

Department of Alcohol and Drug Programs SD/MC

Phase II Project

Frequently Asked Questions

March 18, 2009

1. In SD/MC Phase II, is there a frequency or timeline for when claims must be submitted?

SD/MC Phase II claims can be submitted at any frequency. Claims do not need to be sent in once a month, or on any particular schedule. The SD/MC Phase II system will be constantly checking ITWS for new files submitted and will begin processing immediately after discovering a new transaction file. There still is a timeline within which claims must be submitted, which is not a change from the current system.

2. Can the clients Social Security Number be used to identify clients on claims in the Phase II system?

ADP Bulletin 08-01 describes the requirement for the Client Identification Number's (CIN) on ADP Drug Medi-Cal (DMC) claims. A provider may not submit a DMC claim containing a client's social security number, either in the existing system or in the Phase II system. All providers shall submit DMC claims with the CIN as listed on the client's Medi-Cal Benefits Identification Card (BIC) or Medi-Cal paper ID card. A copy of ADP Bulletin 08-01 can be found here:

http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml.

3. Will Trading Partners continue to use the ADP 5035C – Provider Report of Drug Medi-Cal Adjustments for claims submitted in Phase II, due to Void and Replacement claims?

No, ADP trading partners will be required to use Void or Replacement claims to adjust approved Drug Medi-Cal claims billed in error in Phase II; this replaces the use of the ADP 5035C form. This provides better accountability within the system for these changes, allows financial adjustments resulting from them to be handled more efficiently, and allows claim history to be adjusted so that billings retracted through this mechanism do not cause the denial of legitimate services. This will permit correction of claims for legitimate DMC services that were originally billed with erroneous information, rather than only supporting retraction of claims.

However, the Phase II system will not support voiding or replacing claims originally submitted in the Phase I system, and a transition process to handle the Phase I claims is currently under development.

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4. What is a PLB Adjustment, and what was the PLB segment used for in Phase I 835 claims?

In Phase I, the PLB segment in the 835 was used for the Batch Number in PLB 03-02 and it also included the sum of all approved amounts for services for the provider ID on the 835 in PLB04.

In Phase II, the PLB segment in the 835 will be used to convey provider level adjustment information. Provider level adjustments occur when there is a blanket reduction at the provider level that cannot be tied to a specific claim line or service line amount. ADP may make PLB adjustments during cost settlement, an audit, or a legal attachment (such as from an IRS levy). These adjustments are not tied to a specific claim or service line amount, but they are tied to a provider.

5. What is a 277U and under what circumstances will the 277U be sent to Trading Partners?

The 277U is an unsolicited claim status transaction which will be returned to trading partners, without requiring a claim status request, as notification of certain claim status conditions. A claim's status will be reported on a 277U transaction immediately when the adjudication system has either identified that it requires a manual override or approved the claim so that it is pending payment processing by ADP. A claim's status will also be reported on a 277U when it has not been released by ADP for processing at SD/MC after 7 days from the date it was submitted to ITWS; this serves as a reminder to the trading partner that the certification for the file containing the claim(s) listed needs to be sent to ADP if it has not been already.

6. Will ADP provide a list of Service Facility Location NPI's they have associated to each Billing Provider NPI?

Yes, ADP is working on creating a list that shows which service facility location NPI's are associated with each billing provider. In Phase II, claims are denied if a service facility location NPI does not associate with the specific billing provider NPI ADP has on file. Many trading partners will need to change the way they are currently billing to reflect the correct billing provider in the 2010AA NM109 Billing Provider Name segment. ADP has noticed that some trading partners have been populating the 2010AA NM109 segment with the service facility location NPI, which is only acceptable when the service facility location is part of a different legal entity than the entity submitting the claim.

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7. Will there be a blanket delay reason code for use on late claims due to the implementation of the Phase II system?

Due to the extension of the implementation timeline, extension of the testing timeline, and federal regulations, ADP will not have a blanket delay reason code for late submission of claims in Phase II. Please continue to use the appropriate delay reason code as listed and defined in federal regulations, as necessary. If you feel that you will not be able to meet the revised timeline for implementation of the Phase II system, please contact your FMAB analyst as soon as possible to discuss your individual situation.

8. How will units of service be calculated in Phase II?

Example of Minutes to Units Conversion in P1 and P2

Currently, the 10-minute DMC units are converted to 15-minute HIPAA units of service by trading partners, and the 15-minute unit is used on the 837. When the 837's are received, the Translator converts those 15-minute HIPAA units back to 10-minute DMC units for adjudication. In Phase 2, trading partners will submit 837's with the 10-minute unit of service, eliminating the conversion process. Below are examples of how this works in the current system, and how it will work in Phase 2.

Currently in SD/MC:

To convert the SD/MC 10-minute unit of service to the 15 minute HIPAA unit of service:

- Multiply the minutes for each unit of service by 1/15 (0.066667) and round to two decimal places (column 1 x column 2)
 - For example, 20 minutes, representing 2 units of counseling → $(20 \times 0.066667 = 1.33 \text{ HIPAA Units})$. 1.33 should be entered into the 837.
- The result will be the HIPAA unit(s), which is to be entered in the 837 for the applicable service's Procedure Code (column 3).
- The translator will multiply the resulting HIPAA units by 15 and round to zero decimal places to obtain SD/MC unit(s) of service for processing.

This conversion should be used only for NTP Group and Individual Counseling. ADP approves these services in units representing 10-minute increments. The 10-minute increment for units of service should be claimed consistent with the chart below.

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County/Direct Contract Provider Must Calculate & Enter the HIPAA Unit				State Translator Will Convert to Proprietary DMC Unit for SD/MC Process		
Column 0	Column 1	Column 2	Column 3 (Col. 1 x Col. 2)	Column 4	Column 5 (Col. 3 x Col. 4) (Rounded)	Column 6
DMC Unit	Minutes of Service per Unit	Multiply by:	Converted to HIPAA Units, Equals:	Mult. Factor (15 x HIPAA Unit)	Equals DMC Minutes	DMC Prop. Unit
1	10	0.066667	0.67	15	10	1
2	20	0.066667	1.33	15	20	2
3	30	0.066667	2.00	15	30	3
4	40	0.066667	2.67	15	40	4
5	50	0.066667	3.33	15	50	5
6	60	0.066667	4.00	15	60	6
7	70	0.066667	4.67	15	70	7
8	80	0.066667	5.33	15	80	8
9	90	0.066667	6.00	15	90	9
10	100	0.066667	6.67	15	100	10

In SD/MC Phase 2:

ADP will have all services billed with one unit of service equal to one unit of service as defined in regulation, including the ODF and NTP counseling services billed with HCPCS procedure codes H0004 and H0005. For ODF, one billed unit will be equal to one counseling session, and for NTP counseling of either group or individual type, one billed unit will be equal to a ten-minute increment of counseling services for the appropriate type. No conversion from ten-minute increments to 15-minute increments will be necessary. ADP intends to investigate & implement an alternative in the future which will eliminate the gap between the ADP practice and the HIPAA mandate.

For example: A 30 minute NTP individual counseling session equals 3 units. There is no conversion to HIPAA units of service.

Currently on claims in Phase I, 30 minutes of service equals 2 HIPAA units due to the 15 minute conversion (see above table). In Phase 2, 30 minutes of service will equal 3 units of service (see table below).

There is no conversion in SD/MC Phase 2, so you are using column 0 and column 1 from the table above.

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Minutes of Service	DMC Units
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9
100	10

9. Is the Line Note segment used to identify services in the Phase II system?

No. In the Phase I system, the Line Note segment was used to distinguish LAAM and Naltrexone services, which were billed with the same procedure codes and modifiers. Naltrexone will be uniquely identified by procedure codes in the Phase II system. Because LAAM is no longer being produced in or imported into the United States, and all previously produced or imported stocks have expired, ADP has no current rates for LAAM dosing, and no coding will be established for LAAM dosing at the launch of Phase II. If LAAM becomes available again, ADP will establish rates for those services and coding to identify LAAM on DMC billings, since LAAM dosing remains to be a valid DMC service under the law.