# Short-Doyle Medi-Cal Phase II

# ADP

## Standard Companion Guide Transaction Information

## Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

**Companion Guide Version Number: 1.6**

**August 6, 2013**

# Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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# Transaction Instruction (TI)

# 1 TI Introduction

## 1.1 Background

### 1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

### 1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

### 1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

## 1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

# 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document. The underlying TR3s are available at http://store.x12.org.

| Unique ID | Name |
|---|---|
| 005010X222A1 | Health Care Claim: Professional (837) |
| 005010X221A1 | Health Care Claim Payment/ Advice (835) |
| 005010X212E1 | Health Care Claim Status Request and Response (276/277) |
| 005010X214E2 | Health Care Claim Acknowledgement (277) |
| 005010X228E1 | Health Care Claim Pending Status Information (277) |
| 005010X231 | Implementation Acknowledgement (999) |

# 3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

| Legend |
|---|
| SHADED rows represent “segments” in the X12N implementation guide. |
| NON-SHADED rows represent “data elements” in the X12N implementation guide. |

### 005010X222 Health Care Claim: Professional

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | **BHT** | **BEGINNING OF HIERARCHICAL TRANSACTION** | | |
| | BHT06 | Claim or Encounter Identifier | CH | ADP only processes chargeable claims. ADP only processes claims with the “CH” qualifier. |
| **1000A** | **NM1** | **SUBMITTER NAME** | | Always identify the county or direct provider on whose behalf the transaction set is being submitted. |
| 1000A | NM109 | Submitter Identifier | | ADP requires submitters to be identified by their Federal Tax ID. |
| **1000B** | **NM1** | **RECEIVER NAME** | | |
| 1000B | NM103 | Receiver Name | | “CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS” must be supplied here. |
| | NM109 | Receiver Primary Identifier | | ADP’s Tax ID, “680290013”, must be supplied here. |
| **2000A** | **PRV** | **BILLING PROVIDER SPECIALTY INFORMATION** | | Provider taxonomy codes do not impact adjudication of Drug Medi-Cal claims. |
| **2000A** | **CUR** | **FOREIGN CURRENCY INFORMATION** | | Claims billed in foreign currencies are not processed in Drug Medi-Cal. |
| **2010AC** | **NM1** | **PAY-TO PLAN NAME** | | Subrogation payment requests are not processed in Drug Medi-Cal. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2000B** | **HL** | **SUBSCRIBER HIERARCHICAL LEVEL** | | The subscriber is always the patient in Drug Medi-Cal. |
| 2000B | HL04 | Hierarchical Child Code | 0 | The subscriber is always the patient in Drug Medi-Cal. |
| **2000B** | **SBR** | **SUBSCRIBER INFORMATION** | | |
| 2000B | SBR02 | Individual Relationship Code | 18 | The subscriber is always the patient in Drug Medi-Cal. |
| | SBR03 | Subscriber Group or Policy Number | | This data element is not processed in Drug Medi-Cal. |
| | SBR04 | Subscriber Group Name | | This data element is not process in Drug Medi-Cal. |
| | SBR05 | Insurance Type Code | | This data element is not process in Drug Medi-Cal. |
| | SBR09 | Claim Filing Indicator Code | MC | ADP only processes claims with the “MC” qualifier. |
| **2000B** | **PAT** | **PATIENT INFORMATION** | | |
| 2000B | PAT07 | Unit of Basis or Measurement Code | | Claims involving Medicare Durable Medical Equipment Regional Carriers Certificate of Medical Necessity (DMERC CMN) 02.03, 10.02, or DME MAC 10.03 are not processed in Drug Medi-Cal. |
| | PAT08 | Patient Weight | | Claims involving Medicare Durable Medical Equipment Regional Carriers Certificate of Medical Necessity (DMERC CMN) 02.03, 10.02, or DME MAC 10.03 are not processed in Drug Medi-Cal. |
| | PAT09 | Pregnancy Indicator | | The pregnancy indicator is required where the client is known to the provider to be either pregnant or postpartum as defined in 22 CCR § 51341.1(b) (18). The indicator will be used for statistical purposes, and for adjudicating claims for which the client’s perinatal eligibility is relevant. |
| **2010BA** | **NM1** | **SUBSCRIBER NAME** | | |
| 2010BA | NM102 | Entity Type Qualifier | 1 | Drug Medi-Cal beneficiaries are always individuals so “1” is the only acceptable value. |
| | NM108 | Identification Code Qualifier | MI | ’MI’ is the only acceptable value. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | NM109 | Subscriber Primary Identifier | | The primary identifier for all Drug Medi-Cal beneficiaries is the 9 character Medi-Cal Client Index Number (CIN). |
| **2010BA** | **N3** | **SUBSCRIBER ADDRESS** | | The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent. |
| 2010BA | N301 | Subscriber Address Line | | "HOMELESS" or "UNKNOWN" may be used if appropriate. |
| **2010BA** | **N4** | **SUBSCRIBER CITY, STATE, ZIP CODE** | | The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent. Where the patient is homeless or the correct city, state, and zip are unknown, use the information for the billing provider in this segment. |
| 2010BA | N401 | Subscriber City Name | | If unknown or in case of homeless subscribers, use the billing provider's city. |
| | N403 | Subscriber Postal Zone or ZIP Code | | If unknown or in case of homeless subscribers, use the billing provider's postal code. |
| **2010BA** | **DMG** | **SUBSCRIBER DEMOGRAPHIC INFORMATION** | | The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent. |
| **2010BA** | **REF** | **SUBSCRIBER SECONDARY IDENTIFICATION** | | No additional identification number beyond that provided in NM109 is required to identify subscribers in Drug Medi-Cal. |
| **2010BA** | **REF** | **PROPERTY AND CASUALTY CLAIM NUMBER** | | ADP does not process property and casualty claims. |
| **2010BA** | **PER** | **PROPERTY AND CASUALTY SUBSCRIBER CONTACT INFORMATION** | | ADP does not process property and casualty claims. |
| **2010BB** | **NM1** | **PAYER NAME** | | |
| 2010BB | NM103 | Payer Name | | "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" must be supplied here. |
| | NM109 | Payer Identifier | | ADP's Tax ID, "680290013", must be supplied here. |
| **2010BB** | **N3** | **PAYER ADDRESS** | | Information provided in this segment does not impact processing Drug Medi-Cal claims. |
| **2010BB** | **REF** | **PAYER SECONDARY IDENTIFICATION** | | No additional payer identifier is necessary to identify ADP as the payer. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2000C** | **HL** | **PATIENT HEIRARACHICAL LEVEL** | | The patient is always the subscriber for Drug Medi-Cal, so the information in this loop is not processed for Drug Medi-Cal. |
| **2300** | **CLM** | **CLAIM INFORMATION** | | |
| 2300 | CLM07 | Assignment or Plan Participation Code | A | Any entity billing Drug Medi-Cal must have a Drug Medi-Cal contract with ADP, so this must be "A" for all valid Drug Medi-Cal claims. |
| | CLM11 | Related Causes Information | | Information provided in this data element does not impact adjudication of Drug Medi-Cal Claims. |
| | CLM12 | Special Program Code | | The special circumstances, programs, and projects identified in this data element are not applicable to Drug Medi-Cal. |
| | CLM20 | Delay Reason Code | 1, 2, 4, 7, 8, 10, 11, 15 | Original Drug Medi-Cal claims are late when submitted later than 30 days after the end of the month of service. The adjudication process will deny late original claims and replacement claims where the original claim was late unless they include an appropriate delay reason code.<br><br>–Delay reason codes must only be used when there is good cause for late submission as defined in 22 C.C.R. §§ 51008, 51008.5.<br><br>Only the following delay reason codes will be taken into consideration in adjudication of Drug Medi-Cal claims: 1, 2, 4, 7, 8, 10, 11, and 15. Other delay reason codes will be accepted but will not be considered in adjudication. |
| **2300** | **DTP** | **DATE – INITIAL TREATMENT DATE** | | Information sent in this segment does not impact the processing of Drug Medi-Cal claims. |
| **2300** | **DTP** | **DATE – ACCIDENT** | | Information sent in this segment does not impact the processing of Drug Medi-Cal claims. |
| **2300** | **DTP** | **DATE – DISABILITY DATES** | | Information sent in this segment does not impact the processing of Drug Medi-Cal claims. |
| **2300** | **DTP** | **DATE – LAST WORKED** | | Information sent in this segment does not impact for adjudication of Drug Medi-Cal claims. |
| **2300** | **DTP** | **DATE – AUTHORIZED RETURN TO WORK** | | This information is not necessary for adjudication of Drug Medi-Cal claims. Information sent in this segment does not impact for adjudication of Drug Medi-Cal claims. |
| **2300** | **DTP** | **DATE – ADMISSION** | | Neither ambulance nor inpatient services are covered by Drug Medi-Cal. Information sent in this segment does not impact for adjudication of Drug Medi-Cal claims. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2300** | **DTP** | **DATE – DISCHARGE** | | Information sent in this segment does not impact for adjudication of Drug Medi-Cal claims. |
| **2300** | **PWK** | **CLAIM SUPPLEMENTAL INFORMATION** | | See Section 4.2.6 - Claim Supplemental Information – PWK Segment |
| **2300** | **AMT** | **PATIENT AMOUNT PAID** | | |
| 2300 | AMT02 | Patient Amount Paid | | This amount includes any amount actually paid as well as any amount for which the provider accepts the patient's obligation to pay to clear share of cost. |
| **2300** | **REF** | **SERVICE AUTHORIZATION EXCEPTION CODE** | | No services covered by Drug Medi-Cal require specific prior authorization. |
| **2300** | **REF** | **REFERRAL NUMBER** | | ADP does not assign referral numbers. |
| **2300** | **REF** | **PRIOR AUTHORIZATION** | | ADP does not assign authorization numbers. |
| **2300** | **REF** | **CLAIM IDENTIFICATION FOR TRANSMISSION INTERMEDIARIES** | | Information provided in this segment does not impact processing of Drug Medi-Cal claims and is not returned in any other transaction set. |
| **2300** | **REF** | **DEMONSTRATION PROJECT IDENTIFER** | | There are no atypical claims processed in Drug Medi-Cal where this information is necessary to identify. |
| **2300** | **NTE** | **CLAIM NOTE** | | Information provided in this segment does not impact the processing of Drug Medi-Cal claims. |
| **2300** | **HI** | **HEALTH CARE DIAGNOSIS CODE** | | ADP only accepts certain diagnosis codes as the primary diagnosis. |
| **2310A** | **NM1** | **REFERRING PROVIDER NAME** | | Information provided in this loop does not impact the processing of Drug Medi-Cal claims. |
| **2310B** | **NM1** | **RENDERING PROVIDER NAME** | | ADP requires identification, either here or in Loop 2420A, of the counselor as Rendering Provider for Outpatient Drug Free Group and Individual counseling services, and for NTP Group and Individual counseling services.<br>In other circumstances information provided in this loop does not impact processing of Drug Medi-Cal claims. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2310B | NM102 | Entity Type Qualifier | 1 | Where this segment is mandatory under the segment level notes above, an individual counselor must be identified. The rendering provider is always an individual Counselor for Drug Medi-Cal. "1" is the only acceptable value. |
| | | | | |
| **2310B** | **PRV** | **RENDERING PROVIDER SPECIALTY INFORMATION** | | Rendering provider taxonomy code does not impact the adjudication of Drug Medi-Cal claims. |
| **2310B** | **REF** | **RENDERING PROVIDER SECONDARY IDENTIFICATION** | | An identification number other than an NPI is not necessary to identify rendering providers for Drug Medi-Cal. |
| **2310C** | **NM1** | **SERVICE FACILITY LOCATION NAME** | | Because county-operated service locations, and all service locations of direct contract providers are subparts of the entity billing for services, this loop must only be used when services provided at a county-contracted facility are being billed by a county (and, for such services, either this loop at the claim level or Loop 2420C at the service level must be used.) |
| **2310C** | **REF** | **SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION** | | NPI in NM109 element in this loop is always processed to identify the service facility location for Drug Medi-Cal. The information in this section is not processed. |
| **2320** | **AMT** | **COORDINATION OF BENEFITS TOTAL NON-COVERED AMOUNT** | | Circumstances in which Drug Medi-Cal claims may be submitted bypassing otherwise prior payers are identified in ADP Bulletin #11-01. |
| **2400** | **SV1** | **PROFESSIONAL SERVICE** | | |
| 2400 | SV101-01 | Product or Service ID Qualifier | HC | All Drug Medi-Cal services are described exclusively with HCPCS codes. ADP will only process claims with "HC" value. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | SV101-02 | Procedure Code | H0004, H0005, H0015, H0018, H0019 H0020 | Procedure codes map to Drug Medi-Cal covered services as follows:<br>“H0004”: Individual Counseling (Outpatient Drug Free [ODF] or Narcotic Treatment Program [NTP].)<br>“H0005”: Group Counseling (ODF or NTP)<br>“H0015”: Daycare Rehabilitative<br>“H0018”, “H0019”: Perinatal Residential (must always have the HD modifier, below.)<br>S5000, S5001: Naltrexone<br>“H0020”: Methadone Dosing |
| | SV101-03 | Procedure Modifier | HG, HD, H9, 59, 76, 77 | Services provided in the Drug Medi-Cal perinatal program must report the “HD” modifier in one of SV101-03 through SVC101-06.<br><br>NTP and NAL services must report the “HG” modifier in one of SV101-03 through SV101-06.<br><br>Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify “59”, “76”, or “77”, as appropriate, in one of SVC101-03 through SV101-06. |
| | SV101-04 | Procedure Modifier | HG, HD, H9, 59, 76, 77 | Services provided in the Drug Medi-Cal perinatal program must report the “HD” modifier in one of SV101-03 through SVC101-06.<br><br>NTP and NAL services must report the “HG” modifier in one of SV101-03 through SV101-06.<br><br>Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify “59”, “76”, or “77”, as appropriate, in one of SVC101-03 through SV101-06. |
| | SV101-05 | Procedure Modifier | HG, HD, H9, 59, 76, 77 | Services provided in the Drug Medi-Cal perinatal program must report the “HD” modifier in one of SV101-03 through SVC101-06.<br><br>NTP and NAL services must report the “HG” modifier in one of SV101-03 through SV101-06.<br><br>Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify “59”, “76”, or “77”, as appropriate, in one of SVC101-03 through SV101-06. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | SV101-06 | Procedure Modifier | HG, HD, H9, 59, 76, 77 | Services provided in the Drug Medi-Cal perinatal program must report the “HD” modifier in one of SV101-03 through SVC101-06.<br><br>NTP and NAL services must report the “HG” modifier in one of SV101-03 through SV101-06.<br><br>Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify “59”, “76”, or “77”, as appropriate, in one of SVC101-03 through SV101-06. |
| | SV103 | Units or Basis for Measurement Code | UN | Drug Medi-Cal services must always be billed in units of service. ADP will only process claims with “UN” value. |
| | SV104 | Service Unit Count | | Drug Medi-Cal claims are processed in whole units of service. If a decimal is used, the fractional units will be denied and the whole number portion considered for reimbursement. |
| **2400** | **DTP** | **DATE – SERVICE DATE** | | |
| 2400 | DTP03 | Service Date | | A date range in which the “To and From” dates are not the same is only acceptable for NTP Methadone Dosing and Perinatal Residential services. Billing such a date range for other services will result in service denial. |
| **2400** | **NTE** | **LINE NOTE** | | Information provided in this segment does not impact processing of Drug Medi-Cal claims. |
| **2410** | **LIN** | **DRUG IDENTIFICATION** | | Information provided in this loop does not impact processing of Drug Medi-Cal claims. |
| **2420A** | **NM1** | **RENDERING PROVIDER NAME** | | ADP requires identification, either here or in Loop 2310B, of the counselor as Rendering Provider for Outpatient Drug Free Group and Individual counseling services, and for NTP Group and Individual counseling services.<br>In other circumstances information provided in this loop does not impact processing of Drug Medi-Cal claims. |
| **2420A** | NM102 | **Entity Type Qualifier** | 1 | The rendering provider is always an individual Counselor for Drug Medi-Cal. “1” is the only acceptable value. |
| **2420A** | **PRV** | **RENDERING PROVIDER SPECIALTY INFORMATION** | | Rendering provider taxonomy code does not impact adjudication of Drug Medi-Cal claims. |
| **2420A** | **REF** | **RENDERING PROVIDER SECONDARY IDENTIFICATION** | | An identification number other than an NPI is not necessary to identify rendering providers for Drug Medi-Cal. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2420C** | **NM1** | **SERVICE FACILITY LOCATION NAME** | | Because county-operated service locations, and all service locations of direct contract providers are subparts of the entity billing for services, this loop must only be used when services provided at a county-contracted facility are being billed by a county (and, for such services, either this loop at the service level or Loop 2310C at the claim level must be used.) |

## 005010X221 Health Care Claim Payment/Advice

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | **BPR** | **FINANCIAL INFORMATION** | | |
| | BPR01 | Transaction Handling Code | H, I | All payments for Drug Medi-Cal are made via warrants issued by the State Controller's Office, so all 835s detailing payment will use code "I".<br><br>All other 835s for Drug Medi-Cal will use code "H". |
| | BPR03 | Credit/Debit Flag Code | C | All Drug Medi-Cal payments are made by warrant soADP will always send "C". |
| | **TRN** | **REASSOCIATION TRACE NUMBER** | | |
| | TRN04 | Originating Company Supplemental Code | | ADP will send "DRUG MEDI-CAL" for all Drug Medi-Cal 835s. |
| | **CUR** | **FOREIGN CURRENCY INFORMATION** | | All Drug Medi-Cal payments are made in U.S. dollars. This segment will not be sent. |
| | **REF** | **RECEIVER IDENTIFICATION** | | The receiver for all Drug Medi-Cal 835s will be the payee. This segment will not be sent. |
| **1000A** | **N1** | **PAYER IDENTIFICATION** | | |
| 1000A | N102 | Payer Name | | ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element. |
| | N103 | Identification Code Qualifier | | This element will not be sent. |
| | N104 | Payer Identifier | | This element will not be sent. |
| **1000B** | **N1** | **PAYEE IDENTIFICATION** | | |
| 1000B | N102 | Payee Name | | This element will be populated with the legal name of the payee as reflected in ADP records. |
| | N103 | Identification Code Qualifier | XX | ADP will always send "XX" in this element. |
| | N104 | Payee Identification Code | | This will be the NPI provided to ADP to identify the payee; for organizations with more than one NPI it will be the one provided to ADP to identify the entity at the highest level. |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **1000B** | **REF** | **PAYEE ADDITIONAL IDENTIFICATION** | | |
| 1000B | REF01 | Reference Identification Qualifier | TJ | ADP will always send “TJ” in this element. |
| **2100** | **CLP** | **CLAIM PAYMENT INFORMATION** | | |
| 2100 | CLP02 | Claim Status Code | 1, 2, 3, 4, 22 | As ADP does not forward claims to additional payers, or do predetermination pricing, only codes “1”, “2”, “3”, “4”, and “22” will be used by ADP. |
| | CLP06 | Claim Filling Indicator Code | MC | ADP will always send “MC” in this element. |
| | CLP08 | Facility Type Code | | As ADP does not modify the Facility Code Type in adjudication, this element is never sent. |
| **2100** | **REF** | **OTHER CLAIM RELATED IDENTIFICATION** | | |
| 2100 | REF01 | Reference Identification Qualifier | 1L, F8 | On every Drug Medi-Cal claim reported on an 835 where the identified client was located on MEDS, ADP will return 1 iteration of this loop with the qualifier “1L”.<br><br>On every Drug Medi-Cal Replacement claim reported on an 835, ADP will return 1 iteration of this loop with the qualifier “F8”. Other correction claims will always retain the PCCN of the prior claim. |
| | REF02 | Reference Identification | | When REF01 is “1L”, this will contain a concatenation of the two-digit aid code used in adjudication and the two-digit code identifying the county of responsibility. |
| **2100** | **REF** | **RENDERING PROVIDER IDENTIFICATION** | | Additional rendering provider identification numbers do not affect adjudication of Drug Medi-Cal claims. This segment will not be sent. |
| **2100** | **DTM** | **STATEMENT FROM OR TO DATE** | | Statement From and To Dates will always be provided at the service line level. This segment will not be sent. |
| **2100** | **DTM** | **CLAIM RECEIVED DATE** | | ADP will send this segment for all claims. |
| **2100** | **AMT** | **CLAIM SUPPLEMENTAL INFORMATION** | | |
| 2100 | AMT01 | Amount Qualifier Code | AU, F5 | Qualifiers “AU” and “F5” are the only values that will be sent for this element. |
| **2100** | **QTY** | **CLAIM SUPPLEMENTAL INFORMATION QUANTITY** | | The quantities reported in this segment do not apply to Drug Medi-Cal. This segment will not be sent. |
| **2110** | **AMT** | **SERVICE SUPPLEMENTAL AMOUNT** | | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2110 | AMT01 | Amount Qualifier Code | B6 | The only value that will be sent for this data element is “B6”. |

## 005010X212 Health Care Claim Status Request

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2100A** | **NM1** | **PAYER NAME** | | |
| 2100A | NM109 | Payer Identifier | | ADP’s Tax ID, “680290013”, must be supplied here. |
| **2100B** | **NM1** | **INFORMATION RECEIVER NAME** | | Always identify the county or direct provider on whose behalf the transaction set is being submitted. |
| 2100B | NM109 | Identification Code | | ADP requires submitters to be identified by their Federal Tax ID. |
| **2000D** | **HL** | **SUBSCRIBER LEVEL** | | |
| 2000D | HL04 | Hierarchical Child Code | 0 | The subscriber is always the patient for ADP. |
| **2000D** | **DMG** | **SUBSCRIBER DEMOGRAPHIC INFORMATION** | | In Drug Medi-Cal, the subscriber is always the patient. This segment must always be sent. |
| **2100D** | **NM1** | **SUBSCRIBER NAME** | | |
| 2100D | NM102 | Entity Type Qualifier | 1 | In Drug Medi-Cal, the subscriber is always an individual so “1” is the only acceptable value. |
| | NM108 | Identification Code Qualifier | MI | ”MI” is the only acceptable value. |
| | NM109 | Subscriber Identifier | | The primary identifier for all Drug Medi-Cal beneficiaries is the 9-digit Medi-Cal Client Index Number (CIN). |
| **2200D** | **TRN** | **CLAIM STATUS TRACKING NUMBER** | | In Drug Medi-Cal, the subscriber is always the patient. |
| **2200D** | **REF** | **APPLICATION OR LOCATION SYSTEM IDENTIFIER** | | ADP does not have application or location system identifiers. The information in this segment is not processed by Drug Medi-Cal. |
| **2200D** | **REF** | **GROUP NUMBER** | | Information provided in this segment is not processed by ADP in Claim Status Request processing. |

## 005010X212 Health Care Information Status Notification

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2100A** | **NM1** | **PAYER NAME** | | |
| 2100A | NM103 | Payer Name | | ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element. |
| 2100A | NM108 | Identification Code Qualifier | PI | SD/MC will always send "PI". |
| 2100A | NM109 | Payer Identifier | | ADP will always send ADP's Tax ID. |
| **2000D** | **HL** | **SUBSCRIBER LEVEL** | | |
| 2000D | HL04 | Hierarchical Child Code | 0 | The subscriber is always the patient for Drug Medi-Cal. ADP will always send "0". |
| **2200C** | **TRN** | **PROVIDER OF SERVICE TRACE IDENTIFIER** | | |
| 2200C | TRN02 | Provider of Service Information Trace Identifier | | ADP will always send "0" in this data element. |
| **2200D** | **STC** | **CLAIM LEVEL STATUS INFORMATION** | | |
| 2200D | STC08 | Remittance Date | | ADP will provide the date of a non-payment 835 when one has been issued. |
| | STC09 | Remittance Trace Number | | ADP will provide the Trace Number of a non-payment 835 when one has been issued. |
| **2200D** | **REF** | **VOUCHER IDENTIFIER** | | ADP does not assign a voucher identifier to Drug Medi-Cal claims as part of the Drug Medi-Cal payment process. This segment will not be sent. |
| | NM109 | Payer Identifier | | ADP will always send ADP's Tax ID. |

## 005010X228 Health Care Claim Pending Status Information

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **2100A** | **NM1** | **PAYER NAME** | | |
| 2100A | NM103 | Payer Name | | ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element. |
| | NM108 | Identification Code Qualifier | PI | SD/MC will always send "PI" |
| | NM109 | Payer Identifier | | ADP will always send ADP's Tax ID. |

## 005010X231 Implementation Acknowledgements

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| **AK2** | **IK5** | **TRANSACTION SET RESPONSE TRAILER** | | |
| AK2 | IK501 | Transaction Set Acknowledgment Code | A, R, E | ADP rejects data at the lowest level to which errors can be isolated. Where errors exist that can be isolated to a level lower than the transaction set, ADP will accept the transaction set with errors, reporting an “E” in this segment, and reject any claims impacted by the error via Health Care Claim Acknowledgement (277) transaction set.<br><br>In all other circumstances, ADP will accept (“A”) or reject (“R”) the transaction set in its entirety. |
| | **AK9** | **FUNCTIONAL GROUP RESPONSE TRAILER** | | |
| | AK901 | Functional Group Acknowledge Code | A, R, E | ADP rejects data at the lowest level to which errors can be isolated. Where errors exist that can be isolated to a level lower than the functional group, ADP will accept the functional group with errors, reporting an “E” in this segment.<br><br>In all other circumstances, ADP will accept (“A”) or reject (“R”) the functional group in its entirety. |

# 4 TI Additional Information

## 4.1 Business Scenarios

No business scenarios are needed.

## 4.2 Payer Specific Business Rules and Limitations

### 4.2.1837 Transaction Set Claim Limitation

ADP requires trading partners to limit the number of CLM segments in a single Health Care Claim: Professional (837) transaction set to no more than 5000. Transaction sets containing more claims than this limit will be rejected.

### 4.2.2Claim Overpayment Recovery

ADP recoups overpayments either immediately using reversals and corrections as described in option 1, or using delayed recovery as described in option 3, of implementation guide 05010X221 (835) §1.10.2.17.

### 4.2.3 Other health Coverage (OHC) Billing Scenarios

#### 4.2.3.1 General Rule

Medi-Cal–eligible clients must exhaust benefits available through any other health coverage (OHC) available to the client before they are eligible to have services reimbursed through Medi-Cal, including DMC.

In general, this means that DMC providers must bill OHC carriers for services provided to DMC-eligible clients with OHC to the OHC carrier before billing DMC for reimbursement for those services, and may only bill DMC after the OHC has adjudicated the claim and either denied it for an acceptable reason (as described in ADP Bulletin #11-01) or issued partial payment. The results of the OHC carrier's adjudication must be reported in the submitted DMC claim as specified in the applicable implementation guide (TR3.)

#### 4.2.3.2 Billing DMC without OHC billing results

##### 4.2.3.2.1 General rule for billing DMC without OHC results

In certain circumstances, ADP policy permits billing for DMC services without results from billing the OHC. Unless otherwise noted in more specific instructions, when billing such services trading partners should complete Loops 2320 and 2330A and 2330B with information for OHC carrier and subscriber, just as you would if the OHC carrier had been billed and adjudicated the claim, with the following exceptions:

1. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 CAS–Claim Level Adjustment segment.

2. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 AMT–Coordination of Benefits (COB) Payer Paid Amount segment.

3. Because ADP policy allows bypassing claim submission to the OHC carrier, provide the Loop 2320 AMT-Coordination of Benefits (COB) Total Non-Covered Amount segment.

4. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 AMT–Remaining Patient Liability segment.

5. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 MOA-Outpatient Adjudication Information segment.

6. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2330B DTP-Claim Check or Remittance Date, or any other segment in Loop 2330B with a situational rule referring to information provided by the other payer or relating to the other payer's adjudication of the claim.

7. Do not provide any of the loops providing provider information specific to the other payer (Loop 2330C, 2330D, 2330E, 2330F, and 2330G.)

8. Because the OHC carrier has not adjudicated the claim, do not provide service line level COB information (Loop 2430) for the bypassed payer for the service lines in this claim.

#### 4.2.3.2.2 Methadone Maintenance Treatment Services

Per ADP Bulletin #12-03, claims for Methadone Maintenance Treatment Services (MMTS)—NTP Methadone Dosing, NTP Individual Counseling, and NTP Group Counseling—may be billed to DMC without the results of OHC adjudication where the provider has determined that the client does not have OHC benefits available for the services provided. These services should be billed following the general rule for billing DMC without OHC billing results.

#### 4.2.3.2.3 Minor Consent Services for clients with OHC

When confidential Minor Consent services are provided to an eligible client who does not have a Minor Consent aid code, and the client has OHC available, the OHC does not need to be billed. These services should be billed following the general rule for billing DMC without OHC billing results.

#### 4.2.3.2.4 Presumed Denials

In certain circumstances described in ADP Bulletin #11-01, ADP permits trading partners to presume that an OHC carrier has denied a claim for reimbursement for particular DMC services without receiving adjudication results for the specific services from the OHC carrier. In these circumstances, because the services have not been adjudicated by the OHC carrier, trading partners should bill the services according to the general rule for billing DMC without OHC results. Circumstances permitting billing based on a presumed denial include:

##### 4.2.3.2.4.1 Delayed or No OHC response

Trading partners may presume that a claim submitted to an OHC carrier has been denied by the OHC carrier when the provider has billed the service to the carrier, as required, and at least 90 days have passed without a response from the OHC, provided that the requirements in ADP Bulletin #11-01 (in items #1 and #2 under “Delayed or No OHC Response”) are met.

If, after the claim has been billed to DMC, payment is received from the OHC, a Replacement Claim must be submitted to update the Coordination of Benefits (COB) information for the claim to reflect the payment received.

If, after the claim has been billed to DMC, a denial is received from the OHC for a reason which does not permit billing DMC (as described in ADP Bulletin #11-01), then a Void Claim must be submitted to retract the claim submitted based on the presumed denial.

#### 4.2.3.2.4.2 Prospective Denial Letter

As stated in ADP Bulletin No. 11-01 (#3 and #4 under "Delayed or No OHC Response"), trading partners may presume that a claim submitted to an OHC carrier has been denied when they have received an acceptable notification that future claims meeting specific criteria will not be accepted. When a service is provided in circumstance covered by a notice meeting the requirements laid out in ADP Bulletin #11-01, providers may bill the service to DMC.

### 4.2.3.2.5 OHC policies that do not apply to DMC

Certain OHC policies are known to the State to categorically exclude coverage of the services provided through the DMC program, including Medicare and certain other OHC policies identified in State eligibility records with coding indicating that they do not have the type of coverage which might include DMC services. Which OHCs do and do not apply to DMC services is discussed in detail in ADP Bulletin #11-01. DMC services provided to clients with OHC that does not apply to DMC do not need to be billed to the OHC, and no information about the OHC needs to appear in DMC claims for such services.

## 4.2.3.3 Presumed Denials

### 4.2.3.3.1 General Rule for Presumed Denials

In certain circumstances, ADP permits trading partners to presume that an OHC carrier has denied a claim for reimbursement for particular DMC services without receiving adjudication results for the specific services from the OHC.

### 4.2.4 ICD-9 Codes

| ICD-9-CM Diagnostic Code | ICD-9-CM Description |
|---|---|
| 303.00 | Acute Intoxication with Alcoholism |
| 303.90 | Other And Unspecified Alcohol Dependence - Unspecified |
| 304.00 | Opioid Type Dependence - Unspecified |
| 304.10 | Barbiturate And Similarly Acting Sedative Or Hypnotic Dependence - Unspecified |
| 304.20 | Cocaine Dependence - Unspecified |
| 304.30 | Cannabis Dependence - Unspecified |
| 304.40 | Amphetamine And Other Psychostimulant Dependence - Unspecified |
| 304.50 | Hallucinogen Dependence - Unspecified |
| 304.60 | Other Specified Drug Dependence - Unspecified |
| 304.70 | Combinations of Opioid Type Drug With Any Other - Unspecified |
| 304.80 | Combinations Of Drug Dependence Excluding Opioid Type Drug - Unspecified |
| 304.90 | Unspecified Drug Dependence - Unspecified |
| 305.00 | Alcohol Abuse - Unspecified |
| 305.20 | Cannabis Abuse - Unspecified |
| 305.30 | Hallucinogen Abuse - Unspecified |
| 305.40 | Barbiturate And Similarly Acting Sedative Or Hypnotic Abuse - Unspecified |
| 305.50 | Opioid Abuse - Unspecified |
| 305.60 | Cocaine Abuse - Unspecified |
| 305.70 | Amphetamine or Related Acting Sympathomimetic Abuse - Unspecified |
| 305.80 | Antidepressant Type Abuse - Unspecified |
| 305.90 | Other, Mixed, Or Unspecified Drug Abuse - Unspecified |

### 4.2.5 Adjustment Reason Codes

| Group Code | Adjustment Reason Code | Health Remark Code | Adjustment Reason Code Description |
|---|---|---|---|
| CO | 10 | N/A | Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates this client is male. |
| CO | 11 | N/A | Perinatal service billed, but beneficiary is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided.) |
| CO | 16 | N354 | The claim (Original/Void/Replacement) is an invalid bridge resubmission claim. |
| CO | 18 | N/A | This service is not allowed on the same date as a previously-approved service for this beneficiary without a valid multiple service procedure modifier. |
| CO | 22 | N/A | MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that that coverage has been billed first. |
| CO | 23 | N/A | Coordination of benefits adjustment. |
| CO | 29 | N/A | Claim denied for late submission. |
| CO | 31 | N/A | Beneficiary aid code(s) do not indicate eligibility for Drug Medi-Cal services. |
| CO | 45 | N/A | Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service. |
| CO | 89 | N/A | Administrative Fees retained by State. |
| CO | 109 | N/A | Claim denied because perinatal and non-perinatal services are billed together. Re-bill perinatal and non-perinatal services on separate claims. |
| CO | 110 | M52 | Service date cannot be later than submission date. |
| CO | 119 | N345 | Service line denied because a service (other than NTP counseling) was billed with a number of units different from the number of days billed. |
| CO | 119 | N362 | Service denied because it would exceed limit of 20 units of NTP counseling service per month or it exceeds 1 unit of service for ODF, DCR (Day Care Rehabilitative), RES (Residential) or NAL (Naltrexone) beneficiary. |
| CO | 129 | N/A | The submitted Void or Replacement claim is not eligible to be Voided or Replaced. |
| CO | 137 | N/A | The Non-Federal portion of approved services to be paid with realignment funds. |

| Group Code | Adjustment Reason Code | Health Remark Code | Adjustment Reason Code Description |
|---|---|---|---|
| CO | 138 | N/A | Claim denied because service dates on claim include more than one calendar month. Re-bill in separate claims for each calendar month of service. |
| CO | 143 | N/A | Portion of payment for approved services deferred due to insufficient contract balance. |
| CO | 163 | N/A | Claim denied because it was submitted late, a delay reason code requiring certification was provided and a certification attachment was referenced in the claim, but the certification attachment either was not received or did not cover this claim. |
| CO | 167 | M76 | Service line denied because no diagnosis pointer provided in SV107 references a covered diagnosis code for Drug Medi-Cal services. |
| CO | 177 | N/A | Claim denied because client is ineligible per MEDS. |
| CO | 208 | N257 | Claim denied because Billing Provider EIN and NPI combination is not valid per ADP provider records. |
| CO | A1 | N480 | Claim or service line denied because COB information provided is not balanced.<br><br>At the claim level, the Total Claim Charge Amount provided in the Loop 2300 Claim Information (CLM) segment must equal the Other Payer Paid Amount reported in Loop 2320 plus the sum of all adjustment amounts reported in Claims Adjustment (CAS) segments in Loops 2320 and Line Adjustment (CAS) segments in 2430 for this other payer.<br><br>At the service line level, the Line Item Charge Amount provided in the Loop 2400 Professional Service (SVC) segment must equal the Service Line Paid Amount provided in the Loop 2430 Line Adjudication Information (SVD) segment, plus the sum of all Adjustments Amounts reported in Line Adjustment (CAS) segments in Loop 2430. |
| CO | A1 | M51 | Service line denied because the procedure codes and modifiers provided do not identify a Drug Medi-Cal service. |
| CO | A1 | M59 | Service line denied because service “to” date proceeds “from” date. |
| CO | A1 | M80 | This service is not allowed on the same date as one or more previously-approved services for this beneficiary. |
| CO | A1 | N63 | Service line denied because a service other than NTP Methadone Dosing was billed with a date range rather than a single date of service. |
| CO | A1 | N142 | Void/Replacement claim denied because the original claim is an invalid resubmission claim. |
| CO | A1 | N421 | Service line denied due to disallowance from post-service, post-payment utilization review. |
| CO | B7 | N/A | Service line denied because the Service Facility Location was not a Drug Medi-Cal -certified site for the identified service on the date(s) of service. |

| Group Code | Adjustment Reason Code | Health Remark Code | Adjustment Reason Code Description |
|---|---|---|---|
| CO | B7 | MA114 | Service line denied because the Service Facility Location is not one for which the Billing Provider may submit claims for the date(s) of service.<br><br>If Service Facility Location provider type is 'Sole Proprietor' and the zip code +4 of SFL provider on claim/service line does not equal zip code +4 in ADP's provider file then deny service line. |
| OA | 223 | | Lien and levy recovery |
| PI | 223 | | Recoupement of State General Fund (SGF) due to realignment. |
| PR | 1 | N/A | Service line reimbursement adjusted due to share of cost collected reported by provider. |

### 4.2.6 Claim Supplemental Information – PWK Segment

The PWK segment in Loop 2300 of the 837 transaction set is used to identify that the claim requires manual review of either eligibility documentation or specific delay reason codes. This will allow ADP to identify claims that need additional information sent, hold the claim until the paperwork is received, and to complete a manual override of a claim.

There are two situations where the presence of a PWK segment will cause the SD/MC Phase 2 system to act:

1. If there is documentary evidence that a beneficiary was actually eligible for a service that was previously (or would be) denied for eligibility reasons – the submitter may include a PWK segment with a report type code = "OZ" this will cause the claim to be routed for manual review prior to adjudication.

2. When a submitter uses specific late reason codes the submitter is required to include a PWK segment with report type code = "CT" for manual review of the claim prior to adjudication.

The following delay reason codes require the PWK segment:

| HIPAA Delay Reason Code | HIPAA Description | Description | PWK Required? |
|---|---|---|---|
| 8 | Delay in Eligibility Determination | Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county. | YES |
| 4, 11 | 4 = Delay in Certifying Provider<br>11 = Other | Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable. | YES |

When using the PWK segment the following field values should be used:

| Field Name | Field Value |
|---|---|
| PWK01 | “OZ” or “CT” |
| PWK02 | “BM” or “FX” |
| PWK05 | “AC” |
| PWK06 | A control number that ties the request, to the paper you will be sending via fax or mail. |

## 4.3 Frequently Asked Questions

There are no frequently asked questions.

### 4.4 Other Resources

Drug Medi-Cal billing information can be found on ADP's Drug Medi-Cal billing webpage at http://www.dhcs.ca.gov/services/adp/Pages/DMC_Billing.aspx

# 5 TI Change Summary

| Date | Version | Brief Description of Modifications |
|---|---|---|
| 03/20111 | V 1.1 | 5010 Companion Guide |
| 11/152011 | V 1.2 | Added Methadone Dosing Code "H0020" to SV101-02 Procedure Code |
| 11/15/2011 | V 1.2 | Deleted Table - 005010X214E2 Health Care Claim Acknowledgement |
| 01/13/2012 | V 1.3 | Revised Section 4.2.3 to provide instructions for completing transactions for denied Narcotic Treatment Provider (NTP) claims due to Other Health Coverage (OHC), and submission of prospective NTP claims with OHC based on ADP Bulletin 12-03. |
| 5/09/2012 | V1.4 | 1. Revised Section 3, Table 005010X222 Health Care Claim: Professional Loop 2300 CLM-Claim Information, CLM20 instructions for late claim.<br>2. Revised Notes/Comments field Section 3, Table 005010X222 Health Care Claim: Professional Loop 2300 PWK and Loop 2400 PWK<br>3. Added Section 4.2.6 - Claim Supplemental Information – PWK Segment.<br>4. Revised Section 4.2.3.2.1 # 8, changed citation from Loop 2420 to Loop 2430. |
| 07/06/2012 | V1.5 | 1. Revised Section 6.1.2 to reflect new URL to submit EDI file as of July 1, 2012.<br>2. Added 2 Adjustment Reason Codes (CO137 and COA1N480) to Section 4.2.5. |
| 11/08/2012 | V1.6 | 5010 Companion Guide has been updated to meet the requirements addressed by ASCX12. |

# Short-Doyle Medi-Cal Phase II

# ADP

## Standard Companion Guide Trading Partner Information

## Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

**Companion Guide Version Number: 1.0**

**August 6, 2013**

# Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Trading Partner Information) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 Implementation Guide (IG) (Transaction Instructions). Either the Trading Partner Information component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Trading Partner Information component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12’s copyrights and Fair Use statement.

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# Trading Partner Information (TP)

## 1 TP Introduction

### 1.1 Purpose

This document is intended to provide information from the author of this guide to trading partners to give them the information they need to exchange EDI data with the author. This includes information about registration, testing, support, and specific information about control record setup.

### 1.2 Scope

The scope of this guide is to provide instructions on how to use Control Segments/Envelopes and to list the type of Acknowledgements or Reports generated by the Short Doyle system. Process flow diagrams are also included.

### 1.3 Overview

[This section specifies how to use the various sub-sections of the section in combination with each other.]

### 1.4 References

Drug-Medical Providers gain access to Short Doyle to adjudicate EDI transactions via the Department of Health Care Service's (DHCS) Information Technology Web System (ITWS). Additional information on submitting and returning files via ITWS, including Enrollment information, is available and can be found at https://itws.dhcs.ca.gov.

### 1.5 Additional Information

There is no additional information at this time.

## 2 Getting Started

### 2.1 Working Together

Drug-Medical Providers may contact DHCS by phone or email using the contact information included in Section 5 of this Appendix.

### 2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity.

Drug-Medical Providers register to be a Trading Partner through the IITWS enrollment process. Vendors register through the Drug-Medical Providers.

### 2.3 Trading Partner Testing and Certification Process

DHCS has no separate Testing and Certification process. All Trading Partners are eligible to submit test claims upon enrollment.

# 3 Testing and Certification Requirements

### 3.1 Testing Requirements

DHCS has no separate Testing requirements. All Trading Partners are eligible to submit test claims upon enrollment.

### 3.2 Certification Requirements

DHCS has no separate Certification requirements. All Trading Partners are eligible to submit EDI transactions upon enrollment.

# 4 Connectivity / Communications

### 4.1 Process flows

[This section contains process flow diagrams and appropriate text.]

### 4.2 Transmission Administrative Procedures

**Preparing EDI for Upload**

EDI to be submitted to ADP must:

1. Be contained in ASCII text files named according to the following convention (bold portions are literal text):

   **ADP-***organization***-***transaction***-***date***-***sequence***.DAT** where:

- *organization* is the identifier of the organization on ITWS through which the file will be sent (this will either be a two-digit county code or four-character Drug Medi-Cal identifier.)
- *transaction* identifies the kind of X12 transaction set(s) that are included in the file (SDMC system limitations allow only one type of transaction in a single uploaded file, regardless of how many interchange envelopes or functional groups are included in the file.) This must be one of:
    - "837P" for Health Care Claim: Professional transaction sets, or
    - "276" for Health Care Claim Status Request transaction sets.

2. Have the ASCII text file included (with no other files) in a password-protected ZIP archive with the same filename as the ASCII text file, except that the ".DAT" extension is replaced with ".ZIP".
3. The password used to protect the ZIP archive must be the standard password for the organization on ITWS through which the file will be sent. The standard password is available on the ITWS "System Messages" screen.

**Submitting EDI via ITWS**

To submit EDI prepared according to the preceding instructions to ADP:

1. Log on to ITWS (https://itws.dhcs.ca.gov) with your assigned user name and password.
2. From the *Systems* tab, select *Short-Doyle/Medi-Cal – EOB (for ADP)*.
3. From the *Functions* tab, select *Upload*.
4. Click the *Browse* or *Add* button to choose the zip file to upload.
5. Click the *Upload* button.
6. Select *Processing Status* link from the *Functions* tab to see the status of the file.

### 4.2.1 Re-transmission procedures

If the file fails the HIPAA validation, the file must be resubmitted with a different file name. Please note that the submission date of a file that has failed the HIPAA validation will not be used for the subsequent re-submissions.

A new file name requires a new, signed MH1982A form only if the total dollar amount being claimed changes. Common problems that do not affect the total dollars being claimed include:

a. One or more file names are constructed incorrectly.
b. There is a mismatch between two or more file names (excluding the extension).
c. The PDF or the DAT file is omitted from the compressed file.
d. The compressed file is not password protected.
e. An incorrect password was used to protect the compressed file.
f. ITWS fails to successfully transmit a file.

In these cases, the submitter can fill in the "Revised File Name" block and use the revised form as part of their submittal.

## 4.3 Communication Protocols

DHCS Information Technology Web Services (ITWS) website is the primary communication method to exchange the EDI transactions between trading partners and DHCS.

## 4.4 Security Protocols

ITWS uses Hypertext Transfer Protocol Secure (HTTPS) protocol. Therefore, all the electronic communication between trading partner computers and ITWS web server is encrypted.

# 5 Contact information

## 5.1 EDI Customer Service

[This section contains detailed information concerning EDI Customer Service, including contact numbers.]

## 5.2 EDI Technical Assistance

[This section contains detailed information concerning EDI Technical Assistance, including contact numbers.]

## 5.3 Provider Services

[This section contains detailed information concerning Provider Services, including contact numbers.]

## 5.4 Applicable websites / e-mail

[This section contains detailed information about useful web sites and email addresses.]

# 6 Control Segments / Envelopes

## 6.1 ISA-IEA

| Loop ID | Reference | Name | Codes | Cat. | Notes/Comments |
|---|---|---|---|---|---|
| | **ISA** | **INTERCHANGE CONTROL HEADER** | | 2 | All outbound EDI from ADP will use the following separators:<br>"*" (Asterisk) Data Element Separator<br>":" (Colon) Component element Separator<br>"~" (Tilde) Segment Terminator<br>"^" (Caret) Repetition Separator |
| | ISA01 | Authorization Information Qualifier | | 3 | This data element is not processed by SDMC. |
| | ISA02 | Authorization Information | | 3 | This data element is not processed by SDMC. |
| | ISA03 | Security Information Qualifier | | 3 | This data element is not processed by SDMC. |
| | ISA04 | Security | | 3 | This data element is not processed by SDMC. |

| Loop ID | Reference | Name | Codes | Cat. | Notes/Comments |
|---|---|---|---|---|---|
| | | Information | | | |
| | ISA05 | Interchange ID Qualifier | 30 | 2 | ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively. |
| | ISA06 | Interchange Sender ID | | 2 | ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively. On EDI submitted to ADP, always identify the county or direct contract provider on whose behalf the EDI is being submitted. Trading partners must not include hyphens in the Tax ID. |
| | ISA07 | Interchange ID Qualifier | 30 | 2 | ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively. |
| | ISA08 | Interchange Receiver ID | | 2 | ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively. |
| | ISA11 | Repetition Separator | | 2 | All outbound EDI from ADP will use the caret (“^”) as the Repetition Separator. |
| | ISA16 | Component Element Separator | | 2 | All outbound EDI from ADP will use the colon (“:”) as the Component Element Separator. |

## 6.2 GS-GE

| Loop ID | Reference | Name | Codes | Cat. | Notes/Comments |
|---|---|---|---|---|---|
| | **GS** | **FUNCTIONAL GROUP HEADER** | | | |
| | GS02 | Application Sender Code | | 2 | ADP requires Application Senders and Receivers to be identified by their Federal Tax ID exclusively. Do not include hyphens in the Tax ID. |
| | GS03 | Application Receiver Code | | | ADP requires Application Senders and Receivers to be identified by their Federal Tax ID exclusively. Do not include hyphens in the Tax ID. |
| | **TA1** | **INTERCHANGE ACKNOWLEDGEMENT** | | | |
| | TA104 | Interchange Acknowledgement Code | A, R | 6, 8 | ADP will always reject an interchange where errors are noted, so “A” and “R” are the only values that will be returned for this element. |

### 6.3 ST-SE

There are no additional instructions at this time.

# 7 Acknowledgements and Reports

| Loop ID | Reference | Name | Codes | Cat. | Notes/Comments |
|---|---|---|---|---|---|
| | **TA1** | **INTERCHANGE ACKNOWLEDGEMENT** | | | |
| | TA104 | Interchange Acknowledgement Code | A, R | 6, 8 | ADP will always reject an interchange where errors are noted, so “A” and “R” are the only values that will be returned for this element. |

### 7.1 ASC X12 Acknowledgments

Short-Doyle Phase II system returns the following X12 acknowledgements upon receipt of an EDI file.

- Interchange Acknowledgment, TA1
- Implementation Acknowledgment, 999

### 7.2 Report Inventory

Short-Doyle Phase II system returns the following proprietary acknowledgements upon receipt of an EDI file.

- SNIP Report (html format)

# 8 Additional Trading Partner Information

## 8.1 Implementation Checklist

There is no information at this time.

## 8.2 Transmission Examples

There is no information at this time.

## 8.3 Trading Partner Agreement

EDI Trading Partner Agreements ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

[This section may also contain the publishing entity's actual Trading Partner Agreement or a link to a copy of the trading partner agreement.]

## 8.4 Frequently Asked Questions

There is no information at this time.

## 8.5 Other Resources

There is no information at this time.

# 9 TP Change Summary

| Version | Date | Section(s) changed | Change Summary |
|---|---|---|---|
| 1.0 | 8/24/2012 | All | Initial Version |