** are:
 1. **“Y”** Override Code **will allow two units of service** on the **same day**. A Multiple Billing Override Certification form ADP 7700 (Exhibit E) must be completed and retained at the provider site and be available for audit or monitoring visits.
 2. **“X”** is used to **delete** the entry.

Note: NO OTHER OVERRIDE CODES ARE ALLOWED.

FOR BOTH TYPES OF ECRs: NEVER USE BOTH AN OVERRIDE CODE AND MAKE A CORRECTION. The billing system will ignore both and after 97 days on suspense the claim will deny.

10. Receipt of DHS Generated Report

It is important to understand the time limits in the ECR process. The Department of Health Services (DHS) generates ECRs, they are forwarded to ADP who, in turn, forwards the ECRs to the respective counties. It is the County's responsibility to forward the ECRs to the respective Drug Medi-Cal (DMC) providers so appropriate corrections can be made. The DMC provider is to return the corrected ECRs to the County, which forwards them to ADP. ADP then batches and forwards the corrected ECRs back DHS processing.

DHS allows 97 days from the date the ECR is generated (“Run Date” [current date] identified in upper right hand corner of the ECR) to the date it must be entered back into the DHS billing system for final processing. If the ECR is not processed within the 97-day limit, the claims will be denied. ***THE CORRECTED ECR MUST BE RECEIVED BY ADP EIGHT WEEKS FROM THE RUN DATE. ECRs*** must be treated as an ***EXPEDITE***.

11. Miscellaneous Information

a. Information Network Project (INP)

Counties who participate in the INP process must submit invoices with original, supplemental, and CalWORKs claims. This identifies the submission type of the e-mail claim.

To participate in the INP e-mail process, counties must be actively reporting CADDs through the INP process. ADP will contact those counties who qualify to begin the process of submitting their DMC billings through INP.

There is a minimum testing period of two months. During the testing period, counties must submit concurrent claims using:

1. current media with a paper printout,
2. and; INP e-mail process media.

After two consecutive months of concurrent submission is successful, claims can be submitted via the INP process.

Once the Counties DMC claims are in production, claims are sent through ECXpert only. Counties must fax or e-mail an ADP 1592 invoice form to ADP at (916) 323-0653 or DMCINV@ADP.state.ca.us respectively for each claim submitted via ECXpert. This includes originals, supplementals, and CalWORKs submission types.

The county must have a "Signature Card" on file with the ADP, Fiscal Management Branch (FMB) for each fiscal year in which the county will be submitting Drug Medi-Cal Claims to ADP (Exhibit B).

A rejected claim or a resubmission of denied INP claims must be accompanied by the Drug Medi-Cal INP Rejected/Resubmission Form either faxed or e-mailed to ADP. A resubmission must be accompanied by the denied claims report or the ECR deleting the claim to validate the resubmission.

b. State General Fund Payment - Counties

Counties will continue to automatically receive a monthly payment of 1/12th of their contract amount of State General Fund (SGF) for Drug Medi-Cal services.

c. State General Fund Payment - Direct Providers

The Monthly Interim Payment Claim (MIPC) (Exhibit F) process for direct providers remains the same as explained in ADP bulletin 98-45. Direct Providers who desire to claim the State General Fund portion of projected expenditures for DMC services must submit their claim within 30 days after the end of the month of service. Any MIPCs received after the 30-day limit will **not** be processed. The direct provider will receive both their SGF and Federal Fund Participation (FFP) funds based on approved services after the Approved Services Report is received from DHS.

d. MIPC Signature Cards for Direct Providers

Original signatures on Monthly Interim Payment Claims are not required if you have submitted to ADP a completed Signature Card for MIPC (Exhibit G), for FY 1999-00. It will remain on file through the end of the fiscal year. This will enable you to check the "signature on file" box on the Fiscal Representative signature line and submit the MIPC without original signatures. Please complete the enclosed Signature Card with signatures from the appropriate personnel and return to ADP as soon as possible if you wish to use the signature card provision. New MIPC Signature Cards must be completed and returned to ADP at the beginning of each fiscal year for this provision to remain in effect.

e. Minor Consent Report

Direct Providers can use this report for their record keeping information. Counties contracting with DMC providers can use the Minor Consent Report (Exhibit H) as an approved services report for minor consent clients. Counties should reimburse DMC providers with SGF funds by determining the units of service that were provided to minor consent clients with the Aid Codes of 7M or 7P. These claims are eligible for 100 percent payment from SGF dollars. Claims for eligible clients with an Aid Code of "7N" will continue to be approved for SGF and Federal Financial Participation (FFP) and be listed on the "Detailed Report by Provider of Title XIX Approved Services and Expenditures".

f. Revised Drug Medi-Cal Rates for FY 1999-00

Please utilize the new rates (Exhibit I) when submitting DMC claims for FY 1999-00 (see ADP Bulletin 99-23). These rates will be published in emergency regulations in

Section 51516.1 of Title 22, California Code of Regulations. These rates are effective as of July 1, 1999.

g. Claim ID Number Change on Paradox Diskette System

The Claim ID number on paradox diskettes now begins with the letter "D" to avoid a duplication of claim ID numbers already used on claims in previous fiscal years. Please **do not** change the letter "D". This change should result in fewer erroneous duplicate claims.

h. Attention Point of Service (POS) Device Users

The Department of Health Services (DHS) and Electronic Data Systems (EDS) have released a new version of POS device software that is Y2K compliant. This new version, ZZA0302.V00, incorporates software changes to ensure correct operations in the year 2000. An information packet has been mailed out to all providers who have a POS device. The packet includes a cover letter, detailed download instructions and a schedule by which providers should download. The schedule was designed to have providers download during non-peak business hours so as not to disrupt a provider's practice. However, providers may download their POS device at any time, seven days a week. The POS device can also be pre-programmed to download during evening hours, but only over a 24-hour period.

Warning:

On September 20, 1999, the Department will begin to automatically disable POS devices that have not downloaded the Y2K version of software. This is to ensure that all devices statewide are downloaded before December 31, 1999. Telephone AEVS will be your alternative to verify client eligibility until a successful download has been completed.

If providers have ANY questions regarding this process they may:

- a) Refer to the download instructions provided in the information packet.
- b) Visit the Medi-Cal Internet Web site at <http://www.medi-cal.ca.gov> ; select 'Y2K Download for POS Providers', then select POS Download Instructions'.
- c) Refer to the POS User Guide: Section 500-55 - Software Maintenance Functions; Software Download, Page 500-55-3.
- d) Call the POS Help Desk at 1-800-427-1295.

i. Fiscal Management Branch (FMB) Analyst Assignments

A listing of FMB analysts with telephone numbers is enclosed (Exhibit J).

REFERENCES

Title 22, California Code of Regulations, Section 51341.1, 51516.1 and 51008.
CalWORKs ADP Bulletin 98-14, dated April 2, 1998.
Counselor Indicators Required-ADP Bulletin 99-21, dated June 3, 1999.
FY 1998-99 Monthly Interim Claims ADP Bulletin 98-45, dated August 24, 1998.
Minor Consent Report ADP Bulletin 99-07, dated February 26, 1999.
Revised Drug Medi-Cal Rates for FY 1999-00 ADP Bulletin 99-23, dated June 29, 1999.

HISTORY

Not applicable.

QUESTIONS/MAINTENANCE

Questions regarding these issues may be directed to your Fiscal Management Branch assigned analyst.

EXHIBITS

ADP 1592 Invoice (Revised 7/99)
Signature Card for Monthly Claim FY 1999-00 (for ADP 1592)
ADP 1584-D/MC Eligibility Worksheet (Revised 05/99)
Error Correction Report Processing Instructions and Error Codes
ADP 7700 Multiple Billing Override Certification
Monthly Interim Payment Claim - FY 1999-00
Signature Card for MIPC - FY 1999-00
Sample Minor Consent Report
DMC Rates 1999-00
FMB Analyst Assignments
Drug Medi-Cal Resubmission Form (non-INP)
Drug Medi-Cal INP Rejected/Resubmission Form
Rejected Tape/Disk cover letter with Return Slip for Rejected Disks and Tapes

DISTRIBUTION

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