STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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July 14, 1999

MMCD All Plan Letter 99008

RECEIVED
JUL 28 1999
JACKIE DUPLESSE

RECEIVED
JUL 22 1999
MEDICAL AFFAIRS
Charles E. Signorino, MD

TO: Plan Administrators
Medical Directors

SUBJECT: UPDATES TO MANAGED CARE DATA DICTIONARY

This letter transmits changes in the Managed Care Data Dictionary to reflect current practice. Please add and replace the pages enclosed to update your copy.

The managed Care Encounter Data Dictionary was initially distributed in Sacramento County. Modifications have been issued: twice in 1994, twice in 1995, and once in 1997. All of these versions are modified by transmittal of this letter and it's enclosures.

Should you have questions regarding encounter data reporting or need a complete copy of the Dictionary, contact the Data Management Unit, at (916) 653-5297.

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Enclosure

ENCLOSURE

Insert the following:

1. Medium For Submission of Data:

   Data Transmission Options-Tape, Disk, ~~Telec~~ommunication (5 pages).

2. Edit Process:

   Critical Errors, 1% and 5% Error Table, and Informational Error Table (5 pages).

Replace:

1. Table of Contents (3 pages).
2. The following data element modifications (20 pages).

DE#03 Format Code
Clarifies the place of service for reporting Long Term Care is only when admitted to a Certified Long Term Care Facility.

DE#04 Program Code
New Code "P" is added for reporting outpatient mental health services/Mental Health Managed Care services.

DE#05 Adjustment Code for Claim Reference (2 pages)
Clarifies the use of adjustment codes.

DE#06 Adjustment Claim Reference Number (CRN)
Clarifies the use of adjustment codes.

DE#13 Provider Number (Reporting/Billing) (2 pages)
Clarifies reporting of clinic services. The Medi-Cal Clinic Provider Number or the State Clinic License Number is required.

DE#17 Provider Type Code (2 pages)
Replaces Code #72 "Mental Health Inpatient"
To allow reporting of days prior to determination of payer, and clarifies the use of "Miscellaneous" coding: Medical Records Use "98" and Dental Records Use "99."

DE#21 Referring/Prescribing/Admitting Provider
Clarifies options for reporting prescribing physician include: provider number, license number, or Drug Enforcement Authority number. Deletes cross-reference to data element 22 Prior Authorization/Primary Care Physician Referral Indicator.

DE#22 Prior authorization or Primary Care Physician (PCP) Referral Indicator
Clarifies by deleting cross-reference to data element 21 "Referring/Prescribing/Admitting Provider."

DE#23	Primary Diagnosis (ICD-9-CM) (2 pages) Clarifies that the 4th and/or 5th digits are optional.
DE#24	Secondary Diagnosis (ICD-9-CM) Clarifies that the 4th and/or 5th digits are optional.
DE#25	Tertiary Diagnosis (ICD-9-CM) Clarifies that the 4th and/or 5th digits are optional.
DE#27	Adjudication Status Code Clarifies denied services are no longer to be reported for medical, capitated or paid services. Denials are required for Dental only.
DE#28	Adjudication Date Clarifies medical plans are not to report denied services.
DE#37	Tooth Surface Locations Corrects: Distal is reported as "D."
DE#38	Place of Service (POS) Updates coding.
DE#42	Rendering Provider Number Clarifies out-of-network provider(s) or any provider(s) not listed; must have the provider number, license or certification number. This field blank may be blank when none of these are available, only when reporting medical records. Cannot be blank for dental records.
DE#42	Long-Term Care Accommodation Codes (3 pages) Corrects transposition of numbers for transfer to transitional care.

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MANAGED CARE DATA DICTIONARY

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TELECOMMUNICATION

MEDI-CAL BULLETIN BOARD SYSTEM

All Managed Care Plans may submit encounter data using the Electronic Data Systems (EDS) Medi-Cal Bulletin Board System (BBS) telecommunications link.

Computer Hardware:	Personal Computer, Asynchronous 14,400 bps modem or higher, Communications software to run modem, and Active phone line to plug into modem.
BBS telephone number:	(916) 636-8511 (both testing and production).
File naming convention:	CMCDDATA.DAT
File format:	ASCII
Compression software:	NONE No PKZIP Files must be transmitted uncompressed.
Communication software settings:	8 data bits 1 stop bit No parity Full duplex communication Turn on compression, such as V.42bis Set to highest possible baud rate allowed by software Set flow control to RTS/CTS Industry standard protocols allowed for upload of file are Xmodem, Ymodem, Zmodem (Zmodem is recommended).
Size Limitation:	Maximum file size = 31,744,000 bytes or 40,000 records.

To obtain a copy of the step by step directions for submitting over the BBS call your EDS Analyst.

MEDI-CAL EXTRANET FOR STATE HEALTHCARE (MESH)

The MESH option target date for transmission of encounter data is unknown.

MANAGED CARE DATA DICTIONARY
EDIT PROCESS

Encounter data submissions go through volume, and format edits once received by the fiscal intermediary (Electronic Data Systems). The data is also edited for correct values in the fields. The data is sent to the Department for approval or rejection. Approval or rejection is based on the edits outlined below and correct values in the fields. If acceptable the data is integrated into the Departments' Managed Care Data Base. If the data is not approved by the Department based on edits, the plan is notified of the need for correction of errors and resubmission of the file.

CRITICAL ERRORS:

The data submission is rejected prior to any further edits if any one of the following exist:

1. The header record is not present,

2. An invalid Submitter ID Code is found,

3. The number of records does not match the record count reported in the header,

4. Any single record in the submission has one of the following errors:

    * The health plan identifying code (Data Element #2) in the header is invalid or does not match any of the assigned Health Plan codes.

    * Format Code (Data Element #3) is not Medical (M), Hospital (H), Pharmacy (P), Long Term Care (L), or Dental (D).

    * Number of lines (Data Element #56) is not between 01-22 on Hospital submission.

    * Adjudication Status Code (Data Element #27) is not marked as Paid (P), Capitated (C), or for a Dental service only Denied (D)

1% AND 5% ERRORS:

The error rate is not cumulative from field to field. The error rate is based on individual fields. The Department tolerance for error in the various fields is as follows:

Error Tolerance	Data Element	Comment
1%	# 17 Provider Type	Provider Type Code must be one listed in the Data Dictionary (DD).

MANAGED CARE DATA DICTIONARY
(EDIT PROCESS CONTINUED)

Error Tolerance	Data Element	Comment
1%	# 19 Beginning Date of Service	Beginning Date of Service must be equal to or less than ending data of service.
1%	# 20 Ending Date of Service	Ending Date of Service must be equal to or greater than beginning date of service.
1%	# 31 Reimbursement Amount	Reimbursement Amount must be numeric.
1%	# 33 Medicare Deductible Amount	Medicare Deductible Amount must be numeric.
1%	# 34 Medicare Co-Insurance	Medicare Coinsurance Amount must be numeric.
1%	# 47 Long Term Care Accommodation Codes	LTC Accommodation Code is not one of those listed in the DD.
1%	# 48 Days Stay	Days Stay must be numeric.
1%	# 57 Accommodation and Ancillary Codes	Accommodation and ancillary code must follow the UB-92 coding.
5%	# 07 Medi-Cal Beneficiary Number	DE # 7 & 8 are used together, one or the other must be matched with MEDS file.
5%	# 08 Social Security Number	
5%	# 10 Birth Date	Match must be found on MEDS file, unless a newborn.
5%	# 11 Sex	Match must be found on MEDS file, unless a newborn.
5%	# 30 Billed Amount	Billed amount must be numeric.
5%	# 39 Procedure Code	Procedure Code must be a CPT-4, HCPCS, or Dental Specialty Code(s).
5%	# 41 Outpatient/Medical Procedure Quantity	Outpatient/Medical Procedure Quantity must be numeric.
5%	# 43 Drugs/Medical Supplies	Must be a National Drug Code or Uniform Product Code

INFORMATION ERRORS:

The Department evaluates all previously described edits in addition to those listed below in determining the acceptability of the submission for inclusion in the Managed Care Data base.

Edit Type	Data Element	Comment
Numeric	#01 Claim Reference Number	First four digits in Julian date format.
Match	#04 Program Code	Can be blank or contain a "C", "S", or "P".
Match	#05 Adjustment Code	Can be blank, 1 or 2 as described in DD.
Numeric	#06 Adjustment Claim Reference Number	Can be blank, or contain numbers.
Format	#09 Name of Medi-Cal Recipient	Must follow instructions in DD.
Alpha - Numeric	#12 Ethnic/Race Code of Medi-Cal Recipient	FOR STATE USE
Format	#13 Provider Number	Must follow instructions in DD.
Format	#14 Provider Name	Use the reporting or billing provider name.
Format	#15 Zip Code of Provider (Service Location)	Must be in a valid zip code format. When DE 16 is "99" zip code bypasses edits.
Match	#16 Provider County	Must be one of those listed in the DD table.
Match	#18 Physician Specialty	Must be one of those listed in the DD table.
Format	#21 Referring/Prescribing/ Admitting Provider	Can be blank or contain a Medi-Cal provider, state license number, or DEA number.
Match	#22 Prior Authorization/PCP Referral Indicator	May be blank or use one of the indicator codes listed in the DD .
Match	#23 Primary Diagnosis	Conditional based on type of service. May be blank if not medical, hospital, or LTC. Must be an ICD-9-CM code.
Match	#24 Secondary Diagnosis	May be blank as described in DD.
Match	#25 Tertiary Diagnosis (ICD-9-CM)	May be blank as described in DD.

MANAGED CARE DATA DICTIONARY
(EDIT PROCESS CONTINUED)

Edit Type	Data Element	Comment
Match	#26 Family Planning Indicator	May be blank, or contain a 1 or 2 as specified in DD.
Format	#28 Adjudication Date	Must be numeric as described in DD.
Format	#29 Date of Payment by Plan (Check Date)	Must be numeric. Can be zeros as described in DD.
Format	#32 Patient Liability	Must be numeric. Can be zeroes, last two bytes are considered cents.
Format	#35 Other Health Coverage Amount	Must be numeric. May contain zeros as described in DD.
	# 36 Not used at this time	
Format	#37 Tooth Surface Location	Must be one of those listed in the DD.
Match	#38 Place Of Service	Must be one of those listed in the DD.
Format	#40 Procedure Modifier or Tooth	May be blank or be one listed in DD.
Format	#42 Rendering Provider Number	Must be a license number if a physician. Blank allowed only for medical records.
Match	#44 Drug/Medical Supply Indicator Code	Must follow instructions in the DD and match those listed in the DD.
Format	#45 Drug Quantity	Must follow guidelines specified in DD.
Format	#46 Days Supply	Must follow guidelines specified in DD.
Format	#49 Admission Date	Must be equal to or less than discharge date.
Format	#50 Discharge Date	Must be same as or greater than admission date.
Match	#51 Discharge/Patient Status	Must be one listed in the DD.
Match	#52 Admission Necessity Code	Must be one listed in the DD.
Match	#53 Primary Surgical Procedure	Must be a match to CPT-4 for outpatient services, as specified in the DD. May be ICD-9 Procedure Code only when place of service is hospital.

MANAGED CARE DATA DICTIONARY
(EDIT PROCESS CONTINUED)

Edit Type	Data Element	Comment
Match	#54 Secondary Surgical Procedure	May be blank or match to CPT-4 as specified in DD.
	#55 Not used at this time	

3. FORMAT CODE

PURPOSE:

Identifies the record format code on each record for one of five general types of encounters including medical outpatient, pharmaceutical, long term care, hospital inpatient acute care and dental services.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 19
REQUIRED ON:	All records

COMMENTS:

Record Layout Format Codes = M, P, L, H, D

M = Medical Outpatient Services
Includes but is not limited to the following types of services: physician and nursing visits, surgical procedures, anesthesia services, laboratory tests, X-rays, physical therapy procedures, durable medical equipment, prosthetic and orthotic devices, transportation (i.e., ambulance), outpatient hospital services, dialysis, home health agency and vision services. Medical services must be reported in data element 39 (procedure codes) with either HCPCS procedure codes (level 2 or 3) or CPT- 4 codes.

P = Pharmacy Services
Includes drug or medical supply items provided by a pharmacy. Use National Drug Codes (NDC).

L = Long Term Care Facility Services (Certified Long Term Care Facilities).

H = Hospital Inpatient Acute Care Services.
Applies to each inpatient acute care hospital admission. Use UB 92 hospital accommodation and hospital ancillary codes for data element 57, hospital accommodation/ancillary codes.

D = Dental Services (uses same record layout as medical outpatient records) DHS converts the three digit dental codes to dental HCPCS.

4. PROGRAM CODE

PURPOSE:

To identify specific DHS program services rendered and included in the capitation.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 20
REQUIRED ON:	NOT REQUIRED

COMMENTS:

This field can be left blank or filled with spaces.

Program Codes:

C = Child Health and Disability Prevention

S = California Children Services

P = Mental Health Managed Care

MANAGED CARE DATA DICTIONARY

5. ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN)

PURPOSE:

Indicates whether a previously submitted record is voided or corrected.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 21
REQUIRED:	Only when a previously submitted record is voided or corrected.

COMMENTS:

Leave blank and only enter an adjustment code if the submitted record voids or corrects a previously submitted record. The following two codes indicate the disposition of a previously reported record:

Adjustment Codes

1 = Void or other negative adjustment

2 = Corrected

Blank = Not an adjustment

VOID

It may be desired to completely void out a record of encounter information that was previously reported and submit corrections due to an error in procedure code, recipient identifying information, etc. If record was submitted to the State's system in error, use Adjustment Code "1" to void it out.

The contents of the record fields must be identical to the contents of the original except that:

1. the Adjustment CRN should reflect the CRN of the original; and
2. the Adjustment Code must be "1", which will indicate to the States' system that
    a) this is not a duplicate procedure code, recipient identifier, etc., or that this is not a duplicate payment for the same service; i.e., that the service was not submitted twice; and
    b) that previously submitted fields, dollars, unit and days stay fields must be interpreted by the system as negative numbers which will serve to cancel or void out the amounts reported on the original record.

OTHER NEGATIVE ADJUSTMENT

ADJUSTING FOR PREVIOUS OVERPAYMENT: The contents of the records must be identical to the contents of the original record except that

1. the paid amount on the adjustment should reflect the difference between what has previously been reported and the lower amount that should have been reported;
2. the units and days fields should be zero unless the payment difference resulted from a unit or day being subsequently denied, in which case the number of units or days being denied should be reported;
3. the Adjustment CRN should reflect the CRN of the original record(s); and
4. the Adjustment Code must be "1" so that the dollar, unit(s) and days stay field(s) will be interpreted by the system as negative numbers.

CORRECTED ADJUSTMENT

If a record was sent to the system with an incorrect procedure code or recipient identifying information, or if for any reason it is desired to void out a previously reported record and submit a correct record, use the voiding procedure above and then submit the corrected record as it should have appeared and use Adjustment Code "2".

ADJUSTING FOR PREVIOUS UNDERPAYMENT: The contents of the submitted records must be identical to the contents of the original except that

1. the paid amount on the adjustment should reflect the difference between what has previously been reported and the higher amount that should have been reported;
2. the units and days fields should be zero unless the payment difference resulted from a unit or day being subsequently approved after previous denial, in which case the additional units or days approved should be reported;
3. the Adjustment CRN should reflect the CRN of the original record; and the Adjustment Code must be "2" so that the dollar, unit and days stay field(s) will be interpreted by the system as a positive number(s)

6. ADJUSTMENT CLAIM REFERENCE NUMBER (CRN)

PURPOSE:

Identifies the CRN of a previously submitted record that is voided or corrected/adjusted.

FIELD DESCRIPTION:

CHARACTER TYPE:	Numeric
NUMBER OF BYTE(S):	13
FORMAT:	YDDDXXXXXXXXX
RECORD LOCATION:	Columns 22 through 34
REQUIRED:	Only when an adjustment code is entered in data element 5.

COMMENTS:

The adjustment CRN identifies the original record reference number, in data element 1, pertaining to an encounter record that requires being voided or adjusted. This field also provides an audit trail of voided or adjusted records. Data element 6 must contain a CRN if an adjustment code is entered in data element 5, Adjustment Code. Conversely, if there is no adjustment code in data element 5, there must not be an adjustment CRN in data element 6.

If a previously submitted record does not require to be voided or corrected, this field is to be left blank or filled with spaces.

Cross reference with Adjustment Code for Claim Reference Number in data element 5.

13. PROVIDER NUMBER (REPORTING/BILLING)

PURPOSE:

Identifies the Medi-Cal provider number or state license number of an individual, group, clinic, or facility that has billed a health plan for, or reported a capitated encounter service.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 78 through 89
REQUIRED ON:	All records

COMMENTS:

This is one of three data elements, including data elements 21 and 42, identifying providers' Medi-Cal or state license numbers. Data element 13 must always contain a provider number for each record in order to identify the provider billing the health plan or reporting the delivery of a capitated service. If the provider does not have an individual or group Medi-Cal provider number, the provider's State license number must be used. When the service is reported by a Clinic the Medi-Cal provider number is to be reported. If the clinic does not have a Medi-Cal provider number, the State clinic license number must be used. If the service is reported/billed by a health facility, the Department of Health Services assigned facility number must be entered. When making entries in this field, enter the entire provider or license number, plan provider identifier number, tax identifier number, or national provider identification number, including all leading and trailing characters.

Providers reporting or billing for the provision of dental encounter services are identified in this field with 8 characters 1 alpha, 7 numerics with trailing blanks using the following format:

ANNNNNNN
Alpha = B or G
N = 5 digit numeric license number followed by
N = 2 digit location extender

This field is left justified with trailing blanks.

Cross reference this field with data element 14, provider name.

DENTAL

Providers reporting a billing for the provision of dental encounter services are identified in this field with 8 characters 1 alpha, 7 numerics with trailing blanks using the following format:

ANNNNNNN
Alpha = B or G
N = 5 digit numeric license number followed by
N = 2 digit location extender

This field is left justified with trailing blanks.
Cross reference this field with data element 14, provider name.

Revised April 1999

17. PROVIDER TYPE CODE

PURPOSE:

Identifies the type of provider that rendered the reported service or procedure.

FIELD DESCRIPTION:

CHARACTER TYPE :	Alpha/Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD LOCATION:	Columns 125 through 126
REQUIRED ON:	All records

COMMENTS:

The provider type indicated in this field can be, but is not necessarily, the same as the billing or reporting provider indicated in data elements 13 and 14, provider number and provider name. The provider type refers to the provider who rendered the service. The provider type must be consistent with the type of license held by the provider and the type of service reported on the encounter record.

If provider type codes 22 (physician group), 26 (physician) or DN (dentist) are entered in this field, then a physician or dental specialty code must be entered in data element 18.

See the following page for a list of current provider type codes, updated April 1999.

PROVIDER TYPE CODES

CODE	DESCRIPTION
DN	Dentist
01	Adult Day Care Center
02	Assistive Device & Sick Room Supplies
03	Audiologist
04	Blood Bank
05	Certified Nurse Midwife
06	Chiropractor
07	Certified Pediatric Nurse Practitioner (NP) & Certified Family NP
08	Christian Science Practitioners
09	Clinical Laboratories
10	Group Certified Pediatric NP & Certified Family NP
11	Fabricating Optical Laboratory
12	Dispensing Opticians
13	Hearing Aide Dispensers
14	Home Health Agencies (HHA)
15	Community Hospital Outpatient Departments
16	Community Hospital Inpatient
17	Certified Long Term Care Facility (LTC)
18	Nurse Anesthetists
19	Occupational Therapists
20	Optometrists
21	Orthotists
22	Physicians Group
23	Optometric Group
24	Pharmacies/Pharmacist
25	Physical Therapists
26	Physicians
27	Podiatrists
28	Portable X-ray Laboratory
29	Prosthetists
30	Ground Medical Transportation
31	Psychologists
32	Certified Acupuncturist
33	Genetic Disease Testing
34	Medicare Crossover Provider Only (before 11/98 34 was Rural Health Clinics)
35	Rural Health Clinics & Federally Qualified Health Centers (FQHCs)
36	Home & Community Based-Certified HHA
37	Speech Therapists
38	Air Ambulance Transportation Service
39	Certified Hospice Service per AB 4249
40	Free Clinics
41	Community Clinics
42	Chronic Dialysis Clinics
43	Multispecialty Clinics
44	Surgical Clinics
45	Exempt from Licensure Clinics
46	Rehabilitation Clinics
48	County Clinics not Associated with Hospital
49	Birthing Centers-Primary Care Clinics
50	Clinic-otherwise undesignated
51	Outpatient Heroin Detoxification Center
52	Alternative Birth Centers-Specialty Clinics
53	Breast Cancer Early Detection Program
54	Expanded Access to Primary Care
55	Local Education Agency
56	Respiratory Care Practitioner
57	EPSDT Supplement Services Provider
58	Health Access Program
59	Congregate Living Health Facilities with Type A licensure
60	County Hospital Inpatient
61	County Hospital Outpatient
62	Group Respiratory Care Practitioner
65	Pediatric Subacute Care/LTC
72	Mental Health Inpatient
73	AIDS Waiver Provider
80	California Children's Service (CCS)/Genetically Handicapped Person Program (GHPP) Non-Institutional
81	CCS/GHPP-Institutional
90	Out of State
98	Miscellaneous Dental
99	Miscellaneous Medical

21. REFERRING/PRESCRIBING/ADMITTING PROVIDER

PURPOSE:

Identifies an individual provider's number who has either referred, prescribed medication or admitted a patient into a hospital.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 145 through 156
REQUIRED ON:	Medical outpatient records resulting from referrals, All pharmacy records, All hospital inpatient records, and All long term care records.

COMMENTS:

If the referring or prescribing or admitting provider does not have a Medi-Cal provider number, enter the provider's State license number. Do not enter a group provider or facility license number in this field.

Referring Physician: If the record format is 'M' (medical outpatient) and the reported service resulted from a referral from the patient's Primary Care Physician (PCP), enter the PCP's provider or license number. The referring physician must never be the same as the billing/reporting or rendering provider as indicated in data elements 13 or 42. If no referral was linked with this reported service, leave this field blank or fill it with spaces.

Prescribing Physician: For all pharmacy records, enter the provider number, license number, or Drug Enforcement Authority number of the physician who prescribed the medication or authorized the medical supply.

Admitting Physician: For all hospital and long term care records, enter either the Medi-Cal provider number or the State license number of the physician who admitted the patient into the hospital.

Left justify this field with trailing blanks.

22. PRIOR AUTHORIZATION OR PRIMARY CARE PHYSICIAN (PCP) REFERRAL INDICATOR

PURPOSE:

Identifies whether the service rendered required a referral or prior authorization from the PCP or health plan.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 157
REQUIRED ON:	Medical, Dental, Hospital and Long Term Care records resulting from referrals or prior authorizations

COMMENTS:

If the service reported on this record was the result of a referral or required prior authorization from the PCP or health plan, enter the appropriate indicator code listed below. If no referral or prior authorization preceded this reported service, leave this field blank or fill with spaces.

INDICATOR CODES:

R - Referral from a PCP was required prior to this service being rendered.

P - Prior Authorization was required from the PCP or health plan prior to this service being rendered.

B - Both a PCP referral and prior authorization was required prior to this service being rendered.

Entries in this field must be in CAPS.

23. PRIMARY DIAGNOSIS (ICD-9-CM)

PURPOSE:

Identifies the diagnosis code for the principle condition of the patient.

FIELD DESCRIPTION:

TYPE:	Alpha/Numeric
BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 158 through 162
REQUIRED ON:	Hospital and Long Term Care records and Medical Outpatient records depending on type of provider (see below).

COMMENTS:

Enter all letters and/or numbers of the International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM). The ICD -9 code can be 3 to 5 characters. The three digit code is the most general description of the patient's condition. The 4th and 5th digits provide a more detailed description. Enter the 4th and/or 5th digits if applicable. Do not enter a decimal point when entering the code.

For all hospital and long term care records, enter the patient's diagnosis upon admission to the facility.

For Outpatient Medical records, the primary diagnosis must be entered if the service was rendered by any one of the following types of providers:

05	Certified Nurse Midwife
06	Chiropractors
07	Certified Pediatric Nurse Practitioner, Certified Family Nurse Practitioner
10	Group Certified Pediatric Nurse Practitioner and Certified Family Nurse Practitioner
22	Physicians Group
26	Physicians
27	Podiatrists
31	Psychologists
32	Certified Acupuncturist
34	Medicare Crossover Provider Only (before 11/98 34 was Rural Health Care)
35	Rural Health Clinics and Federally Qualified Health Care Centers
40	Free Clinics

41	Community Clinics
43	Multispecialty Clinics
44	Surgical Clinics
46	Rehabilitation Clinics
49	Birthing Center-Primary Care Clinics

For all other provider types, ICD-9 entries in this field are optional.

Left justify this field with trailing blanks.

Cross reference this field with data element 17, provider type.

24. SECONARY DIAGNOSIS (ICD-9-CM)

PURPOSE:

Identifies the diagnosis code for the secondary condition, if any, of the patient.

FIELD DESCRIPTION:

TYPE:	Alpha/Numeric
BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 163 through 167
REQUIRED ON:	Hospital and Long Term Care records and Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:

Enter all letters and/or numbers of the ICD-9-CM code for the secondary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a secondary diagnosis, this field can be blank or filled with spaces.

See DE # 23

25. TERTIARY DIAGNOSIS (ICD-9-CM)

PURPOSE:

Identifies the diagnosis code for the tertiary condition of the patient.

FIELD DESCRIPTION:

TYPE:	Alpha/Numeric
BYTE(S):	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 168 through 172
REQUIRED ON:	Hospital and Long Term Care records Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:

Enter all letters and/or numbers of the ICD-9-CM code for the tertiary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a tertiary diagnosis, this field can be blank or filled with spaces.

See DE #23.

27. ADJUDICATION STATUS CODE

PURPOSE:

To identify whether the service rendered was provided on a capitated or non-capitated basis. If non-capitated, this field also indicates whether the health plan paid, or denied payment for a service, procedure or supply.

FIELD DESCRIPTION:

TYPE:	Alpha
BYTE(S):	1
FORMAT:	X
RECORD LOCATION:	Column 175
REQUIRED ON:	All records

COMMENTS:

If the service was provided by a provider having a capitated or negotiated rate arrangement with the health plan, then enter code C in this field.

If the service was provided by a provider not having a capitated or negotiated rate arrangement with the health plan, and the health plan paid the provider for the specific service rendered, enter code P.

Enter the codes in CAPS.

ADJUDICATION STATUS CODES FOR ALL CLAIM TYPES IDENTIFIED AS DATA ELEMENT #3 FORMAT CODE:

C - Capitated.....Service provided on a capitated or negotiated rate arrangement basis.
P - Paid.....Plan paid provider for specific service, procedure or supply.

ADJUDICATION STATUS CODES FOR DENTAL SERVICES - DENTAL ONLY

If payment was denied and was a Dental service, enter code D.

D - Denied.....Payment was denied for Dental only.

28. ADJUDICATION DATE

PURPOSE:

Identifies the date this record was adjudicated.

FIELD DESCRIPTION:

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 176 through 183
REQUIRED ON:	All records

COMMENTS:

Entries in this field must be numeric and greater than zero.

The first two bytes are the century, followed by two bytes for the year, two bytes for the month and two bytes for the day of the month. For example, October 31, 2000 would be entered as 20001031.

If the record resulted from a capitated service (i.e., adjudication status, code "C") enter the date the record was processed by the health plan.

If the record resulted from a service provided as non-capitated, fee for service arrangement, (i.e., adjudication status, code "P") enter the date when the health plan determined to pay, for the reported service or supply.

Cross reference with data element 27, adjudication status.

37. TOOTH SURFACE LOCATIONS

PURPOSE:

Used to report tooth surface locations.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 256 through 260
REQUIRED ON:	Dental Outpatient records

COMMENTS:

Up to 5 (1) byte surface locations can be reported per encounter record. Required for Dental format "D" (DE #3), for others leave blank. Cross reference this field with data element 39, procedure code. Refer to the list of procedure modifier codes and surface descriptions in the appendix.

The Acceptable codes are:

B =	Buccal
D =	Distal
F =	Facial
L =	Lingual
M=	Mesial
I =	Incisal
O =	Occlusal
G =	Gingival

MANAGED CARE DATA DICTIONARY

38. PLACE OF SERVICE (POS)

PURPOSE:

Identifies where the service was rendered.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTE(S):	2
FORMAT:	XX
RECORD POSITION:	Column 301 through 302 for medical and dental records Column 321 through 322 for pharmacy records
REQUIRED ON:	Medical Outpatient, Dental and Pharmacy records

COMMENTS:

For pharmacy records, if the POS is a long term care facility, enter code 31, 32, 54, 92, or 93. For all other pharmacy records enter code 99, other unlisted facility. For outpatient medical, vision, and dental records, enter one of the following appropriate HCFA Place of Service Codes:

11	Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgery Clinic
25	Inpatient Hospital Birthing Center
26	Military Treatment Center
31	Skilled Nursing Facility Level B
32	Nursing Facility level A (Intermediate Care Facility)
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Developmentally Disabled, Habilitative
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	Independent Kidney Treatment Clinic
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
91	Nursing Facility Level B (Adult Subacute)
92	Intermediate Care Facilities - Developmentally Disabled, Nursing (ICF/DD-N)
93	Intermediate Care Facilities – Developmentally Disabled, Habilitative (ICF/DD-H)
94	Non-Home
95	Mobile Van
96	Nursing Facility Level B (Pediatric Subacute)
97	Transitional Inpatient Care (effective 1/1/96)
99	Other

All other numbers are unassigned.

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42. RENDERING PROVIDER NUMBER

PURPOSE:

Identifies the individual provider who directly rendered the service reported on the record.

FIELD DESCRIPTION:

CHARACTER TYPE :	Alpha/Numeric
NUMBER OF BYTE(S):	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 315 through 326
REQUIRED ON:	Medical and dental records when the service was provided by one of the following types of providers: physician or physician assistant, dentist or dental hygienist, certified pediatric or family nurse practitioner, certified nurse midwife, or certified physician's assistant.

COMMENTS:

Entries in this field are for specific types of individually identified providers only. Do not enter a group provider number or facility license number in this field. If any one of the above listed types of providers rendered the service, enter the individual provider's Medi-Cal provider number (preferred) or State license or certification number. When entering the appropriate provider, license or certification number, enter the individual's full number including alpha characters, using leading and trailing zeroes.

For dental records, the provider's identifier is formatted as having a leading alpha character followed by 5 numeric characters and six trailing blanks.

Left justify this field. Medical records are to use trailing blanks. Trailing blanks are not allowed on dental records.

If the reported service or procedure was provided by any type of provider not listed above, or the service or procedure was provided by an out-of-network provider, the options for medical records are to enter the individual's provider, license, or certification number or leave this field blank or fill with spaces.

47. LONG TERM CARE (LTC) ACCOMMODATION CODES

PURPOSE:

Identifies type of accommodation for stays in long term care facilities.

FIELD DESCRIPTION:

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT :	XX
RECORD LOCATION:	LTC records: Columns 301 through 302
REQUIRED ON:	Long Term Care records

COMMENTS:

If the patient has been admitted to a nursing or intermediate care facility, enter the appropriate LTC accommodation code in this field.

See following page for Long Term Care Accommodation codes as updated April 1999.

MANAGED CARE DATA DICTIONARY
(DE # 47 CONTINUED)

LONG TERM CARE ACCOMMODATION CODES

TYPE OF ACCOMMODATION	REGULAR INPATIENT SERVICES	PATIENT LEAVE DAYS		BED HOLD
		DD	NON-DD	
Nursing Facilities (NF):				
Regular	21	23	22	39 for transfer to transitional care (TC)
Rehabilitation Program - Mentally Disordered	31	N/A	32	N/A
Level B Formerly Skilled Nursing Facility (SNF):				
NF Regular	01	03	02	09 for transfer to TC
NF Rural Swing Bed Program	04	N/A	05	N/A
NF Special Treatment Program - Mentally Disordered	11	N/A	12	N/A
Transitional Inpatient Care (TC):				
Hospital-based – Medical	06	N/A	08	N/A
Hospital-based – Rehabilitative	07	N/A	08	N/A
Freestanding NF – Medical	24	N/A	26	N/A
Freestanding NF – Rehabilitative	25	N/A	26	N/A
Level B - Adult Subacute:				
Hospital-based - Ventilator Dependent	71	N/A	79	73
Hospital-based - Non-Ventilator Dependent	72	N/A	80	74
Freestanding NF - Ventilator Dependent	75	N/A	81	77
Freestanding NF - Non-Ventilator Dependent	76	N/A	82	78
Level B - Pediatric Subacute:				
Hospital-based Distince Part (DP) Ventilator Dependent	85	N/A	89	87
Hospital-based DP Non-Ventilator Dependent	86	NA	90	88
Freestanding NF Ventilator Dependent	91	N/A	95	93
Freestanding NF Non-Ventilator Dependent	92	N/A	96	94

TYPE OF ACCOMMODATION	REGULAR INPATIENT SERVICES	PATIENT LEAVE DAYS		BED HOLD
		DD	NON-DD	
Intermediate Care Facilities (ICF)				
ICF-Developmentally Disabled (DD) Program	41	43	N/A	N/A
ICF-DD 60 or more beds with 1-59 Distinct Part Beds	45	48	N/A	N/A
ICF-DD 100 or more beds with 60-99 Distinct Part Beds	51	53	N/A	N/A
ICF-DD-Habilitative 4-6 beds	61	63	N/A	N/A
ICF-DD-Habilitative 7-15 beds	65	68	N/A	N/A
ICF-DD-Nursing 4-6 beds	62	64	N/A	N/A
ICF-DD-Nursing 7-15 beds	66	69	N/A	N/A

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