

Short-Doyle / Medi-Cal System Change Schedule

Updated: 1/27/2016

Announcement:

Effective immediately, Counties must stop submitting claims to Short Doyle II system with CINs eligible for aid codes G0, G1, G2, G9, N5, N6, and N9 because these aid codes are “state” inmate aid codes that should not be reimbursed for specialty mental health services. Services rendered to “state” inmates through the Medi-Cal State Inmate Program are adjudicated through the Department of Health Care Services’ (Department) Fiscal Intermediary system. Therefore, the Department is in the process of disabling these aid codes in the Short Doyle II system for specialty mental health services.

Planned Changes

February 9th 2016 (Anticipated Release Date)

1. Certified Medicare Advantage Plans:
 - a. Health Plan of San Mateo (adding 1/1/16 – 12/31/16)
 - b. Health Net of California (adding 1/1/14 – 12/31/15)
 - c. Cal Optima (adding 1/1/16 - 12/31/16)

Planned SD2 Effective Date - TBD

1. Adjudication of Claims for Beneficiaries with Multiple Aid Codes. Claims will be adjudicated using the first allowable aid code with the highest FMAP (Specialty Mental Health and Drug Medi-Cal.) Programming and testing multiple aid code adjudication in SD2 to start on or about January 2016 and completed on or about June 2016.
2. Implement process in SD2 to adjudicate Over-One-Year Claims with Retroactive Eligibility.
3. Allow SD2 to Validate Rendering Providers Against the Suspended and Ineligible Provider List
4. Reject only the claims with SNIP errors, not the entire claim file.
5. Resolve improper denials caused by a beneficiary having OHC=A in MEDS for month of service, due to retroactive OHC=F process by Third Party Liability.
6. Incorrect Maximum Allowed Calculations are occurring in a limited number of approved claims. Once the fix is implemented, counties will be advised of affected claims by PCCN number.
7. Disable aid codes G0, G1, G2, G9, N5, N6, and N9 because these aid codes are “state” inmate aid codes that should not be reimbursed for specialty mental health services.
8. Add aid codes F3, F4, G3, and G4. Reimbursement of FFP is available effective January 1, 2014 for either; 1) acute psychiatric inpatient hospital services, or 2) psychiatric hospital professional services provided in a Fee For Service/Medi-Cal hospital for Medi-Cal eligible individuals who have been transferred off the grounds of a public institution.

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Past Changes

January 27th 2016 (Effective Date)

1. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.20, 8.6, 8.6.1, 8.6.2, 8.6.3, and 8.6.4) (Specialty Mental Health and Drug Medi-Cal.)

January 7th 2016 (Effective Date)

1. Only show successful replacing/voiding claims with Original Reference Number on 835.
2. Correct deceased beneficiary rules introduced on Nov 26th, 2013, to deny service lines with service dates after the date of death, instead of denying the entire claim when any service line within the claim has service dates after the date of death

December 8th 2015 (Effective Date)

1. Archiving of older SD2 claims completed. No impact to counties.

November 10th 2015 (Effective date)

1. Deny any claim for which the Subscriber Primary Identifier (Loop 2010BA Subscriber Name segment, data element NM109) provided is not a structurally valid Medi-Cal Client Index Number (CIN). A structurally valid CIN is 9 characters, starting with a “9”, followed by seven numeric digits and ending with an uppercase letter (Specialty Mental Health and Drug Medi-Cal.)
2. Identify Cal-MediConnect plans by the Health Care Plan code, not the OHC value.
3. Correct Rates for MHSD Rate Table (FY 15/16)

October 30th 2015 (Effective Date)

1. EFT Transactions Implementation; INFO Notice being drafted.

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September 8th 2015 (Effective Date)

1. ICD-10 Updates Implement ICD-10-CM (Diagnosis) for 837I/Ps and ICD-10-PCS (Procedures) for 837Is. Effective October 1, 2015. (PRODUCTION)
2. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.15, 8.4.16, 8.4.17, 8.4.18 and 8.4.19 - (Specialty Mental Health and Drug Medi-Cal.)
3. Update CORE code Combinations for CAQH CORE 360 CARC and RARCs. This subsequent implementation covers versions 3.2.0, published March 1, 2015.
 - a. Services overlap an inpatient stay (service may be billed only if rendered on date of admission or date of discharge).
 - b. Service not payable with other service rendered on the same date.
 - i. From: CO/96/N20
 - ii. To: CO/96/M80
4. In the course of internal and trading partner testing of SDMC system changes to support ICD-10 scheduled for **deployment to production on September 8, 2015**, DHCS has identified that updates the EDIFECs XEngine code used for front-end edits are enforcing the situational rule requiring the SV101-7 (on the 837P) or SV202-7 (on the 837I) free-form Description element to be present when the HCPCS code reported in SV101-2 (on the 837P) or SV202-2 (on the 837I) was a non-specific procedure code. At least one Mental Health trading partner has had 837I test files rejected as a result of this change, because they were not following the requirement to provide SV202-7 with procedure code H0046, which is a non-specific code. Other non-specific codes currently used to identify services in SDMC include S5000/S5001, the Generic and Brand-Name Prescription Drug codes used for Naltrexone service in Drug Medi-Cal.

Trading partners should assure that their systems are correctly populating the SV101-7 or SV202-7 data elements where required by the Type 3 Technical Reports (TR3s or “Implementation Guides”) specified as standards under HIPAA. Transactions which fail to do so on or after September 8, 2015 will be rejected by SDMC. Trading partners should also be aware that transactions not populating these elements where required are already being rejected in the SDMC Staging (test) environment.

Mental Health trading partners are reminded that, as part of the same set of system changes, SDMC will no longer be using the HCPCS procedure codes on 837I transactions for adjudication. Using the revenue code alone without the HCPCS procedure code will, for 837I transactions, avoid the need to populate SV202-7.

For details on the situational rules, see the relevant X12 TR3s:

- i. ASC X12N/005010X222 *Health Care Claim: Professional (837)*, p. 354
- ii. ASC X12N/005010X223 *Health Care Claim: Institutional (837)*, p. 427

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July 27th 2015 (Effective Date)

1. ICD-10 Updates Implement ICD-10-CM (Diagnosis) for 837I/Ps and ICD-10-PCS (Procedures) for 837Is. ICD-10 System Changes deployed to the Testing environment (Staging) on 7/27/15. The Compliance Date of ICD-10 implementation for testing will be 6/1/15. All Claims submitted to Staging with a Date of Service of 6/1/15 or after, will require ICD-10 code sets; Claims with Dates of Service prior to 6/1/15 will not require ICD-10 code sets. The Compliance Date in Staging will be set to 10/1/15 on 10/16/15.
(TEST)

- See Technical Requirements
<https://itws.dhcs.ca.gov/viewdocs.asp?DocID=3275>

July 14th 2015 (Effective Date)

1. Implemented County Interim Rate (CIR) tables for FY 15/16 services. Counties were asked to not submit claims for service dates from July 1, 2015 and after, until 15/16 CIR table implemented.

July 1st 2015 (Effective Date)

1. Effective for dates on or after July 1st 2015 OHC billing Code A7 will be replaced with Code 210.
 - Other Health Coverage (OHC) – No Response within 90 calendar days. When OHC is required and no response is received within 90 calendar days, submit the claim with Coordination of Benefits information for the other health coverage that was billed as follows:
 - Use Loop 2320 CAS segment with OA***210** to indicate the OHC has not responded within 90 calendar days. The adjustment amount should be the amount of the claim. The adjudication date should be the 91st calendar day after the OHC billing date.
 - Note: The use of OA***210** for OHC billing overcomes the HIPAA SNIP rejection of OA*A7 effective for dates on or after July 1, 2015. The use of OA***210** may be used on all OHC billing claims with dates before, on and after July 1, 2015.

June 8th 2015 (Effective Date)

1. Update CORE code Combinations for CAQH CORE 360 CARC and RARCs. This subsequent implementation covers versions 3.1.3, published November 1, 2014.
 - a. All dates of service on claim must be within same calendar month, except discharge date can be 1st day of following month.
 - i. From: CO/16/N61
 - ii. To: CO/267/N74
2. Delete L2, L3, L4 and L5 Aid Codes from Short Doyle
3. Certified Medicare Advantage Plans:
 - a. CalOptima

May 14th 2015 (Effective Date)

1. Correct rule causing occasional inappropriate denials for duplicate services with different rendering NPI. Affected counties will be notified at a later date.

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April 16th 2015 (Effective Date)

1. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.11 to 8.4.14) (Specialty Mental Health and Drug Medi-Cal.)
2. Correct the EPSDT indicator in the claim summary, which has caused Void Claim files to not be consumed by USL.

February 10th 2015 (Effective Date)

1. Prevent partially accepted 837P or 837I, when at least one transaction set is rejected, from adjudicating in Short Doyle 2.

January 29th 2015 (Effective Date)

1. The MediCare Advantage Plans certified by MedCCC in 2014 and expiring on December 31, 2014 will be extended to expire on December 31, 2015.

January 13th 2015 (Effective Date)

1. Certified Medicare Advantage Plans:
 - a. Community
 - b. Easy

December 8th 2014 (Effective Date)

1. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.6, 8.4.7, 8.4.8 8.4.9 and 8.4.10) (Specialty Mental Health and Drug Medi-Cal.)
2. Update CORE code Combinations for CAQH CORE 360 CARC and RARCs. This subsequent implementation covers versions 3.0.3, published October 1, 2013; version 3.0.4, published February 1, 2014; version 3.1.0, published June 2014; and version 3.1.1, July 2014.

November 21st 2014 (Effective Date)

1. Allow claims with taxonomy code prefix 101 (Licensed Professional Clinical Counselor or "LPCC") to bill Medi-Cal directly under the SD/MC Dual Eligible Claiming rules. (Please see Info Notice 11-06 more on SD/MC Dual Eligible Claiming). It is now appropriate to issue the LPCC provider numbers as describe in this Information Notice. http://www.dhcs.ca.gov/services/MH/Documents/14-005_MHSUDS_Info_Notice.pdf.
2. Certified Medicare Advantage Plans:
 - a. Inter Valley Health Plan
3. Aid Codes L3 and L5 are entered into the Master Aid Code Table as Full Scope. They will be corrected and changed to Restricted

September 3rd 2014 Effective Date

1. Certified Medicare Advantage Plans:
 - a. Molina Healthcare Inc.
 - b. Aetna Health of California
 - c. Blue Shield of California

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August 15th 2014 Effective Date

1. Correct MHS lockout rules for 837P. The change excludes the discharge date from the dates that are considered for lockouts for 24-hour services, except when it is an admission day.
2. Place an end date of 6/30/2014 (service date) on Aid Codes E2, E4, E5
3. Add Aid Codes L2, L3, L4, L5.
4. For DMC, correct Aid Codes 69, 74, and 80
5. Correct Aid Code 4K to reflect that it is not valid after 6/30/1996 for both DMC and MHS.
6. Certified Medicare Advantage Plans:
 - a. Inland Empire Health Plan
 - b. SCAN Health Plan

July 23 2014 Effective Date

1. Implemented County Interim Rate (CIR) tables for FY 14/15 services. Counties were asked to not submit claims for service dates from July 1, 2014 and after, until 14/15 CIR table implemented.

June 16 2014 Effective Date

1. Certified Medicare Advantage Plans:
 - a. Central Health Medicare Plan of California
 - b. Inland Empire Health Plan
 - c. United Healthcare of California/Secure Horizons

May 30, 2014 Effective Date

1. Adjudication of "2nd Modifier" (GT, HQ, SC) Katie A. Subclass Member claims billed with Intensive Care Coordination (T1017: HK) and Intensive Home-Based Services (H2015: HK) services.
2. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.4; 8.4.5) (Specialty Mental Health and Drug Medi-Cal.)
3. Update the Cal MediConnect Plans Table with information from Medicare Risk HMO Plans identified as Duals Demonstration, Cal MediConnect Health Plans - to allow adjudication of claims using Fee-for-Service Medicare coverage rules (see related Info Notice 13-24, Specialty Mental Health only).
4. Certified Medicare Advantage Plans:
 - a. Citizens Choice Healthplan HMO

May 13, 2014 Effective Date

1. Add Aid Code E6, 7S, 7U, 7W
2. Change EPSDT to "Yes" for Aid Codes: G0, J1, J2, J7, M3, M7, P2, P3, L1, M1
3. Certified Medicare Advantage Plans:
 - a. Partnership HealthPlan of California

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April 24, 2014 Effective Date

1. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.4.2; 8.4.3) (Specialty Mental Health and Drug Medi-Cal.)
2. Certified Medicare Advantage Plans:
 - a. Alameda Alliance for Health
 - b. Care1st Health Plan
 - c. Community Health Group

April 1, 2014 Effective Date

1. Aid code K1 and 3F update to include EPSDT
2. Support optional separate maximum rate for County-Contract and FFS Providers (AB1297) (Specialty Mental Health only.)
3. Certified Medicare Advantage Plans:
 - a. Health Plan of San Mateo

Mar 11, 2014 Effective Date)

1. Operating Rules Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs)
2. Apply HIPAA Code Set Update (Edifecs EDI Standards – HIPAA External Code Lists version: 8.3.1; 8.3.2; 8.3.3; 8.3.4; 8.3.5; 8.3.6; 8.4; 8.4.1) (Specialty Mental Health and Drug Medi-Cal.)

Mar 05, 2013 Effective Date, Staging Only)

1. DHCS "CIN-REQUEST Process" is available for testing Short/Doyle Medi-Cal claims. Instructions are available in the Word document "SDMCII Testing Strategy -Trading Partner Instructions v1.6.docx" that is posted on the Test ITWS SDMC website. Submission of test claims, using beneficiary eligibility data that has been copied from the production Medi-Cal Eligibility Determination System (MEDS) into a testing areas (the "MEDS ExITE Region") with identifying information masked to avoid use of PHI in the staging system (*Staging system only*, Specialty Mental Health and Drug Medi-Cal.)

Nov 26, 2013 Effective Date

1. Deny claims submitted for beneficiaries with date of death prior to the billed date of service (Specialty Mental Health and Drug Medi-Cal.)
2. Add new Aid Codes effective Jan 1, 2014 (Specialty Mental Health and Drug Medi-Cal.)

Nov 12, 2013 Effective Date

1. Support identification of Medicare Risk HMO's plans that should be adjudicated using Fee-for-Service Medicare coverage rules rather than OHC coverage rules. For MHPs to implement, they will also need the related OHC-F Info Notice 13-24 (Specialty Mental Health only.)

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Nov 1, 2013 (Effective Date, Staging Only)

1. Submission of test claims to Staging system was disabled to allow test claims with production beneficiary information to complete processing before conversion of staging environment to process claims without using PHI (Staging system only, Specialty Mental Health and Drug Medi-Cal.)

July 22, 2013 (Effective Date)

1. Implement County Interim Rate Tables for FY 13/14 services.

May 28, 2013 (Effective Date)

1. Activate new aid codes for Juvenile Inmate Eligibility: G1, G2, G5, G6, G7 and G8 – effective for claims submitted with service dates on or after 1/1/2012. G0 – effective for claims submitted with service dates on or after 6/1/2011.

May 14, 2013 (Effective Date)

1. Enable Emergency Services for Aid Code 48
2. Warrant Number will now be unique on denied 835s
3. Install Edifecs code list update – Permit valid CPT codes included in COB segments for 837I

May 1, 2013 (Effective Date)

1. Reject EDI using version 4010 transaction submitted effective May 1, 2013

April 18, 2013 (Effective Date)

1. SDMC will produce separate 835s identifying Minor Consent claim (for Drug Medi-Cal counties and direct contract providers).

April 10, 2013 (Effective Date)

1. Install Edifecs code list update – Permit valid CPT codes included in COB segments for 837P

March 26, 2013 (Effective Date)

1. Install Edifecs patch – Permit Adjustment Reason Code valid at time of COB adjudication for 837P

January 1, 2013 (Effective Date)

1. Permit MHPs to bill Intensive Home-Based Mental Health Service (IHBS) and Intensive Care Coordination (ICC) as required by *Katie A* lawsuit settlement, using “HK” modifier to distinguish these services from Mental Health Service and Targeted Case Management, respectively.

December 19, 2012 (Effective Date)

1. Support new Medi-Cal aid codes for clients transitioning to Medi-Cal from Healthy Families (H1, H2, H3, H4, H5, 5C and 5D)

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December 11, 2012 (Effective Date)

1. Trading Partner Validation between File Name and ISA

November 27, 2012 (Effective Date)

1. Allow replacement of DMH original claims incorrectly denied as late due to inserted value in DRC field

November 7, 2012 (Effective Date)

1. Apply HIPAA Code Set Update (EDIFECs EDI Standards – HIPAA External Code Lists version v8.0.6/v6.6.52. Release Notes)

September 13, 2012 (Effective Date)

1. Turn off all SNIP warnings generated on SNIP HTML (SR) report.

September 6, 2012 (Effective Date)

1. Change status of Disallowed Phase I SDMC Claims to “VoidProcessed” in SDMC Phase II
2. Do not deny timely DMH claims with invalid DRC.

August 23, 2012 (Effective Date)

1. Allow direct Medi-Cal reimbursement for claims for services to beneficiaries with OHC code “A”
2. Report DHCS EIN in place of ADP and DMH EINs reported previously on 835 (Reassociation Trace Number segment, TRN03) and 277/277PSI (Loop 2100A Payer Name segment, NM109)

July 9, 2012 (SD2 Effective Date)

1. Implement County Interim Rate Tables for FY 12/13 services (AB1297)
2. Amended Procedure Codes for FFS to include Plan Development (H0032 and H0034) and Rehabilitation (H2017) for a FFS provider.

June 19, 2012 (SD2 Effective Date)

1. Increase timely claims submission requirement from 6 to 12 months effective July 1, 2012 for all claim service periods. (AB1297)
2. DMH Statewide Maximum Allowance (SMA) Rates for Fiscal Year 12/13 were implemented

June 5, 2012 (SD2 Effective Date)

1. Clarification of SNIP Report information along with measures to reduce files accepted into SD2 that can become ‘halted’.
2. Void claims are being affected by the 15-month timeliness rule intended only for replacement claims – (Error Code CO-129). SD2 is denying void claims for DMH when greater than 15 months from month of service. This change is expected to correct Void claim behavior as there is no timeliness associated with straight voids.
3. Correct False Negative SR issue

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May 29, 2012 (SD2 Effective Date)

1. SD/MC will process Claim Frequency Type Code 5 for 837I

April 10, 2012 (SD2 Effective Date)

1. Correct OHC Rules for incorrect claim denials of Medicare Risk HMOs (CO-22) as of 12/30/2011 (5010 Implementation)
2. Initiate 5010 277PSI (Pending Status Information) Transaction – information similar to 4010 277U

March 22, 2012 (SD2 Effective Date)

1. HIPAA Code Set Update (EDIFECs EDI Standards - HIPAA External Code Lists v7.0.21/v6.6.45 Release Notes) Claim Frequency Type Codes 1, 7, 8 acceptable 837P submission.

February 23, 2012 (SD2 Effective Date)

1. 276/277 – Health Care Claim Status Request and Response – functionality to be activated
2. Change 835 filename format so that last three characters of the 835 filename will be alphanumeric. For example:
Current 835 filename: 12112011-DMH-01-835-12112011-999.dat (up to 999 files)
Enhanced 835 filename: 12112011-DMH-01-835-12112011-A00.dat (starting at 1000)

January 20, 2012 (SD2 Effective Date)

1. Install update to resume claim processing of 837P claims with non Medi-Medi OHC and 837I claims with any OHC.
2. Install fix to 5010 835 to add Line Item Control Number (REF*6R).

January 6, 2012 (SD2 Effective Date)

1. Effective for claims submitted on or after 1/1/2012, DRC 9 maybe used through June 30, 2012, on original claims delayed due to 5010 implementation.
2. Activate new aid codes: 4N, 4S, 4W, 07, 43, 49. Effective for claims submitted with service dates on or after 1/1/2012.

December 30, 2011 (SD2 Effective Date)

1. SD/MC Phase II System 5010 Implementation.

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November 23, 2011 (SD2 Effective Date)

1. Extend Delay Reason Code 3 usage from 9/30/11 to 6/30/2012.
2. Effective for claims submitted after 9/30/2011, when a claim for service filed by an MHP is denied due to an error in the claim or due to incomplete information, the MHP may submit one or more replacement claims no later than fifteen months after the month of service. If the original claim included a Delay Reason Code (DRC), resubmit the same DRC on the replacement claim.
3. Bifurcated Databases for ADP and DMH: System Improvement to reduce current Backlog of claims adjudication.
4. Discontinue 277U Process until Further Notice: Temporary Suspension of 277U Transaction with the potential to help reduce the current Backlog of claims adjudication.

October 15, 2011 (SD2 Effective Date)

1. Data Archival of the Phase I claims (both DMH and ADP) that were submitted prior to 36 months into a separate database. All phase I claims submitted prior to 10/1/2008 will be archived.

September 22, 2011 (SD2 Effective Date)

Program Coding Optimization:

1. Enhanced improved indexing to speed look up processes.
2. Reduced redundancy in storage.
3. Reconfigure BizTalk rules to be more efficient.
4. Reconfigure SQL server for improved performance.

August 22, 2011 (SD2 Effective Date)

1. Allow claims for Therapeutic Behavioral Services (H2019) to be directly billed to Medi-Cal (both Medi-Medi and Other Health Coverage COB exclusions). *(Note: Targeted Case Management Services (T1017) are currently Directly Billable service claims to Medi-Cal regardless of Medi-Medi or Other Health Coverage status.)*
2. DMH Statewide Maximum Allowance (SMA) Rates for Fiscal Year 11/12 were implemented per DMH Information Notice 11-08.
3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State General Fund (SGF) Reimbursement Rate for Fiscal Year 11/12 changed to 0% per AB 100.
4. Phase II Void and Replacement claims referencing Phase I Claim IDs as the Original Reference Number (REF02) will be Denied with a CO-129 Error.

May 20, 2011 (SD2 Effective Date)

1. Allow the use of DRC 3 through 9/30/11 for original claims. Denied DRC 3 claims may be replaced through the 97-day period after 9/30/11.

May 2, 2011 (SD2 Effective Date)

1. System fix for claims inappropriately denied with the error code CO A1, N480 [Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].

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April 5, 2011 (SD2 Effective Date)

1. Termination of G8437. Claims with procedure code G8437 and a date of service **after** December 31, 2010, will be rejected by the HIPAA edits.
2. HIPAA Code Set Update (EDIFECs EDI Standards - HIPAA External Code Lists v7.0.8 /v6.6.32 Release Notes)
3. System will not reject transaction sets for Coordination of Benefits (COB) balancing errors. Unbalanced COB information in a transaction set shall not cause any unit of EDI (transaction set, functional group, or interchange envelope/file) to be rejected. Claims with unbalanced COB will be denied with CO A1, N480 [Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].
4. System will allow replacement claims with a delay reason code to be adjudicated for original claims that were denied for being late, and could not be replaced when the replacement claim was submitted more than 12 months after the month of service. This scenario of replacement claim was previously denied with a denial reason code of CO 129.

February 25, 2011 (SD2 Effective Date)

1. System fix for claims with the following procedure codes and modifiers being inappropriately denied.
H2015:HE:HQ:59 -- H2015:HE:HQ:76 -- H2015:HE:HQ:77
H2015:HE:SC:59 -- H2015:HE:SC:76-- H2015:HE:SC:77
H2010:HE:HQ:59 -- H2010:HE:HQ:76 -- H2010:HE:HQ:77
H2010:HE:SC:59 -- H2010:HE:SC:76-- H2010:HE:SC:77
2. Allow modifiers HQ (Community) and SC (Telephone) to be used with or without the following procedure codes: T1017, H0032, H2017, H2019, G8437, H2011, H0034
3. Allow the use of procedure code H0034 (Medication Training and Support) for billing the following medication support service, service activities directly to Medi-Cal. Allow use of DRC "3" for H0034 and any dates of service.
 - Obtaining informed consent
 - Instruction in the use, risks, and benefits of alternatives for medications
 - Plan development related to medication support services

February 9, 2011 (SD2 Effective Date)

1. Correction to 1/25/2011 System Update - Due to a system logic issue with the taxonomy edit implemented January 25, 2011 (item 2.), certain DMH claims were incorrectly denied with the error CO-22-N192 (Medicare must be billed prior to the claim submission). This is the correction to the issue. (Action Item 232)

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January 25, 2011 (SD2 Effective Date)

1. Reactivate Aid Code 4G.
2. Allow Mental Health Services (H2015) and Medication Support Services (H2010) as directly billable services to Medi-Cal when the provider taxonomy code prefix is 'not':
 - 103 (Psychologists)
 - 104 (Social Worker)
 - 207 (Physician)
 - 208 (Physician)
 - 363 (Nurse Practitioner / Physician Assistant)
 - 364 (Nurse Specialists)

NOTES:

- H2010 and H2015 services processed prior to April 1, 2011, will not be denied if the rendering provider taxonomy code is blank as long as the Provider Accept Assignment Code (Loop 2300 CLM07) is set to 'C.'
- H2010 and H2015 services processed on or after April 1, 2011, will be denied if the rendering provider taxonomy code is blank, regardless of the Provider Accept Assignment Code.
- It is acceptable to provide the taxonomy code on any claim regardless of the circumstances.

January 10, 2011 (SD2 Effective Date)

1. Make the 835 units of service negative for void (and related replacement) claims. (Action Item 210)
2. Return 835 responses for approved zero dollar claims. (Action Item 157)
3. Allow the use of DRC 3 through 6/30/11 for original claims. Denied DRC 3 claims may be replaced through the 97-day period after 6/30/11.
4. Allow the use of good cause delay reason code (DRC) "3" for Medication Support Services (H2010).
5. Enable Aid Code 4T. Deactivating Aid Codes 4G, 5X, 5Y, 0R, 0T, 53, 8Y, 81.
6. Allow the use of procedure code G8437 (documentation of clinician and patient involvement with the development of a care plan) for billing the following medication support service, service activities directly to Medi-Cal. Allow use of DRC "3" for G8437.
 - Obtaining informed consent.
 - Instruction in the use, risks, and benefits of alternatives for medications
 - Plan development related to medication support services

December 28, 2010 (SD2 Effective Date)

1. Update ARRA FMAP percentages (by date of service):
 - a. 10/01/08 through 12/31/10: 61.59%
 - b. 01/01/11 through 03/31/11: 58.77%
 - c. 04/01/11 through 06/30/11: 56.88%
 - d. 07/01/11 and on: 50.00%
2. Allow the use of good cause delay reason code (DRC) "3" for Mental Health Services (H2015).

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December 15, 2010 (SD2 Effective Date)

1. Allow procedure modifier "GT" on tele-psychiatry claims so that these Medicare billable services can be subsequently billed to SD/MC with "GT".
2. Allow the use of good cause delay reason code (DRC) "3" and repeat procedure modifiers for Rehabilitation Services (H2017).
3. Allow Plan Development (H0032) as a directly billable service to Medi-Cal. Allow DRC 3 with H0032.
4. Deny claims with zero dollar Line Item Charge Amount.
5. Make the HIPAA validation report ("SR file") available to counties in HTML format.

November 24, 2010 (SD2 Effective Date)

1. Enable Aid Codes 4H and 4L
2. Internal system updates.

November 12, 2010 (SD2 Effective Date)

1. Emergency fix for billing Outpatient Hospital Services (Mode 12 - General Hospital or Psychiatric Hospital taxonomies) by an MFT.
2. Allow the use of good cause delay reason code (DRC) "3" for Targeted Case Management (T1017). The use of DRC "3" expires for all Medi-Medi billing after April 30, 2011. Claims with DRC "3" after this date will be denied.
3. Specialty mental health services are directly billable to Medi-Cal when the procedure modifier indicates:
 - Telephone services (SC procedure modifier, any place of service)
 - Services in the community (HQ procedure modifier with place of service 99 - 'Other')
4. Update COB edit so that OHC = "F" (Medicare RISK HMO) is not considered Medicare coverage.

October 25, 2010 (SD2 Effective Date)

1. Allow outpatient billing on day of discharge from inpatient psychiatric hospital.

October 11, 2010 (SD2 Effective Date)

1. Mobile or School (03 or 15) place of service (Action Item 79A)
2. Marriage Family Therapist (MFT) rendering provider taxonomy code (106H00000X) (Action Item 79A)
3. H2017 - Rehabilitation Services (Action Item 79A)

August 26, 2010 (Companion Guide Update)

1. OHC – No Response after 90 Days (Action Item 121)
When billing to other health coverage is required, billing is initiated, and no response is received after 90 days, the claim may be submitted with COB information for the other health coverage that was billed as follows:
 - Loop 2320 CAS segment with OA*A7 will indicate an over 90 day situation. The adjustment should be the amount of the claim. The adjudication date should be the 91st day after the OHC billing date.

Short-Doyle / Medi-Cal System Change Schedule

Updated: 1/27/2016

May 18, 2010 (SD2 Effective date)

1. The following services were made directly billable to Medi-Cal (see DMH Information Notice 10-11 for more information):

- H2011 - Crisis Intervention
- H2013 - Psychiatric Health Facility
- H0018 - Crisis Residential Treatment Services
- H0019 - Adult Residential Treatment Services
- S9484 - Crisis Stabilization
- H2012 - Day Treatment Intensive / Day Rehabilitation
- H2019 - Therapeutic Behavioral Services
- H0046 - Administrative Day Services

- Good cause delay reason code (DRC) "3" will allow counties to submit claims for dual eligible clients that are older than six months from the month of service but less than one year from the month of service. DRC "3" may be used for original or replacement Medi-Medi claims delayed due to implementation of new State edits for Medi-Medi billing. Medi-Medi replacement claims submitted due to the new edits will be exempt from the 97 day replacement rule.
- Original claims submitted over one year from the month of service will be denied.

June 30, 2009

1. Per, DMH Information Notice 09-09, Targeted Case Management (T1017) was made directly billable to Medi-Cal upon Short-Doyle 2 (SD2) system startup.