CALIFORNIA DEPARTMENT OF
Mental Health

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April 19, 2007

DMH LETTER NO.:07-05

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: INFORMATION ON CHANGES TO SHORT-DOYLE MEDI-CAL (SD/MC) SYSTEM:
- TOTAL BILLED AMOUNT CALCULATION
- DISCONTINUATION OF PROPRIETARY CLAIM FORMAT
- VOID, REPLACE AND CORRECTION TRANSACTIONS
- UNIQUE IDENTIFIER REQUIREMENTS FOR CLAIMS

REFERENCE: DMH INFORMATION NOTICE NO: 03-10
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF1996 (HIPAA)

The purpose of this letter is to inform counties of important changes to the Short-Doyle/Medi-Cal (SD/MC) system that impacts claim payments. Please forward copies of this letter to your county HIPAA Coordinator and to your SD/MC Program, SD/MC Fiscal, and Information Technology staff. DMH Office of HIPAA Compliance staff are available to assist counties and their business partners in understanding the technical guides and resolving technical issues regarding HIPAA compliant 837 claim submission and testing procedures.

Net Billed Amount Calculation
There is an important change to the calculation of the “Net Billed Amount” for the Department of Mental Health (DMH) SD/MC proprietary system for claims submitted in the HIPAA compliant format. The HIPAA translator configuration was originally developed by DMH to mirror the current proprietary SD/MC processing system. In the proprietary system, the counties balanced the claim by subtracting the payments (Share Of Cost, Other Health Coverage, etc.) from the “usual and customary charge” and placed the net amount on the SD/MC field called the “Net Billed Amount.” In a HIPAA compliant claim, the “Line Item Charge Amount” must be the “usual and customary charge” (or gross amount) and the

payer (DMH) must calculate the net billed amount. DMH has modified the HIPAA translator to subtract the "CAS" segment payments from the "Line Item Charge Amount" and to calculate the "Net Billed Amount" data element in the generation of the SD/MC proprietary file.

DMH is requiring that all counties use the HIPAA compliant method of reporting the gross amount and allowing the translator to calculate the "Net Billed Amount." [Napa and Tehama counties are currently submitting HIPAA 837 claims in this format.] All counties not currently submitting HIPAA 837 compliant claims related to the "Line Item Charge Amount" will need to make this change by June 30, 2007. The DMH Companion Guide, Chapter 12, provides additional specific details on how to create an 837 file that meets the HIPAA compliance regulation. The most current DMH Companion Guide is available on the DMH web site at the following hyperlink: http://www.dmh.ca.gov/hipaa/tcs.asp.

Discontinuation of "Proprietary Claim" Format

Effective July 1, 2007, DMH is adopting standard electronic transactions as the only allowable format for SD/MC claims processing for State and Federal funds reimbursement. Specifically, the HIPAA 837 P/I claim transactions will be the standard format accepted for SD/MC claims. DMH will not accept "proprietary claims" for the reimbursement of SD/MC services. All counties unable to meet this effective date must submit a compliance schedule to DMH Office of HIPAA Compliance, via email to HIPAA-TCS@dmh.ca.gov by June 1, 2007. DMH will review the compliance schedule and contact the county mental health director to discuss his or her county's compliance plans.

The Department of Health Services (DHS) is in the process of rewriting the SD/MC claiming system as Phase II of their HIPAA compliance plan. This standardization of submitting claims is critical to the timely processing and payment of SD/MC claims in the DHS Phase II SD/MC System. The early standardization of HIPAA compliant claims will ensure the availability of 18 months of claims history when the DHS Phase II SD/MC system is implemented in late 2008. The new DHS Phase II SD/MC System will not be designed to accept or interact with non-HIPAA compliant formats. In addition, the standardization of submitting HIPAA-complaint claims is necessary to successfully implement the National Provider Identifier rule.

All claims must follow the DMH HIPAA claim testing and certification procedure. For detailed information, refer to the DMH Information Notice 03-10, dated October 16, 2003, regarding HIPAA testing and certification procedures for the SD/MC system. A copy of this information notice is available on the DMH web site at: http://www.dmh.ca.gov/DMHDocs. DMH will post an updated Companion Guide in April 2007 on the DMH web site at: http://www.dmh.ca.gov/hipaa/tcs.asp.

Void, Replace and Correction Claim Transactions
The Void and Replace project, scheduled for implementation in mid 2007, will be introducing new functionality to the SD/MC claiming system. Using existing HIPAA 837/835 transactions, counties will now have the ability to perform the following:

1. Void erroneous approved claims (disallow or adjust Medi-Cal units) using an electronic claim transaction (HIPAA 837 P/I). This transaction eliminates the need for using the manual Disallow Claims System (DCS) process.
2. Replace voided claims by using an electronic claim transaction (HIPAA 837 P/I) while utilizing the original claim's received date up to 18 months from the month of service.
3. Correct previously denied claims by using an electronic claim transaction (HIPAA 837 P/I) while utilizing the original claim's received date up to 18 months from the month of service. This transaction eliminates the need for using the manual Error Correction Report (ECR) process.
4. Establish a permanent Global Unique Identifier (GUID) for every claim to eliminate the potential for duplicate claims in the SD/MC system.

To implement this project, the first step impacting counties is enforcing the use of the GUID for all claims as described below. This new edit will be effective on June 8, 2007 and will not affect claims already submitted to DMH.

GUID Requirements for Claims
All claims must be submitted with a GUID. The translator will reject a file if any claim within it fails the GUID edit. Counties will be able to determine the source of this error through the ITWS SD/MC Processing Status web page. (Note: Less than 0.5% of all claims submitted in fiscal year 2006 would fail the Unique Identifier requirement.) The updated DMH Companion Guide, Chapter 13, will provide additional specific details on how to create an 837 file that meets the GUID requirement. DMH will post an updated Companion Guide in April 2007 on the DMH web site at http://www.dmh.ca.gov/hipaa/tcs.asp.

DMH will provide more detailed information about the forthcoming void and replace functionality in the near future, including instructions related to certification for these new transaction types. (Note: Counties must first be HIPAA certified before beginning certification for void, replacement, and correction transactions.)

For questions about this DMH letter, please contact Vonnie Ryser, Chief of the DMH Office of HIPAA Compliance, at (916) 654-0497 or Vonnie.Ryser@dmh.ca.gov.

Sincerely,

Original signed by:

STEPHEN W. MAYBERG, Ph.D.
Director