



Medicare Disproportionate Share Hospitals

Eligibility Re-Verification Process

User Manual - Draft

Medi-Cal Eligibility
Division

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Purpose of the Document

The purpose of this User Manual is to provide information regarding the Medicare Disproportionate Share Hospital (DSH) eligibility re-verification process to all participating parties. This manual includes an overview of the process, detailed instructions for each step of the process, and includes appendices that provide templates and additional insight. This manual will focus on the submitter/auditor portion of the process.

This manual is not intended for use for the Medicaid DSH program.

Updates to this manual:

- Updated Appendix E: Aid Code Information

Program Overview

Background

Since 2003, the Department of Health Care Services (DHCS) has provided DSH eligibility re-verification processing for hospitals and their vendors. This manual provides an overview of the current DSH process.

DSH Re-Verification Processing

Re-verification of disproportionate share patients' eligibility status is necessary for hospitals to address Centers for Medicare & Medicaid Services (CMS) audits and lawsuits. Per Health Care Financing Administration (HCFA) Ruling No. 97-2, the hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid for some covered services each day of an inpatient hospital stay. In some cases, the re-verification requires access to eligibility data no longer available on the Automated Eligibility Verification System (AEVS); the Medi-Cal Internet eligibility verification applications, both real-time or batch processing; and the Point of Service (POS) network. As a result, hospitals require DHCS' assistance to re-verify patient eligibility against historical data.

With the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, changes were made to the allocation formulas utilized in determining DSH funding. Hospitals and vendors use the DHCS DSH re-verification system to obtain the data required for DSH calculations.

Eligibility Information Availability

DHCS retains eligibility information from 1987 to the present; however, older eligibility information is less reliable than more recent information. All requests dated older than 10 years from the current year must be submitted by calendar year. In addition, requests dated older than 10 years can only be searched by using the patient's Social Security Number (SSN) instead of using the beneficiary's County Identification Number (CIN) or the combination of First Name/Last Name/Date of Birth that can be used for more recent searches.

Eligibility Determinations

Please note the following: At the time that services were provided, the hospital would have submitted an inquiry to the Eligibility Verification System (EVS). Possession of a positive eligibility verification is a strong indication that the beneficiary was Medicaid eligible during the period of service but may be subject to restrictions or limitations. In

addition, DHCS pays claims if the patient is eligible and the claim meets the necessary criteria, restrictions, and limitations. The payment of a claim is a strong indication that the patient was Medicaid eligible at the time of service and met all necessary criteria, restrictions, and limitations based on information available at the time of payment.

About the DSH Database

The DSH matching program uses the Disproportionate Share Database (DSHDB) to locate the eligibility information for the requested recipient.

Initial Creation and Load

The DSHDB is created from the Monthly Medi-Cal Eligibility File (MMEF). The DSHDB load data is extracted in six-month intervals, allowing a minimum of six months to a maximum of 12 months of retroactive eligibility reporting to occur. For example, the DSHDB records for the time period 1/2010 through 6/2010 will be created from the January 2011 MMEF file.

The DSHDB will contain client demographic data (such as name and date of birth) and a table containing monthly eligibility data (such as eligible aid codes, Medicare status, and unmet share of cost indicators) for each month in the eligibility year. The DSHDB file contains the following fields:

- MEDS ID
- Client Index Number
- Year of Eligibility
- Starting Month of Eligibility
- Last Name
- First Name
- Middle Initial
- Birth Date
- Gender
- HIC Number
- Eligibility History Table, containing:
 - Eligibility Aid Code – Primary
 - Eligibility Aid Code – 1st Special
 - Eligibility Aid Code – 2nd Special
 - Eligibility Aid Code – 3rd Special
 - Medicare Status Code
 - Medical Health Care Plan Indicator
 - Unmet Share of Cost Indicator

Database Update Process

After the initial load process is completed, the DSHDB will be updated monthly after the Medi-Cal Eligibility Data System (MEDS) renewal process is concluded, rolling the MEDS system into the new month of eligibility. This occurs around the 25th of each month. Using the pre-renewal MEDS database backups as input, a DSHDB record will be created containing the twelfth prior month of eligibility. These monthly DSHDB updates will be applied to the DSHDB, either adding a new record for the eligibility year or adding a new month of data to an existing DSHDB record.

Process Overview

Introduction

The DSH eligibility re-verification process relies on a coordinated effort of several parties to ensure timely completion of all steps in the process.

DSH Access

An account is created for each DSH submitter. Submitters include hospitals, vendors, and auditors. This account allows the submitter to access the DSH system through the Transaction Services tab on the provider page of the Medi-Cal Internet site. Each submitter will be provided with a unique login and password to access the Internet site, and all submitters are instructed to ensure the safekeeping of the login and password information. **Any breach in the security of the Medi-Cal Internet site will result in the submitter's loss of access to the DSH system.**

The Medi-Cal Internet site is available to submitters 24 hours per day, seven days per week. However, file processing occurs during normal business hours, Monday through Friday, excluding State holidays.

High-Level Overview of the Eligibility Re-Verification Process

At the highest level, the eligibility re-verification process includes the following steps:

1. The submitter prepares a file of all requests for eligibility re-verification.
2. The submitter uploads the file to the Medi-Cal Internet site.
3. California Medicaid Management Information Systems (CA-MMIS) receives the file from the Medi-Cal Internet site.
4. CA-MMIS transfers the file to the DHCS mainframe for processing.
5. DHCS processes the request file.
6. DHCS transfers all files associated with the DSH processing, including the response and attestation files, to CA-MMIS.
7. CA-MMIS distributes the files to the appropriate submitter account locations on the Medi-Cal Internet site.
8. Submitters and auditors download their files from the Medi-Cal Internet site.

The next section provides a detailed description of each step of the process.

Process – Detailed Description

Set up a DSH Account with DHCS

Prior to use of the system, the hospital, vendor, or auditor must contact DHCS to initiate the opening of an account. All hospitals involved in this process must have the six-digit provider identification number (provider ID) assigned by CMS.

The steps for a **hospital** to follow to open a DSH account are:

- Hospitals will contact DHCS to initiate the process.
- Hospitals will provide DHCS with a signed, original Hospital Authorization Letter using the template provided in Appendix A of this manual.
- Hospitals will provide the hospital's six-digit CMS provider ID to DHCS.
- Hospitals will provide DHCS with a signed, original Web Site Agreement using the template provided at Appendix B of this manual. It is the responsibility of the hospital to update this agreement when contact information changes.
- Once the letter and agreement are received, DHCS will open the account for the submitter and obtain a submitter ID, which DHCS will provide to the hospital via secure email.
- Once the submitter ID has been obtained, DHCS will acquire a password for the Medi-Cal Internet site for the submitter from CA-MMIS, which DHCS will provide to the hospital via secure email.

The steps for a **vendor** to follow to set up a DSH account are:

- Vendors will contact DHCS to initiate the process.
- Vendors will provide DHCS with a signed, original Hospital Authorization Letter using the template provided at Appendix A of this manual for each hospital for which they will be submitting files.
 - Specific beginning dates and ending dates are required for the letters to be accepted by DHCS. The authorization is only valid for the period of time specified in the letters.
 - The six-digit CMS provider IDs are required for each hospital.

- Vendors will provide DHCS with a signed, original Web Site Agreement using the template provided at Appendix B of this manual. It is the responsibility of the vendor to update this agreement when contact information changes.
- Once the letters and agreement are received, DHCS will open an account for the submitter and obtain a submitter ID, which DHCS will provide to the vendor via secure email.
- Once the submitter ID has been obtained, DHCS will acquire a password for the Medi-Cal Internet site for the submitter from CA-MMIS, which DHCS will provide to the vendor via secure email.

The steps for an **auditor** to follow to set up a DSH account are:

- Auditors will contact DHCS to initiate the process.
- Auditors will provide DHCS with a signed, original Web Site Agreement using the template provided at Appendix B of this manual. It is the responsibility of the auditor to update this agreement when contact information changes.
- Once the agreement is received, DHCS will open an account for the auditor and obtain a submitter ID, which DHCS will provide to the auditor via secure email.
- Once the submitter ID has been obtained, DHCS will acquire a password for the Medi-Cal Internet site for the auditor from CA-MMIS, which DHCS will provide to the auditor via secure email.

Prepare the Request File

The hospital or vendor is responsible for preparing the request file that initiates the eligibility re-verification process.

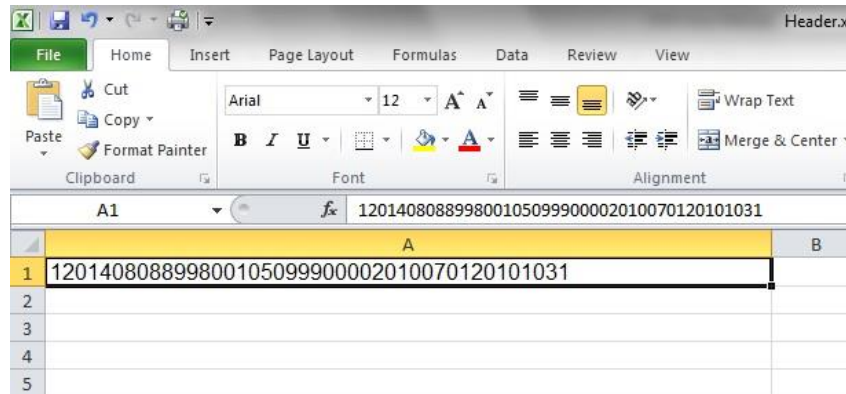
The request file contains fixed length records of 120 bytes each, formatted and filled in by the submitter. Each file will contain one header record and one or more request records. During processing, DHCS will update the header record and request records. Once processing is completed, DHCS will create a trailer record containing file counts. The submitter will receive a response file containing one header, one or more response records, and one trailer record.

The steps to follow to prepare a request file are:

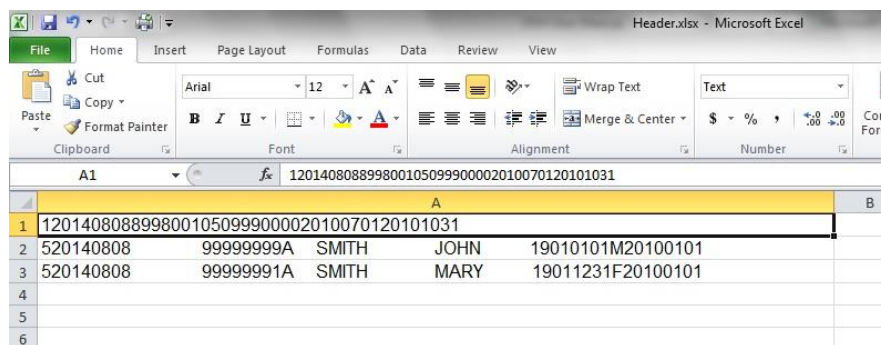
1. The submitter determines whether the DSH processing is appropriate based on the date of inpatient service. If the date of service is within the previous 13 months, **STOP**. You must use the AEVS/Internet/POS process to obtain

eligibility information. DSH processing is only appropriate when the dates of inpatient service are older than 13 months.

- Using a spreadsheet, enter the header information into cell A1 on the first line of your spreadsheet. There should be 120 characters in your cell, either filled with alpha characters, numerical characters, or blank spaces. The header should look like this:

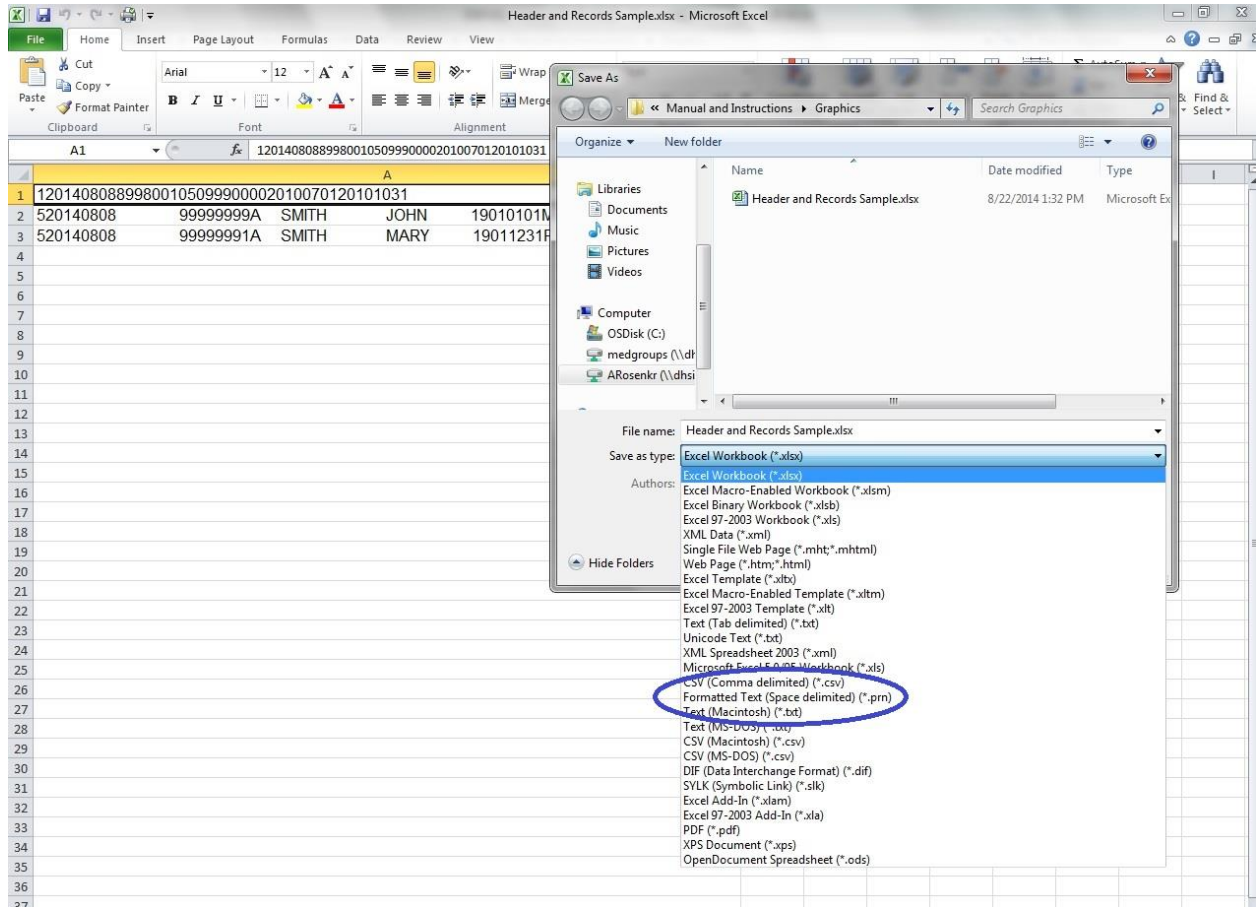


- Beginning on the second line of the spreadsheet in cell A2, enter the information of the recipient into a single cell, just below the header. There should be 120 characters in your cell, either filled with alpha characters, numerical characters, or blank spaces. **All alphabetical characters must be upper case.** The following example depicts a header entry line followed by two records:



- Add any additional recipients on the following lines of your spreadsheet in the same manner.

- Save the file as Formatted Text (space delimited) in Notepad, which will result in a file extension of .prn.



- Your resulting Notepad file should look like this:



Below are the instructions for completing each of the required fields for the header. A header is required for each submission. Files submitted without headers will not be processed by DHCS.

The Header Record Format is outlined in the table below: The total record length is 120 characters.

Field Number	Field Name	Length
1	Record type	1
2	File Creation / Processed Date	8
3	Submitter ID	4
4	Batch Number	3
5	Federal Provider ID	6
6	Auditor Submitter ID	4
7	Inquiry Range – Beginning Date	8
8	Inquiry Range – Ending Date	8
9	Hospital Use Only	15
10	Filler (or messages)	63

This is the breakdown for each of the 10 header record fields:

1. Record Type (length = 1 character)

This field contains the number 1, which signifies that this is a header.

This is an indicator regarding the type of record (such as header, request/response, or trailer). This field is required and is filled in by the submitter.

2. File Creation / Processed Date (length = 8 characters)

This field is populated with the 8-digit date formatted as YYYYMMDD.

This date indicates the date the request file was created. After DHCS processes the file, this date will change to the date the file was processed by DHCS. This field is required and is filled in by the submitter.

3. Submitter ID (length = 4 characters)

This is the 4-digit submitter ID associated with your organization as assigned by DHCS.

This field is required and is filled in by the submitter. Be sure to include the leading zeroes in the field.

4. Batch Number (length = 3 characters)

This is a sequential number populated by the submitter to uniquely identify the file.

This field consists of 3 digits, and the submitter should begin with the batch number of 001 and increase it incrementally by one for each file submitted to DHCS. Once the submitter reaches 999, the submitter should begin back at 001. This field is required and is filled in by the submitter. Be sure to include leading zeroes in the field.

5. Federal Provider ID (length = 6 characters)

This is the CMS 6-digit provider ID associated with the hospital providing the service.

This field is required and is filled in by the submitter. California hospital provider numbers are formatted as 050###. Omit the hyphens in the CMS provider ID. This field will be used by CMS auditors to validate the file against the attestation report generated by the DSH process. Incorrect reporting of the provider ID may cause the CMS auditors to reject the file.

Uploaded files containing provider IDs of hospitals for which there is no Hospital Authorization Letter on file with DHCS will be rejected and not processed. Repeated attempts to upload files for hospitals without proper authorization will result in a submitter's loss of access to the DSH system.

6. Auditor Submitter ID (length = 4 characters)

This is the submitter ID associated with your CMS auditor. If you do not need to have a copy created for your CMS auditor, fill this field with zeroes.

This field is required and is filled in by the submitter. The auditor submitter ID is used to ensure the attestation report file and auditor copy of the response file are routed to the proper location on the Medi-Cal Internet site. Contact your auditor to obtain this number as an incorrect auditor submitter number will cause misrouting of information and may result in the submitter having to reprocess files.

Use of the Auditor Submitter ID is the only method of transmitting a copy of your submission to the auditor. DHCS does not have the capability of transmitting this information for you.

7. Inquiry Range – Beginning Date (length = 8 characters)

This field is populated with the 8-digit date formatted as YYYYMMDD.

This is the date associated with the earliest date of service being requested in the full request file. This field is required and is filled in by the submitter.

8. Inquiry Range – Ending Date (length = 8 characters)

This field is populated with the 8-digit date formatted as YYYYMMDD.

This is the date associated with the latest date of service being requested in the full request file. This field is required and is filled in by the submitter.

9. Hospital Use Only (length = 15 characters)

This is a free field for submitter use.

DHCS will not edit or use this field during processing. This field is optional and is filled in by the submitter. Auditors may specify that additional information be placed in this field.

10. Filler or message (length = 63 characters)

This field filler is used to communicate error messages to the submitter.

Do not populate this field. This field is populated by DHCS during DSH processing. If an auditor ID is invalid, this field will contain an error message of “Invalid Federal Auditor ID.” If the submitter ID is invalid, this field will contain an error message of “Invalid Submitter.”

Once the header has been completed, the submitter will enter the data for one to multiple recipients. The final four fields, consisting of 16 characters, are left blank using the space bar. These four fields are completed by DHCS and consist of your eligibility response. A description of the four response fields are found on page 28 of this User Manual.

The Request/Response Record Format is outlined in the two tables below. The first table outlines the fields in the request portion of the record that is filled in by the submitter. The second table outlines the fields in the response portion of the record that is filled in by DHCS. The total record length of the request portion is 104 characters, and the total record length of the response portion is 16 characters, for a total of 120 characters.

Request Portion (filled in by submitter)

Field Number	Field Name	Length
1	Record type	1
2	Record Creation Date	8
3	Request Record Number	7
4	SSN	9
5	Medi-Cal ID or Benefits Information Card (BIC) ID Number	14
6	Last Name	20
7	First Name	15
8	Birth Date	8
9	Gender	1
10	Date of Service	6
11	Hospital Use Only	15

Response Portion (filled in by DHCS)

Field Number	Field Name	Length
12	Medi-Cal Eligibility Indicator	1
13	Medicare Part A Eligibility Indicator	1
14	HIC Number	12
15	Title XIX Restricted Aid Code	2

This is the breakdown for each of the 11 request record fields devoted to the request portion of the record, Fields 1 through 11. The response portion of the record, Fields 12 through 15 will be discussed on page 28.

1. Record Type (length = 1 character)

This field contains the number 5, which signifies that this is a request.

This is an indicator regarding the type of record (such as header, request/response, or trailer). This field is required and is filled in by the submitter.

2. Record Creation Date (length = 8 characters)

This field is populated with the 8-digit date formatted as YYYYMMDD.

This is the creation date of the request record. This field is required and is filled in by the submitter.

3. Request Record Number (length = 7 characters)

This is a sequential number to uniquely identify the record.

This field is populated by DHCS during DSH processing. Use the space bar to fill this 7-digit field.

4. SSN (length = 9 characters)

This is the field for the nine-digit SSN.

At least one search criteria are required (SSN or Medi-Cal ID or BIC ID or the combination of Last Name, First Name and Date of Birth). This field is optional for inquiries newer than 10 years and is filled in by the submitter.

For inquiries over 10 years old, this field is required. The older inquiries match against an eligibility file in which SSNs are the only search criteria.

If this field is not used, leave it blank by using the space bar. If there are leading zeroes in the SSN, make sure they are included.

5. Medi-Cal ID or BIC ID (length = 14 characters)

This is the field for the ID associated with the recipient.

The ID can be one of the following:

- A Client Index Number (CIN) assigned by DHCS consisting of 9 characters where the first character is a 9 and the last character is a letter other than "P"
- Pseudo MEDS ID assigned by DHCS consisting of 9 characters where the first character is an 8 or 9 and the last character is a "P"
- County ID assigned by the county consisting of 14 characters
- BIC ID assigned by the county consisting of 14 characters

At least one search criteria are required (SSN or Medi-Cal ID or BIC or the combination of Last Name, First Name, and Date of Birth). This field is optional and is filled in by the submitter. Do not use the SSN in this field.

Left justify the number with trailing spaces for a total of 14 spaces in this field. If the field is not used, leave it blank using the space bar. If there are leading zeroes in the ID, make sure they are included.

6. Last Name (length = 20 characters)

This is the field for the last name of the recipient.

At least one search criteria are required (SSN or Medi-Cal ID or BIC or the combination of Last Name, First Name, and Date of Birth). For the name and date of birth search, all three fields must be present (last name, first name, and date of birth).

This field is optional and is filled in by the submitter. Left justify the last name with trailing spaces for 20 spaces in this field. If the field is not used, leave it blank using the space bar.

7. First Name (length = 15 characters)

This is the field for the first name of the recipient.

At least one search criteria are required (SSN or Medi-Cal ID or BIC or the combination of Last Name, First Name, and Date of Birth). For the name and date of birth search, all three fields must be present (last name, first name, and date of birth).

This field is optional and is filled in by the submitter. Left justify the first name with trailing spaces for 15 spaces in this field. If the field is not used, leave it blank using the space bar.

Many times the name match fails because submitters include the middle initial in the first name field. The first name should only include the first name of the recipient. Keep in mind some first names are more than one name (such as Mary Ann). In these cases the first name field should contain the full first name.

8. Date of Birth (length = 8 characters)

This field is for the 8-digit date of birth of the recipient formatted as YYYYMMDD.

At least one search criteria are required (SSN or Medi-Cal ID or BIC or the combination of Last Name, First Name, and Date of Birth). For the name and date of birth search, all three fields must be present (last name, first name, and date of birth).

This field is optional and is filled in by the submitter. If the field is not used, leave it blank using the space bar.

9. Gender (length = 1 character)

This field is for the gender associated with this recipient.

This field is optional and is filled in by the submitter. The specific format for this field is as follows:

M = Male
F = Female
U = Unborn
Blank = Unknown

If the gender is unknown, leave the field blank by using the space bar.

10. Date of Service (length = 6 characters)

This field is for the 6-digit month and year the services were provided formatted as YYYYMM.

This field will be used to determine eligibility. This field is required and is filled in by the submitter. If the date of service spans multiple months, an inquiry record for each month must be created.

If the date of service is within the current 13 months, use the AEVS/Internet/POS System to determine eligibility.

11. Hospital Use Only (length = 15 characters)

This is a free field for submitter use.

DHCS will not edit or use this field during processing. This field is optional and is filled in by the submitter. Auditors may specify that additional data be placed in this field.

Once the submitter prepares the file, the file size should be considered. The file size must be appropriate for the time of day the upload will occur. File size can be up to 2MB for regular business hours of 8:00 am to 6:00 pm Monday through Friday. The file size can be as large as 6MB outside regular business hours.

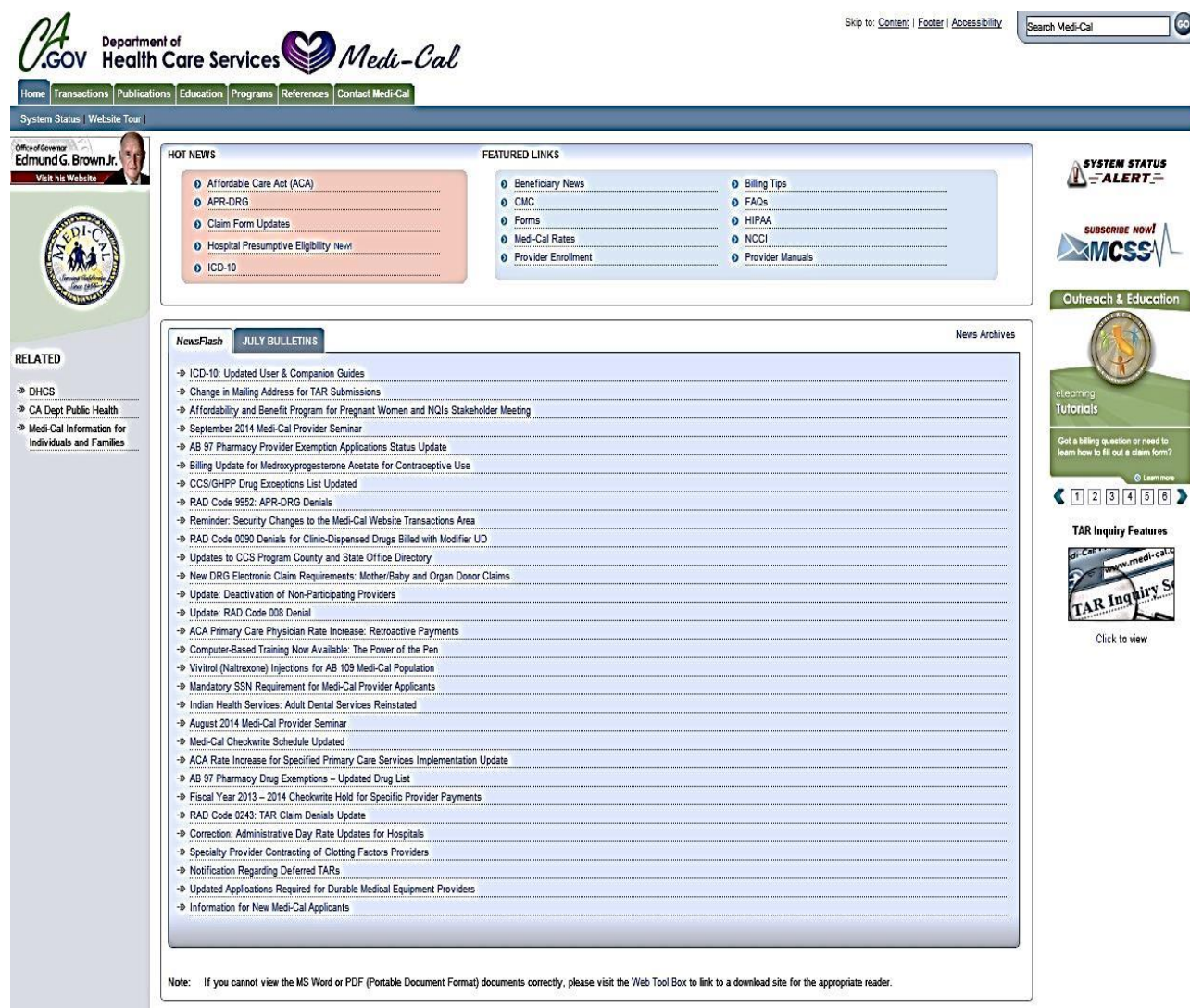
Each request file can be individually compressed using PKZIP or WINZIP. Do not bundle several files together. **Do not password protect or encrypt your files.**

Submit the Request File to DHCS

The submitter is responsible for uploading the file(s) to DHCS for processing. All files must be uploaded using the Medi-Cal Internet site.

This is a seven step process:

1. The submitter accesses the Medi-Cal Internet site. The Medi-Cal Internet website address is: <http://www.medi-cal.ca.gov>. The following opening screen will appear upon entry into the Medi-Cal Internet site:

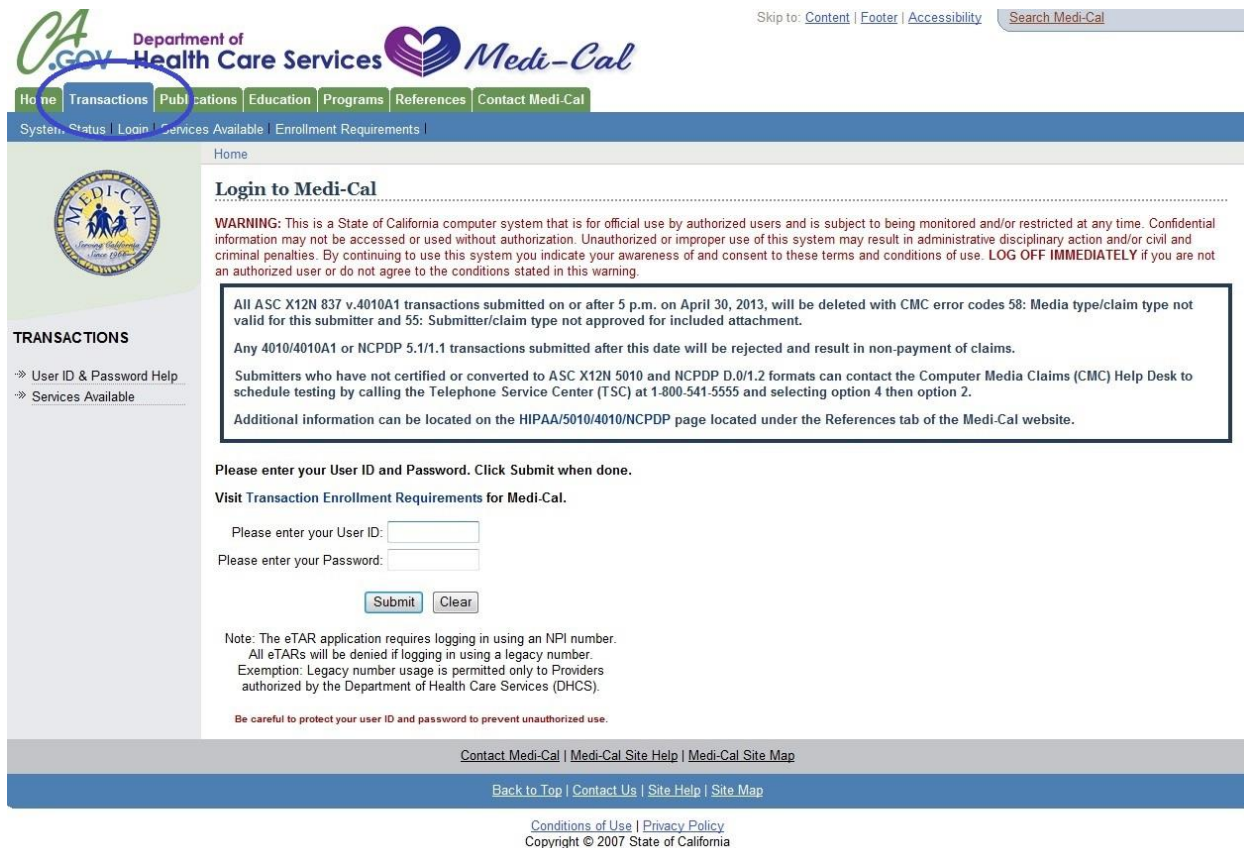


The screenshot shows the Medi-Cal website homepage. At the top, there is a navigation bar with links: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a search bar and a "GO" button. The main content area is divided into several sections:

- Office of Governor Edmund G. Brown Jr.:** A section on the left with a photo of the governor and a link to "Visit his Website".
- Medi-Cal Logo:** A circular logo with the text "Medi-Cal" and "California Department of Health Care Services".
- RELATED:** A list of links: DHCS, CA Dept Public Health, and Medi-Cal Information for Individuals and Families.
- HOT NEWS:** A list of news items: Affordable Care Act (ACA), APR-DRG, Claim Form Updates, Hospital Presumptive Eligibility New!, and ICD-10.
- FEATURED LINKS:** A list of links: Beneficiary News, CMC, Forms, Medi-Cal Rates, Provider Enrollment, Billing Tips, FAQs, HIPAA, NCCI, and Provider Manuals.
- NewsFlash:** A section with a "JULY BULLETINS" tab. It contains a long list of news items, including updates on ICD-10, ACA, and various Medi-Cal programs.
- News Archives:** A section on the right with a "Click to view" link.
- SYSTEM STATUS ALERT:** A red alert box on the right.
- Subscribe Now! MCSS:** A section on the right with a "Learn more" link.
- Outreach & Education:** A section on the right with a "Click to view" link.
- TAR Inquiry Features:** A section on the right with a "Click to view" link.

Note: If you cannot view the MS Word or PDF (Portable Document Format) documents correctly, please visit the Web Tool Box to link to a download site for the appropriate reader.

2. The submitter selects the “Transactions” tab to access Transaction Services.

A screenshot of the Medi-Cal website's Transactions page. The page has a blue header with the "CA.GOV" logo, "Department of Health Care Services", and "Medi-Cal" text. Below the header is a navigation bar with tabs: Home, Transactions (selected), Publications, Education, Programs, References, and Contact Medi-Cal. A secondary navigation bar includes links for System, Status, Login, Services Available, and Enrollment Requirements. The main content area is titled "Login to Medi-Cal" and contains a warning about transaction deletions, a note about rejected transactions, and instructions for submitting claims. It includes a login form with fields for User ID and Password, and "Submit" and "Clear" buttons. A sidebar on the left lists "TRANSACTIONS" with links for "User ID & Password Help" and "Services Available". The footer contains links for "Contact Medi-Cal", "Medi-Cal Site Help", and "Medi-Cal Site Map", along with "Conditions of Use" and "Privacy Policy" links, and a copyright notice for 2007 State of California.

CA.GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status Login Services Available Enrollment Requirements

Home

Login to Medi-Cal

WARNING: This is a State of California computer system that is for official use by authorized users and is subject to being monitored and/or restricted at any time. Confidential information may not be accessed or used without authorization. Unauthorized or improper use of this system may result in administrative disciplinary action and/or civil and criminal penalties. By continuing to use this system you indicate your awareness of and consent to these terms and conditions of use. **LOG OFF IMMEDIATELY** if you are not an authorized user or do not agree to the conditions stated in this warning.

All ASC X12N 837 v.4010A1 transactions submitted on or after 5 p.m. on April 30, 2013, will be deleted with CMC error codes 58: Media type/claim type not valid for this submitter and 55: Submitter/claim type not approved for included attachment.

Any 4010/4010A1 or NCPDP 5.1/1.1 transactions submitted after this date will be rejected and result in non-payment of claims.

Submitters who have not certified or converted to ASC X12N 5010 and NCPDP D.0/1.2 formats can contact the Computer Media Claims (CMC) Help Desk to schedule testing by calling the Telephone Service Center (TSC) at 1-800-541-5555 and selecting option 4 then option 2.

Additional information can be located on the HIPAA/5010/4010/NCPDP page located under the References tab of the Medi-Cal website.

Please enter your User ID and Password. Click Submit when done.

Visit Transaction Enrollment Requirements for Medi-Cal.

Please enter your User ID:

Please enter your Password:

Note: The eTAR application requires logging in using an NPI number.
All eTARs will be denied if logging in using a legacy number.
Exemption: Legacy number usage is permitted only to Providers authorized by the Department of Health Care Services (DHCS).

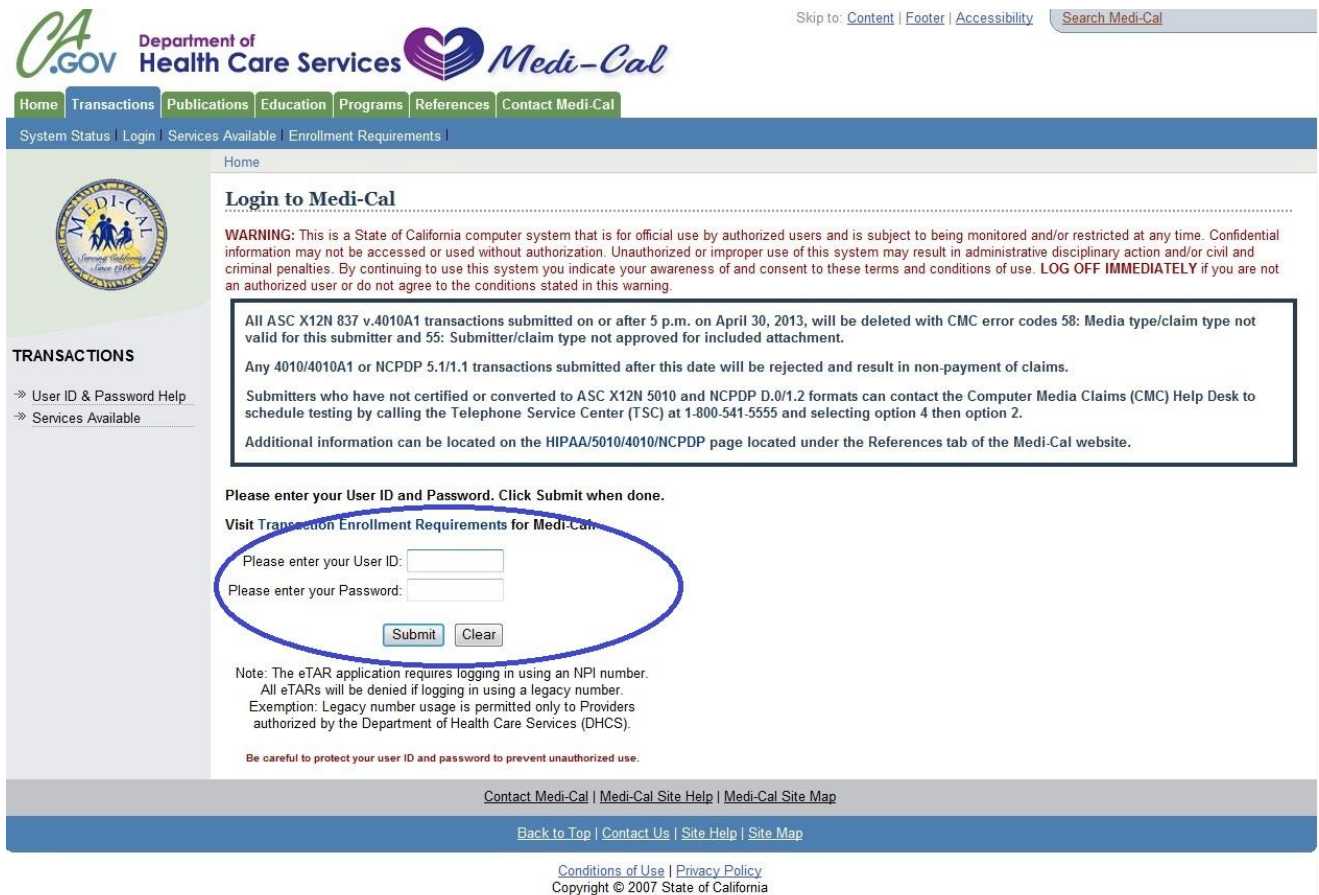
Be careful to protect your user ID and password to prevent unauthorized use.

[Contact Medi-Cal](#) | [Medi-Cal Site Help](#) | [Medi-Cal Site Map](#)

[Back to Top](#) | [Contact Us](#) | [Site Help](#) | [Site Map](#)

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- The submitter enters the user ID and password provided by DHCS to access Transaction Services and clicks on the “submit” button. The user ID consists of seven digits, beginning with “DSH” and followed by the submitter ID and “01.”



The screenshot shows the Medi-Cal login page. At the top, there is a navigation bar with links: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a blue bar with links: System Status, Login, Services Available, and Enrollment Requirements. The main content area has a header with the Medi-Cal logo and the text "Login to Medi-Cal". Below this is a warning box with text about transaction deletion and submission rules. A blue oval highlights the login fields: "Please enter your User ID:" and "Please enter your Password:", each followed by a text input box. Below these fields are "Submit" and "Clear" buttons. At the bottom, there is a note about eTAR application requirements and a footer with links: Contact Medi-Cal, Medi-Cal Site Help, and Medi-Cal Site Map. The footer also includes "Back to Top", "Contact Us", "Site Help", and "Site Map".

CA .GOV Department of Health Care Services Medi-Cal

Home Transactions Publications Education Programs References Contact Medi-Cal

System Status | Login | Services Available | Enrollment Requirements |

Home

Login to Medi-Cal

WARNING: This is a State of California computer system that is for official use by authorized users and is subject to being monitored and/or restricted at any time. Confidential information may not be accessed or used without authorization. Unauthorized or improper use of this system may result in administrative disciplinary action and/or civil and criminal penalties. By continuing to use this system you indicate your awareness of and consent to these terms and conditions of use. **LOG OFF IMMEDIATELY** if you are not an authorized user or do not agree to the conditions stated in this warning.

All ASC X12N 837 v.4010A1 transactions submitted on or after 5 p.m. on April 30, 2013, will be deleted with CMC error codes 58: Media type/claim type not valid for this submitter and 55: Submitter/claim type not approved for included attachment.

Any 4010/4010A1 or NCPDP 5.1/1.1 transactions submitted after this date will be rejected and result in non-payment of claims.

Submitters who have not certified or converted to ASC X12N 5010 and NCPDP D.0/1.2 formats can contact the Computer Media Claims (CMC) Help Desk to schedule testing by calling the Telephone Service Center (TSC) at 1-800-541-5555 and selecting option 4 then option 2.

Additional information can be located on the HIPAA/5010/4010/NCPDP page located under the References tab of the Medi-Cal website.

Please enter your User ID and Password. Click Submit when done.

Visit Transaction Enrollment Requirements for Medi-Cal.

Please enter your User ID:

Please enter your Password:

Note: The eTAR application requires logging in using an NPI number.
All eTARs will be denied if logging in using a legacy number.
Exemption: Legacy number usage is permitted only to Providers authorized by the Department of Health Care Services (DHCS).

Be careful to protect your user ID and password to prevent unauthorized use.

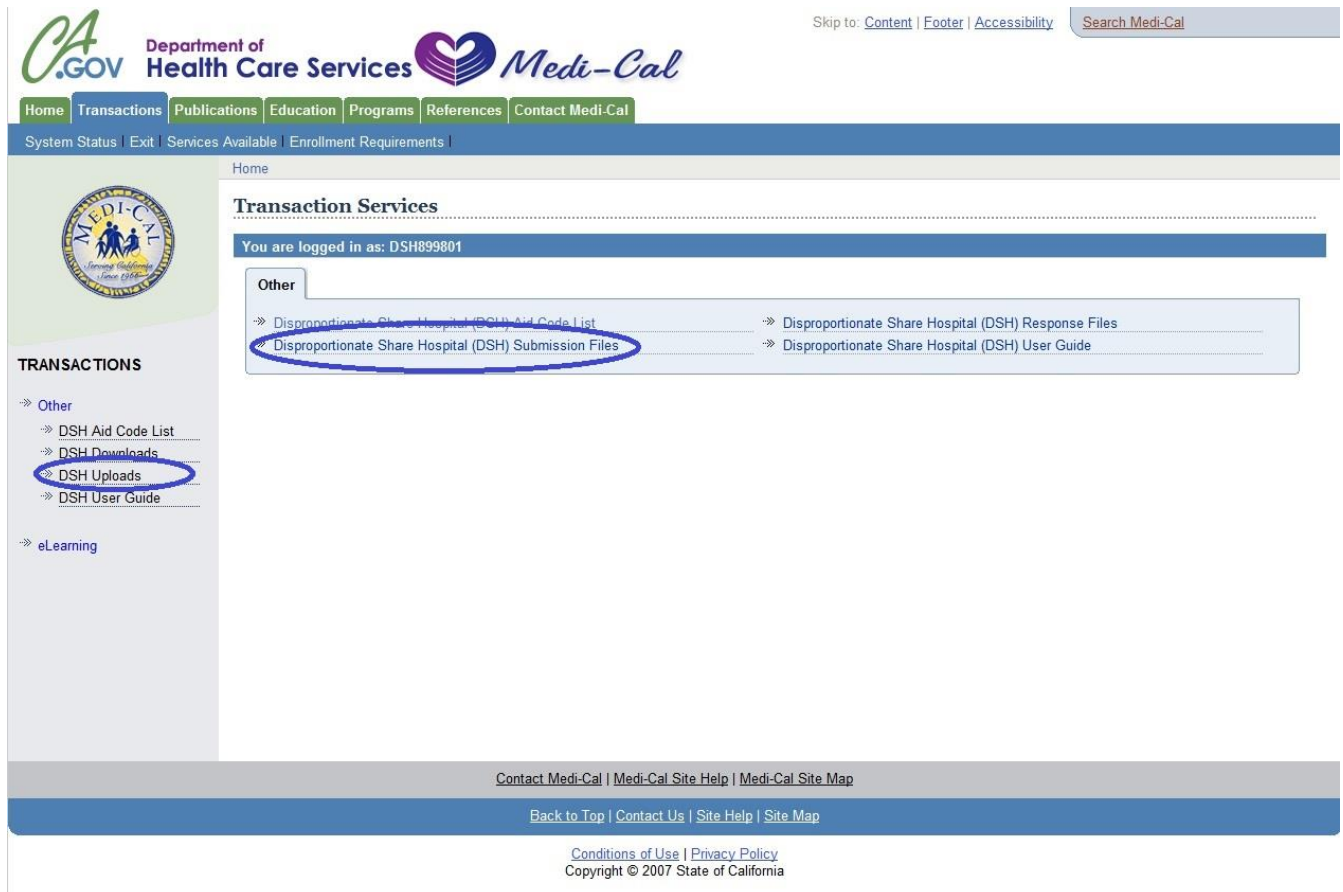
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4. After logging into Transaction Services, the main menu appears as links in the middle of the page. Click on the “Disproportionate Share Hospital (DSH) Submission Files” option to begin the submission process.

The submitter can also select the “Other” tab on the left of the page to display a variety of DSH activities. One of the options under the “Other” tab is the “DSH Uploads” link. The submitter can also click on this link to begin the submission process.



CA .GOV Department of Health Care Services Medi-Cal

Skip to: [Content](#) | [Footer](#) | [Accessibility](#) [Search Medi-Cal](#)

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Home

Transaction Services

You are logged in as: DSH899801

Other

- [Disproportionate Share Hospital \(DSH\) Aid Code List](#)
- [Disproportionate Share Hospital \(DSH\) Response Files](#)
- [Disproportionate Share Hospital \(DSH\) Submission Files](#)
- [Disproportionate Share Hospital \(DSH\) User Guide](#)

TRANSACTIONS

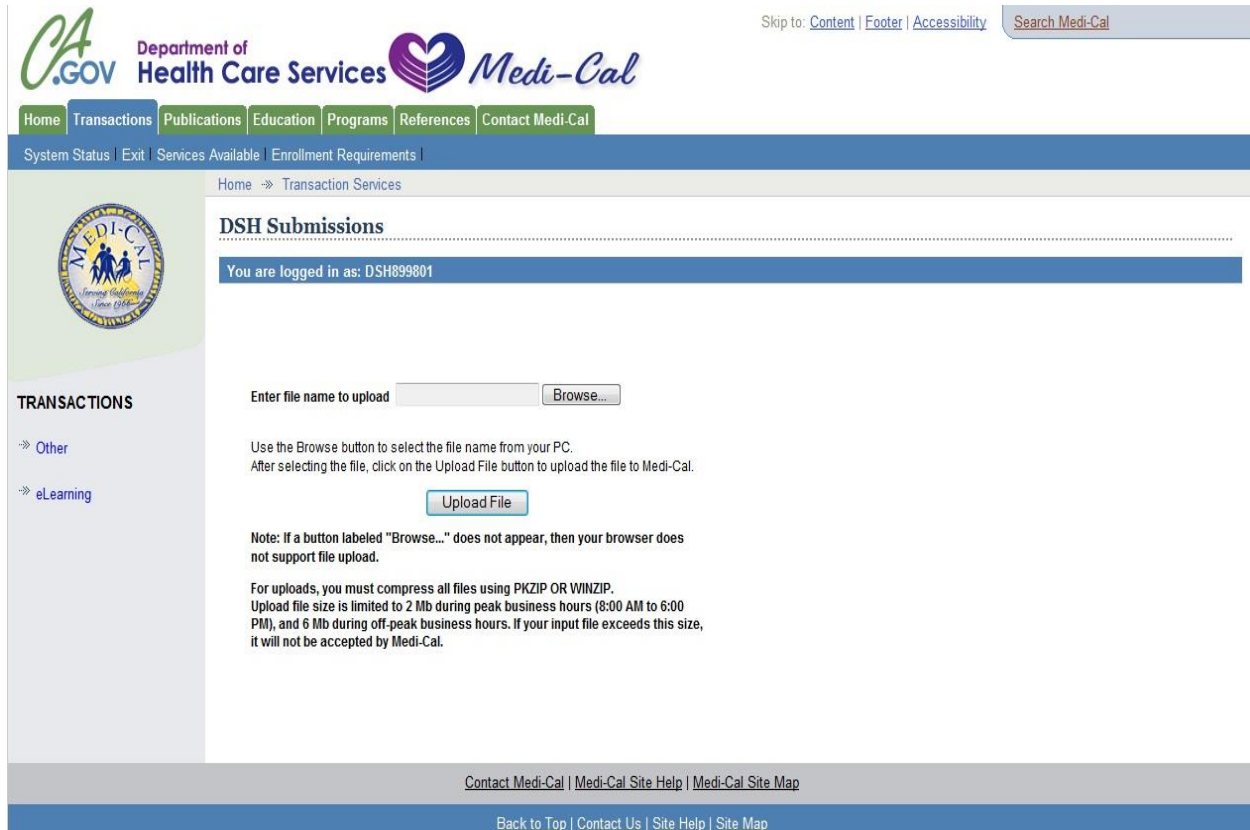
- [Other](#)
 - [DSH Aid Code List](#)
 - [DSH Downloads](#)
 - [DSH Uploads](#)
 - [DSH User Guide](#)
- [eLearning](#)

[Contact Medi-Cal](#) | [Medi-Cal Site Help](#) | [Medi-Cal Site Map](#)

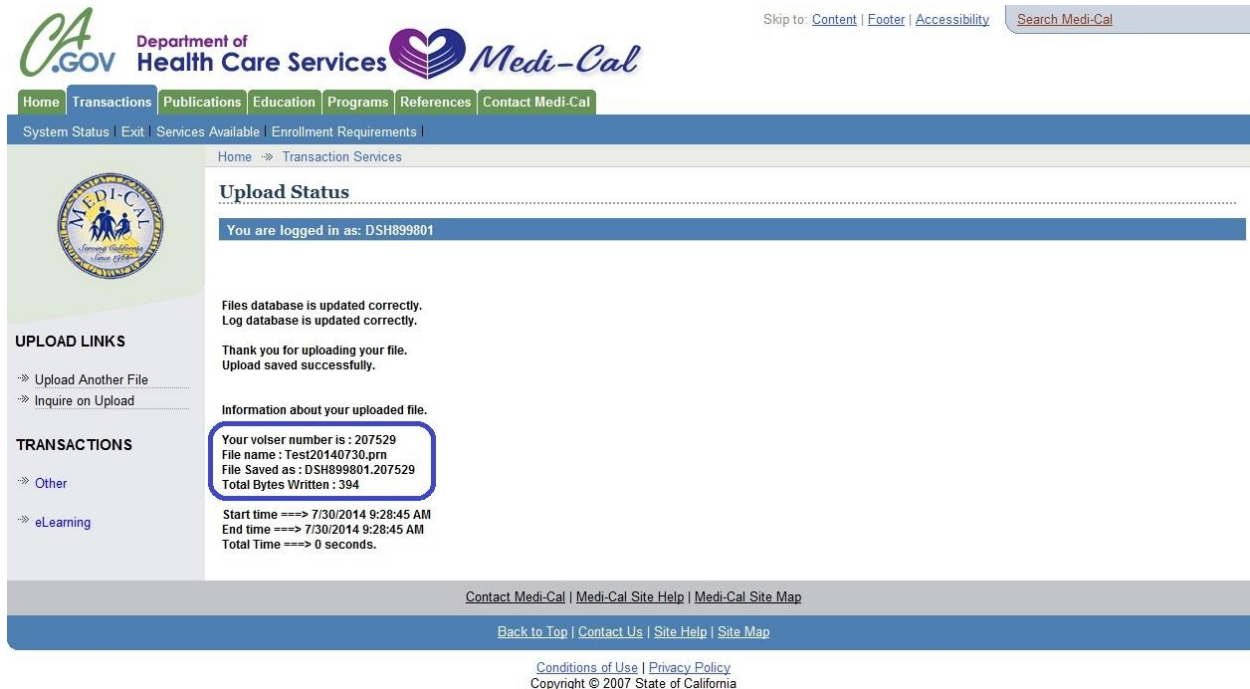
[Back to Top](#) | [Contact Us](#) | [Site Help](#) | [Site Map](#)

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5. Type in the location and name of the file to be uploaded or click on the “Browse” button.
6. Once the file name is provided, click the “Upload File” button. For faster uploads, compress your files using PKZIP or WINZIP. The file size must be appropriate for the time of day the upload will occur (see page 18).

A screenshot of the Medi-Cal website's "DSH Submissions" page. The page header includes the "CA.GOV" logo, "Department of Health Care Services", and the "Medi-Cal" logo. A navigation bar contains links for Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a secondary navigation bar with links for System Status, Exit, Services Available, and Enrollment Requirements. The main content area is titled "DSH Submissions" and shows the user is logged in as "DSH899801". There is a form with a text input field for "Enter file name to upload" and a "Browse..." button. Below the input field, instructions state: "Use the Browse button to select the file name from your PC. After selecting the file, click on the Upload File button to upload the file to Medi-Cal." An "Upload File" button is present. A note indicates that if the "Browse..." button does not appear, the browser does not support file upload. Another note specifies file size limits: "For uploads, you must compress all files using PKZIP OR WINZIP. Upload file size is limited to 2 Mb during peak business hours (8:00 AM to 6:00 PM), and 6 Mb during off-peak business hours. If your input file exceeds this size, it will not be accepted by Medi-Cal." The footer contains links for "Contact Medi-Cal", "Medi-Cal Site Help", and "Medi-Cal Site Map". A secondary footer bar contains links for "Back to Top", "Contact Us", "Site Help", and "Site Map".

- Upon completion of the upload, an Upload Status screen will appear. The “File Saved as” name is the file name assigned by the upload process and will be used from this point forward on the Medi-Cal Internet site to identify your file. Note the “volser” number. If you should have issues with an uploaded file, DHCS will ask for the “volser” in order to track your file through the process and research any upload issues.



The screenshot shows the Medi-Cal website interface. At the top, there is a navigation bar with links: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a secondary navigation bar with links: System Status, Exit, Services Available, and Enrollment Requirements. The main content area is titled "Upload Status" and displays the following information:

- You are logged in as: DSH899801
- Files database is updated correctly.
- Log database is updated correctly.
- Thank you for uploading your file.
- Upload saved successfully.
- Information about your uploaded file.
 - Your volser number is : 207529
 - File name : Test20140730.prm
 - File Saved as : DSH899801.207529
 - Total Bytes Written : 394
- Start time ==> 7/30/2014 9:28:45 AM
- End time ==> 7/30/2014 9:28:45 AM
- Total Time ==> 0 seconds.

At the bottom of the page, there are links for "Contact Medi-Cal", "Medi-Cal Site Help", and "Medi-Cal Site Map".

Now that the upload process is completed, the submitter may:

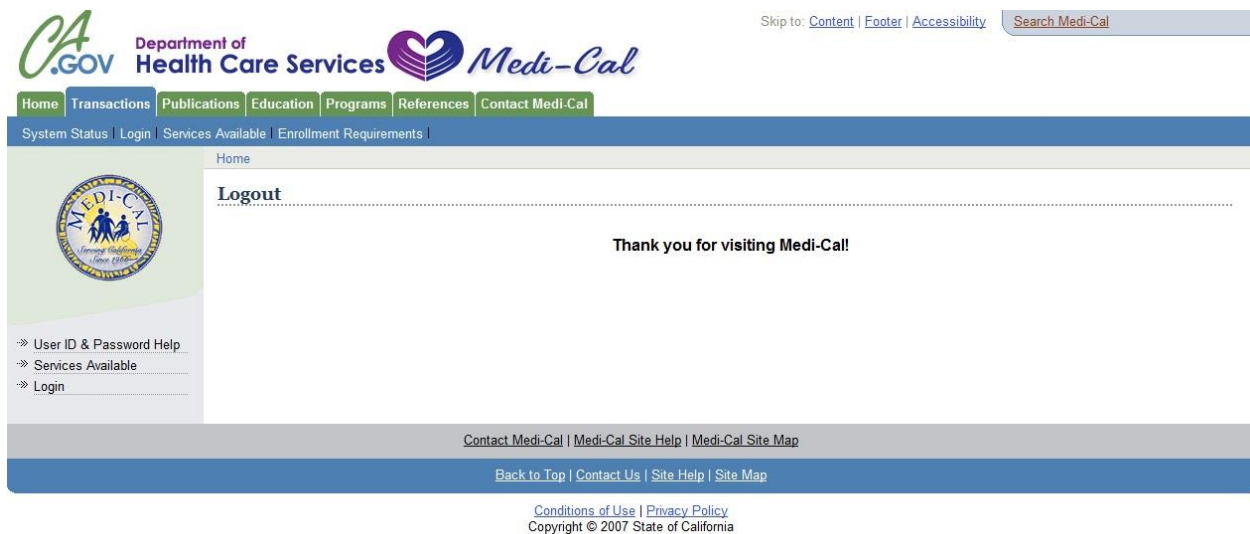
- Upload additional files. Click on the “Upload Another File” option and follow the steps outlined in this section.
- Inquire on all files that have been uploaded and not processed by CA-MMIS.
- Exit by clicking on the “Exit” option to log out of the session.



The screenshot shows the Medi-Cal website interface. At the top, there is a navigation bar with links: Home, Transactions, Publications, Education, Programs, References, and Contact Medi-Cal. Below this is a secondary navigation bar with links: System Status, Exit, Services Available, and Enrollment Requirements. The main content area is titled "Transaction Services" and displays the following information:

- You are logged in as: DSH899801
- Other
 - Disproportionate Share Hospital (DSH) Aid Code List
 - Disproportionate Share Hospital (DSH) Submission Files
 - Disproportionate Share Hospital (DSH) Response Files
 - Disproportionate Share Hospital (DSH) User Guide

When you have successfully logged off, the Logout screen will appear.



Receive Request Files

At 9:00 pm on a nightly basis, CA-MMIS retrieves all files from the individual locations on the Medi-Cal Internet site.

Transfer Files for Processing

After retrieving the files, CA-MMIS transfers the files from the Internet site to the CA-MMIS mainframe for transfer to the DHCS mainframe.

Process Request Files

The DSH Unit within DHCS processes the request files using the DSH matching process and supporting programs. This process creates response files as well as attestation letter files (see Appendix C) for both the submitter and auditor.

Transfer Files for Delivery

The DSH Unit within DHCS transfers all files created during the matching process to the CA-MMIS mainframe.

Sweep Files from Mainframe

CA-MMIS takes all files transferred by the DSH Unit to the CA-MMIS mainframe and prepares them for delivery to the submitter and auditor locations on the Medi-Cal Internet site.

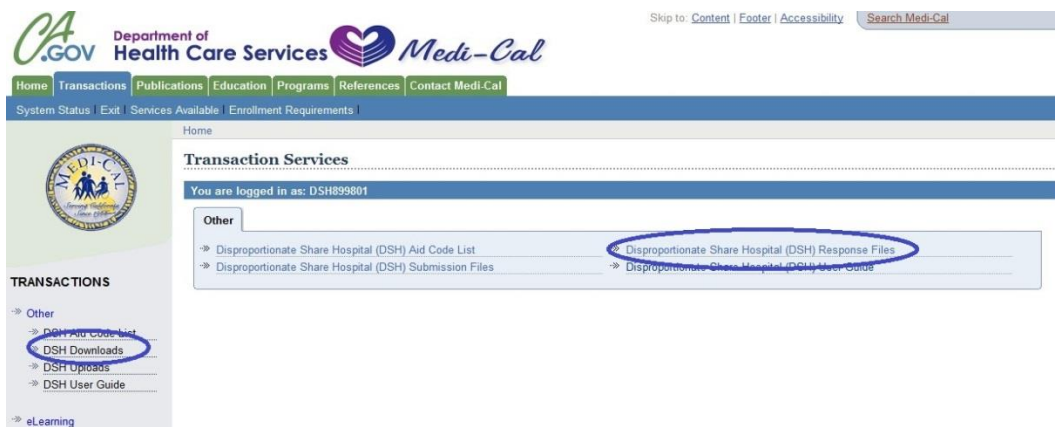
Distribute Response Files

CA-MMIS deposits all files created from the matching process to the submitter and auditor locations on the Medi-Cal Internet site. CA-MMIS will deliver files on a daily basis at 5:00 pm. Files are posted to the DSH Response Files portion of the Transaction Services screen.

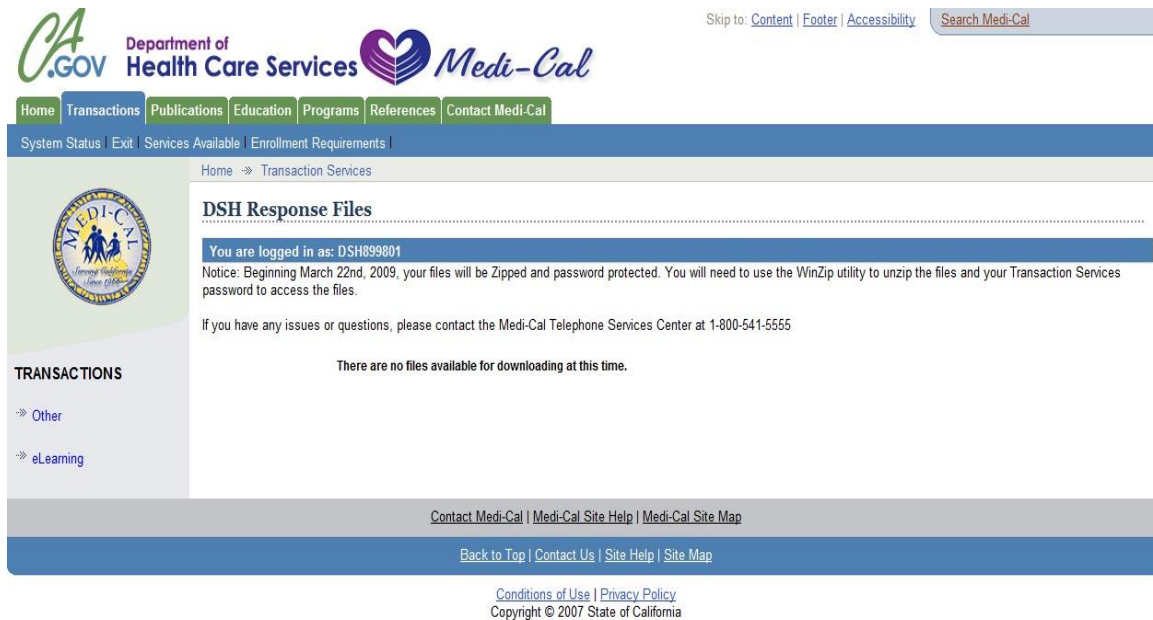
Pick-up Files

The submitter or auditor is responsible for logging into the Medi-Cal Internet site to check for and download response files. Please note that all processed files will remain on the Internet site for 14 days. After 14 days, files will be purged from the site. This rule does not apply to Medicare auditors, who are allowed six weeks before the files are purged. DHCS is unable to access purged files. The files will have to be uploaded again and re-processed.

1. The submitter or auditor accesses the Medi-Cal Internet site and logs in.
2. The submitter or auditor clicks on the “Disproportionate Share Hospital (DSH) Response Files” option to retrieve files. The submitter or auditor can also select the “Other” tab on the left side of the page to display a variety of DSH activities. One of the options under the “Other” link is the “DSH Downloads” link. The submitter can also click on this link to begin the retrieval process.



If no files are available, the following screen will appear:



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System Status | Exit | Services Available | Enrollment Requirements |

Home → Transaction Services

DSH Response Files

You are logged in as: DSH899801

Notice: Beginning March 22nd, 2009, your files will be Zipped and password protected. You will need to use the WinZip utility to unzip the files and your Transaction Services password to access the files.

If you have any issues or questions, please contact the Medi-Cal Telephone Services Center at 1-800-541-5555

There are no files available for downloading at this time.

TRANSACTIONS

→ Other

→ eLearning

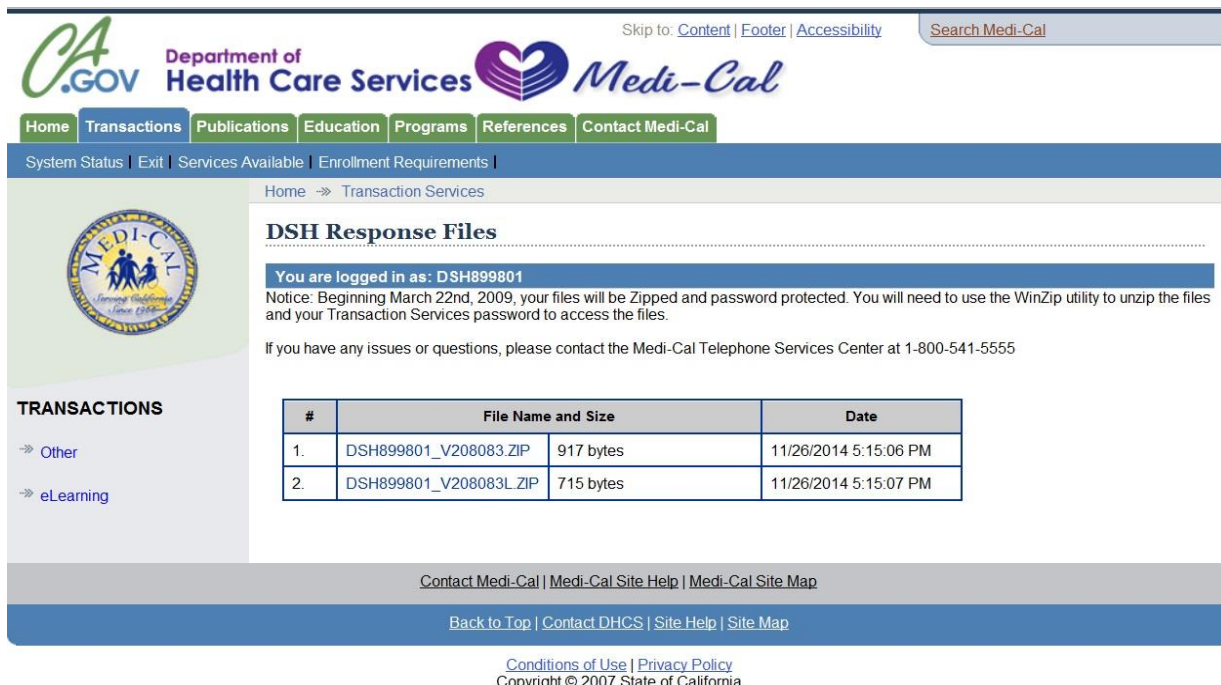
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- When files are available for downloading, the submitter/auditor clicks on the file. The file name on this screen is the same as the “File Save As” name as discussed on page 24. The response file will be password protected with the submitter’s login password.



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Home Transactions Publications Education Programs References Contact Medi-Cal

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Home → Transaction Services

DSH Response Files

You are logged in as: DSH899801

Notice: Beginning March 22nd, 2009, your files will be Zipped and password protected. You will need to use the WinZip utility to unzip the files and your Transaction Services password to access the files.

If you have any issues or questions, please contact the Medi-Cal Telephone Services Center at 1-800-541-5555

#	File Name and Size	Date
1.	DSH899801_V208083.ZIP 917 bytes	11/26/2014 5:15:06 PM
2.	DSH899801_V208083L.ZIP 715 bytes	11/26/2014 5:15:07 PM

TRANSACTIONS

→ Other

→ eLearning

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4. When the File Download dialog box appears, the submitter/auditor clicks the OK button to begin the download process.
5. Once the download process is completed, a Download Complete dialog box will appear. The submitter/auditor clicks the CLOSE button to complete the process.
6. When all processing is completed, the submitter/auditor clicks the Exit option to log off the system.

Response Files

These fields correspond to the response fields listed in the Request/Response Record Format Table on page 15, fields 12 through 15. Do not populate these fields. These fields are populated by DHCS during the DSH matching process.

12. Medi-Cal Eligibility Indicator (length = 1 character)

This is the response code generated during the processing of the matching program.

The key for the response codes is as follows:

- 1 = eligible
- 2 = potentially eligible with unmet share of cost
- 3 = matched and potentially eligible
- 4 = unmatched
- 5 = multiple name match
- 6 = invalid date of service format
- 7 = invalid date of service, within the 13 month billing window
- 8 = not used at this time
- 9 = invalid submitter ID

13. Medicare Part A Eligibility Indicator (length = 1 character)

This indicates whether the recipient is eligible for Medicare Part A.

A response of “Y” indicates that the recipient is eligible for Medicare Part A. If the field is blank, the recipient is not eligible for Medicare Part A.

14. HIC Number (length = 12 characters)

This field contains the Medicare Health Insurance Claim (HIC) number.

15. Title XIX Restricted Aid Code (length = 2 characters)

If a recipient has a Title XIX eligible restricted aid code, the aid code will be displayed in this field.

The restricted aid codes are only returned in correlation with response codes 2 and 3.

It is recommended that submitters display the list and save a copy via “Save As” or print this screen for future reference.

Trailer Record Format and Data Dictionary

During the DHCS processing, the final step of the matching program is to tabulate various counts and create a trailer record to be sent back on the response file. **Do not create the trailer record – this record is created and populated by DHCS during DSH processing.** The Trailer Record Format is outlined in the table below. The total record length is 120 characters.

Field Number	Field Name	Length
1	Record Type	1
2	Response File Creation Date	8
3	Submitter ID	4
4	Batch Number	3
5	File Record Count	7
6	Response Code 1 Count	7
7	Response Code 2 Count	7
8	Response Code 3 Count	7
9	Response Code 4 Count	7
10	Response Code 5 Count	7
11	Response Code 6 Count	7
12	Response Code 7 Count	7
13	Response Code 8 Count	7
14	Response Code 9 Count	7
15	Part A Count	7
16	Filler	27

1. Record Type (length = 1 character)

This field contains the number 9, which signifies that this is a Trailer.

This is an indicator regarding the type of record (such as header, request/response, or trailer).

2. Response File Creation Date (length = 8 characters)

This field is populated with the 8-digit date as YYYYMMDD.

This is the date the file was processed by DHCS.

3. Submitter ID (length = 4 characters)

This is the 4-digit submitter ID of the organization submitting the request.

This is taken from the header record.

4. Batch Number (length = 3 characters)

This is a sequential number populated by the submitter to uniquely identify the file.

This is taken from the header record.

5. File Record Count (length = 7 characters)

This is the total number of records contained on the response file.

6. Response Code 1 Count (length = 7 characters)

This is the total number of records found to be eligible during processing of the file (response code 1).

7. Response Code 2 Count (length = 7 characters)

This is the total number of records with unmet share of cost in the file (response code 2).

8. Response Code 3 Count (length = 7 characters)

This is the total number of records found but not eligible in the file (response code 3).

9. Response Code 4 Count (length = 7 characters)

This is the total number of records not found during processing (response code 4).

10. Response Code 5 Count (length = 7 characters)

This is the total number of records with multiple names found during the name/date of birth search in the file (response code 5).

11. Response Code 6 Count (length = 7 characters)

This is the total number of records with invalid formats for date of service in the file (response code 6).

12. Response Code 7 Count (length = 7 characters)

This is the total number of records within the current 13 month window on the file (response code 7).

13. Response Code 8 Count (length = 7 characters)

This field is not used at this time.

14. Response Code 9 Count (length = 7 characters)

This is the total number of records indicating an invalid submitter ID (response code 9).

15. Part A Count (length = 7 characters)

This is the total number of records indicating Medicare Part A eligibility in the file.

Process – Overview of Program Logic

This section provides an overview of the logic performed by the matching program.

Validate Submitter ID

The Submitter ID field is examined to determine if it is valid. Invalid entries result in a response code of “9” in the Medi-Cal Eligibility indicator field. However, since the input submitter ID is used to route the response record to the appropriate submitting entity, the submitter may not receive a response record in these cases.

Validate Auditor ID

The Auditor ID field is examined to determine if the ID is valid. Invalid entries result in a message appearing in the filler field of the header record.

Validate Date of Service

Next, the match process will examine the inquiry Date of Service (DOS) field for both valid format and inquiry window.

- **Valid Format** – The valid format for the DOS is a numeric year and month. If the DOS is not in a valid format, a response code of “6” will be returned in the Medi-Cal Eligibility Indicator field.
- **Valid Inquiry Window** – The valid inquiry window precedes the standard 13-month claims adjudication time period (current month and prior 12 months). Eligibility inquiries for dates of service within the last 13 months should be processed via AEVS, the Internet, or POS network and will not be processed by this program. Inquiries with a DOS that is too recent will result in a response code of “7” in the Medi-Cal Eligibility indicator field.

Examine Recipient ID

After verifying the DOS, the appropriate database search key will be identified. The following actions attempt to identify the recipient’s MEDS ID, which is then combined with the year of service. This is used to read the DSHDB.

- If the Social Security Number (SSN) is present on the inquiry record, then it will be used to read the DSHDB.
- If there’s no input SSN, or the input SSN was not found in the DSHDB, and the Medi-Cal ID or BIC ID contains less than 14 characters, then the first nine (9) characters are examined. If the first character is an “8” or “9” and the last character is a “P”, then the Medi-Cal ID is a pseudo MEDS ID and can be used to read the DSHDB.

- If the Medi-Cal ID contains less than 14 characters, then the first nine (9) characters are examined. If the first character is a “9” and the last character is an alpha (letter) other than “P”, then the Medi-Cal ID is assumed to be a Client Index Number (CIN). The CIN is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.
- If the Medi-Cal ID contains 14 characters, then the Medi-Cal ID is assumed to be a county ID or the BIC ID. The county ID is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.
- If no DSHDB record has been found after examining the SSN, Medi-Cal ID or BIC ID, then the name and date of birth are cross-referenced to a MEDS ID. The cross-referencing must result in a unique, exact match. If more than one match is found having the exact same name and birth date, but having different MEDS IDs, then a response code of “5” is returned. If a unique exact match is found, then that MEDS ID number is used to read the DSHDB.

If none of the recipient identifiers resulted in a record being found on the DSHDB, then a response code of “4” is returned on the response record.

Determine Eligibility

The month of service (within the DOS field) is used to identify the corresponding month of eligibility on the DSHDB record. The eligible aid codes for that month will be examined to determine if a valid Title XIX aid code exists on the record (the aid codes considered Title XIX are listed in **Appendix E** of this User Manual). The aid codes in the DSHDB will be examined in the following order:

1. Primary Medi-Cal
2. Special Program 1
3. Special Program 2
4. Special Program 3

If an eligible Title XIX aid code is identified, then the share of cost (SOC) indicator is examined. If the SOC indicator indicates an unmet share of cost, then a response code of “2” is returned. If a restricted Title XIX aid code is found during processing, it will be returned on the response record for response code “2.” If no unmet SOC is indicated, then a response code of “1” is returned.

If there is no aid code found (indicating no eligibility), or if an aid code is found but it is not within the defined Title XIX aid code list, then a response code of “3” is returned on the response record. In addition, if the aid code is defined as restricted, the aid code will be returned with the response code (see **Appendix E** for a list of restricted aid codes).

The recipient's Medicare status code for the month of service is examined. If the Medicare status indicates Medicare Part A eligibility, then the response Medicare Part A indicator is set to "Y" and the Medicare HIC number, if present, is moved to the response record.

Create Response Record

Lastly, the response record is written and returned to the submitter with the eligibility response information appended to the original inquiry record. Additionally, once all processing is completed for the submitted file, a trailer record is produced containing control totals by response code. The auditor's cleaned response file and attestation letter files are also created.

APPENDIX A

Hospital Authorization Letter Templates

Appendix A: Hospital Authorization Letters

DHCS requires that an original, signed hospital authorization letter, written on hospital letterhead, be mailed to DHCS for each hospital for which files are submitted. There are two templates for these letters.

The first template is to be used by hospitals submitting files themselves.

The second template is to be used by vendors submitting files for hospitals. The requirements for letters submitted by vendors are as follows:

- Vendors must provide a letter for each hospital for which it submits files.
- Specific beginning dates and ending dates are required for the letters to be accepted by DHCS. The authorization is only valid for the period of time specified in the letters.
- The six-digit CMS provider ID for each hospital must be provided to DHCS for each hospital.

Below is the Hospital Authorization Letter template for use by hospitals not using vendors for submittals. It must be submitted on hospital letterhead.

[Insert the date here.]

DSH Representative
Department of Health Care Services
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

Re: Medi-Cal Eligibility Re-Verification for Disproportionate Share (DSH) Determination

Dear DSH Representative:

By this letter, [Insert the full hospital legal name here] (Hospital) will be identifying Medi-Cal eligible patients for purposes of determining our Hospital's disproportionate share. In exchange for the Department of Health Care Services (DHCS) permitting the Hospital to re-verify Medi-Cal eligibility of the hospital's inpatients, the Hospital agrees to do so pursuant to the following terms:

1. Hospital shall access Medi-Cal eligibility information on the Hospital's inpatients that may be entitled to Medicare Part A benefits. The hospital will provide data to the DHCS to re-verify the eligibility of those patients who we believe were eligible for Medi-Cal coverage for medical care and services that the Hospital provided.
2. The Hospital shall use recipient Medi-Cal eligibility information the Hospital obtains for the purpose of the Hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHCS.
3. The Hospital shall not bring any legal action against DHCS that is in any way related to the re-verification of Medi-Cal eligibility.
4. The Hospital shall adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records.
5. The Hospital shall not alter any of the recipient information.
6. The Hospital shall not retain any of the recipient information for anything other than Medicare Disproportionate Share payment determination purposes.

Sincerely,

[Insert signature and signature block here.]

Below is the Hospital Authorization Letter template for use by vendors. It must be submitted on the appropriate hospital letterhead.

[Insert the date here.]

DSH Representative
Department of Health Care Services
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

Re: Medi-Cal Eligibility Re-Verification for Disproportionate Share (DSH) Determination

Dear DSH Representative:

By this letter, [insert the full hospital legal name here] (Hospital) has designated [insert the full name of the vender company here] (Agent) as its agent to assist in identifying Medi-Cal eligible patients for purposes of determining the Hospital's disproportionate share for the period of [insert the beginning date of the period] through [insert the end date of the period]. In exchange for the DHCS permitting the Hospital and its Agent to re-verify Medi-Cal eligibility of the hospital's inpatients, the Hospital and Agent agree to do so pursuant to the following terms:

1. Hospital and its Agent shall access Medi-Cal eligibility information on the Hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between Agent and Hospital, the Agent will provide data to the DHCS to re-verify the eligibility of those patients who we believe were eligible for Medi-Cal coverage for medical care and services that the Hospital provided.
2. Hospital and its Agent shall use recipient Medi-Cal eligibility information obtained for the purpose of the Hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHCS.
3. The Hospital or its Agent shall not bring any legal action against DHCS that is in any way related to the re-verification of Medi-Cal eligibility.
4. The Agent designated by the Hospital to access Medi-Cal eligibility has a signed agreement with the Hospital agreeing to, among other things, the following terms:
 - Be bound by paragraphs 1-3 of this request
 - Re-verify eligibility only as a direct result of the Hospital's inquiry on a specific individual
 - Adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records
 - Not alter any of the recipient information
 - Not retain any of the recipient information for anything other than Medicare Disproportionate Share payment determination purposes

Please contact us if you have any questions regarding this matter.

Sincerely,

[Insert the signature and signature block here.]

APPENDIX B

Medi-Cal Web Site Agreement Template

Appendix B: Medi-Cal Web Site Agreement Template

All submitters and auditors must complete the following agreement:

Medi-Cal Web Site Agreement Form for Disproportionate Share Hospital Eligibility Re-Verification

This agreement is required for all Medi-Cal Disproportionate Share Hospitals (DSH), vendors, and auditors intending to utilize the Medi-Cal Web Site applications at <http://www.medi-cal.ca.gov>.

1. The California Department of Health Care Services (DHCS) will permit use of the DSH eligibility re-verification process for the following organization (Submitter):

Full Legal Hospital Name/Company Name/Auditor Name:

The submitter requests a Submitter ID to allow access to Medi-Cal eligibility information to assist in the re-verification of eligible patients for purposes of determining hospital disproportionate share. In exchange for the DHCS permitting the Submitter to re-verify Medi-Cal eligibility of their hospital's (or vendor's) inpatients, the Submitter agrees to do so pursuant to the following terms:

- a) The Submitter (a hospital or its designated vendor) shall access Medi-Cal eligibility information for the hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between the vendor and hospital, the vendor will provide data to the DHCS to re-verify the eligibility of those patients who may have been eligible for Medi-Cal coverage for medical care and services that the hospital provided.
- b) The Submitter (a hospital or its designated vendor) shall use recipient Medi-Cal eligibility information the hospital obtains for the purpose of the hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHCS.
- c) The Submitter (the hospital or its designated vendor) shall not bring any legal action against DHCS that is in any way related to the re-verification of Medi-Cal eligibility.
- d) The Submitter agrees to pay for re-verification services once an agreed upon fee schedule is developed by DHCS.
- e) When the Submitter is a vendor designated by the hospital to access Medi-Cal eligibility on their behalf, the Submitter has a signed agreement with the hospital agreeing to, among other things, the following terms:
 - i. Be bound by paragraphs a–c of this request
 - ii. Re-verify eligibility only as a direct result of the hospital's inquiry on a specific individual

- iii. Adhere to relevant confidentiality and privacy laws, regulations, and contractual safeguards to ensure the security and confidentiality of records
 - iv. Not alter any of the recipient information
 - v. Not retain any of the recipient information for anything other than Medicare Disproportionate Share payment determination
2. DHCS will permit use of the California Medi-Cal Web Site by the Submitter subject to the terms and conditions of this agreement. The submitter agrees to limit the usage of the Medi-Cal Web Site to the following Medi-Cal eligibility-related transactions:
- a) Submission and retrieval of DSH inquiry transactions as permitted by DHCS and as documented in the *DSH Eligibility Re-Verification Process User Manual* (published by MCED)
 - b) Browsing of the Medi-Cal Web Site

Submitter acknowledges that failure to limit usage of the Medi-Cal Web Site to the above transactions may, at a minimum, result in DHCS revoking the privilege to use the Medi-Cal Web Site. Abuse or fraudulent use of transactions available on the Medi-Cal Web Site may result in DHCS revoking Submitter access to the Medi-Cal Internet Transaction Services and possible legal ramifications.

3. Submitter agrees to report all malfunctions of the Medi-Cal Web Site to MCED or CA-MMIS' POS/Internet Help Desk at the phone number and/or address documented in the *DSH Eligibility Re-Verification Process User Manual*.
4. Submitter acknowledges that neither DHCS nor its vendor is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHCS.
5. For POS/Internet Help Desk validation, provide the following Submitter contact validation information:

Information Requested	Primary Contact	Backup Contact
Name:		
Telephone Number:		
Email Address:		
Mailing Address:		

Submitter's Authentication Word (for identification purposes):

Submitter Signature

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement. I am providing contact information in the event that both the primary and backup are not the caller requesting help from the POS/Internet Help Desk. The authorized signatory will be contacted to confirm the caller's identification.

Authorized Signature: _____

Printed Name of Signatory: _____

Title: _____

Telephone Number: _____

Email: _____

Date: _____

Return the completed and signed agreement to:

DSH Representative
Department of Health Care Services
Medi-Cal Eligibility Division, MS 4607
Program Integrity Unit
P.O. Box 997417
Sacramento, CA 95899-7417

APPENDIX C

Attestation Letter Report

Appendix C: Attestation Letter Report

The intent of the attestation letter is to provide the file counts to the auditors to allow them to verify that the correct files were used during the audits. The attestation letter is automatically created by DHCS during the file processing. A readable print file is created and sent to both the auditor and the submitter. An example of an attestation letter is as follows:

**State of California
Department of Health Care Services
Disproportionate Share Processing Control Totals**

Report #: RS-DSH100-R002

Process Date: mm/dd/yyyy

The California Department of Health Care Services is providing the following Medi-Cal Eligibility control totals report for the attestation of the disproportionate share eligibility re-verification process.

Submitted by: **<Submitter Name>**

Eligibility data provided for **<Provider Name>**
Federal Provider Number **<Provider Number>**
Dates of Inquiry **<Inquiry Date Range>**

File processed on **<Response File Creation Date>**

Processing Control Totals

Total number of records processed: **<File Record County>**

Total number of records with response code:

- 1 Eligible **<Response Code 1 Count>**
- 2 Unmet share of cost **<Response Code 2 Count>**
- 3 Matched and potentially eligible **<Response Code 3 Count>**
- 4 Unmatched **<Response Code 4 Count>**
- 5 Multiple name match **<Response Code 5 Count>**
- 6 Invalid date of service **<Response Code 6 Count>**
- 7 Date of service too recent **<Response Code 7 Count>**
- 9 Invalid submitter ID **<Response Code 9 Count>**
- Total number of records with Medicare Part A: **<Part A Count>**

The following list provides the sources of the data used to compile the Attestation Report:

1. Submitter Name – the Submitter Name is derived from the Submitter ID on the header record from the submitter. The Submitter ID will be cross-referenced to the Submitter Name using a new file/table maintained by MCED.
2. Provider Number – using the first record from the inquiry/response file, the provider number will be moved to the report as provided by the submitter.
3. Inquiry Date Range – using the first record from the inquiry/response file, the date range will be moved to the report as provided by the submitter.
4. Response File Creation Date – the date from the trailer record will be moved to the report.
5. File Record Count – the count from the trailer record will be moved to the report.
6. Response Code 1 through 9 Counts – the counts from the trailer record will be moved to the report.
7. Part A Count – the count from the trailer record will be moved to the report.

APPENDIX D

Medi-Cal Identifiers

Appendix D: Medi-Cal Identifiers

History of Medi-Cal Identifiers

The plastic Beneficiary Identification Card (BIC) debuted in 1994. Before that, DHCS mailed paper ID cards to the recipients every month. The primary identifier on the paper cards was the county ID, which was a 14-character identifier with the format cc-aa-sssssss-f-pp:

- cc = county code. This is a numeric value from 01-58; counties are numbered in alphabetical order starting with Alameda (01) and ending with Yuba (58)
- aa = aid code. This is an alphanumeric code used to describe scope of coverage and funding sources
- ssssss = serial number. This is an alphanumeric identifier assigned by the counties to group members of the same case
- f = family budget unit (FBU). This is an alphanumeric value used by the counties to group members of the same case into sub-units based on eligibility, residence, etc.
- pp = person number. This is a numeric value that identifies the individual members of a case.

For non-county managed recipients (such as SSI/SSP – aged, blind, disabled, etc.), MEDS assigns a pseudo (or fake) county ID consisting of cc-aa-CIN.

Pre-1994, most claims were billed using the county ID. Starting in 1994, BIC cards were issued with either the SSN or CIN as the primary identifier on the face of the card. At that point, providers started putting the BIC ID number (SSN or CIN) on the claims. The fiscal Intermediaries (FI) have access to all of the eligibility data via their connection to DHCS. When the FI get a claim billed with an SSN or CIN, they access our data to retrieve the county code, aid code, etc. to determine how to adjudicate the claim. During processing, the FI puts a “fake” county ID on the claim using the county code and the aid code used for adjudication and the provider-submitted identifier.

Determination of Medi-Cal Identifiers

To determine which ID you have, use the same logic used by DHCS during the matching process:

1. If you have a 14-byte identifier, then it’s probably a county ID or a BIC ID. Remove the dashes and put it in the Medi-Cal ID field.
2. If you have a 9-byte identifier, then it can be an SSN, pseudo-ID or CIN. If all 9 bytes are numeric, then put it in the SSN field and leave the Medi-Cal ID blank. If it’s not numeric, then put it in the Medi-Cal ID field and DHCS will figure it out during the match process.

3. If you have a 10-byte identifier, then it's probably an SSN or CIN with the check digit attached. Put it in the Medi-Cal ID field and DHCS will figure it out during the match process.
4. If you have a 13-byte identifier, then it's probably a "fake" county-ID. Assume the last 9-bytes are an SSN, CIN or pseudo-ID and put those last 9 bytes in the Medi-Cal ID field.
5. If you have an 11 or 12 byte identifier, you will have to look at your data to see if there are any patterns. A simple edit to identify a pseudo-ID is that the first byte is 8 or 9 and the last byte is P. A simple edit to identify a CIN is that the first byte is 9 and the last byte is alphabetic other than P.
6. The only identifier other than those discussed above is the Medicare Health Insurance Claim (HIC) number. The HIC number is usually an SSN followed by a 1- to 3-byte alphabetic suffix.

If the SSN and the Medi-Cal ID fields don't result in a match, the DSH matching logic will attempt to do a name/date of birth match.

APPENDIX E

Aid Code Information

Appendix E: Aid Code Information

Aid Code Information as of January 2017*:

List of Title XIX Aid Codes

0M, 0N, 0P, 0W, 03, 04, 06, 07, 10, 13, 14, 16, 17, 1H, 1X, 1Y, 20, 23, 24, 26, 27, 2A, 2E, 2G, 2H, 2J, 2P, 2R, 2S, 2T, 2U, 30, 32, 33, 34, 35, 36, 37, 38, 39, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 40, 42, 43, 45, 46, 47, 49, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 54, 59, 5E, 5K, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, 72, 7A, 7J, 7S, 7T, 7U, 7W, 82, 83, 86, 87, 8E, 8G, 8U, 8V, 8W, G0, H7, H8, J1, J2, J5, J7, K1, K2, K4, K6, K8, L1, L6, M1, M3, M7, P1, P2, P3, P5, P7, P9

List of Restricted Title XIX Aid Codes

0L, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 44, 48, 55, 58, 5F, 5J, 5R, 5T, 5W, 69, 6U, 74, 76, 7C, 7F, 7G, 7H, 7K, 80, 8A, 8C, 8D, 8H, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, L7, M2, M4, M6, M8, M9, M0, N5, N6, N7, N8, N9, N0, P4, P6, P8, P0

Changes from January 2016 list:

1. Aid code 1E was removed as it was never implemented.
2. Aid codes 2G, 2J, K2, K3, K4, and K5 were added.

*DSH processing is only available when the dates of inpatient service are older than 13 months; therefore, the system will only contain those aid codes active as of January 2017.

APPENDIX F

Contact Information

Appendix F: Contact Information

If you are having problems accessing the Medi-Cal Internet site, call the POS Help Desk at 1-800-541-5555.

For all other questions or issues, contact:

DSH Representative
Department of Health Care Services
Medi-Cal Eligibility Division
1501 Capitol Avenue, MS 4607
Sacramento, CA 95814

Telephone: (916) 552-9200