



Mental Health Medi-Cal Billing Manual

VERSION 1.0
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MENTAL HEALTH MEDI-CAL BILLING MANUAL

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1. INTRODUCTION

MENTAL HEALTH MEDI-CAL BILLING MANUAL

Chapter 1: Introduction

1 Introduction

The Short-Doyle/Medi-Cal (SD/MC) claims processing system enables California county Mental Health Plans (MHPs) to obtain reimbursement of Federal funds for medically necessary specialty mental health services¹ provided to Medi-Cal-eligible beneficiaries and to Healthy Families subscribers diagnosed as Seriously Emotionally Disturbed (SED).² The Mental Health Medi-Cal program oversees the SD/MC claims processing system. This manual provides information about the system. This chapter includes:

- [About This Manual](#)
- [Program Background](#)
- [Authority](#)
- [The DMH Medi-Cal Claims Customer Service Office](#)

1.1 About This Manual

The Mental Health Medi-Cal billing manual is a publication of the California Department of Mental Health (DMH), which administers the Mental Health Medi-Cal program. The manual is designed to provide a guide to claims processing procedures. California regulations, the SD/MC Claims Processing System, Health Insurance Portability and Accountability Act (HIPAA), Trading Partner Companion Guide for the 837 Professional and Institutional Health Care Claims, and the 835 Payment Advice³ (commonly known as the HIPAA Companion Guide)⁴ are the authorities for the subjects covered in this manual.

1.1.1 Objectives

The primary objectives of the manual are to:

- Provide uniform procedures and requirements for claiming
- Provide claiming system overviews and process descriptions
- Provide relevant links related to:
 - State and Federal laws and regulations
 - DMH policy letters and information notices
 - Reference documents such as DMH system user guides, the HIPAA Companion Guide, HIPAA Implementation Guides,⁵ etc.

¹ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.247.

² Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

³ HIPAA transactions are commonly referred to by their transaction set/version such as: 837I (Institutional) transactions, 837P (Professional) transactions, and 835 Health Care Claim Payment/Advice transactions.

⁴ California Department of Mental Health (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide for the 837 Professional and Institutional Health, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

⁵ Retrieved July 1, 2008 from: I:\ProjDocs\HIPAA\Implementation Guides\4010 Implementation Guides

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Chapter 1: Introduction

1.1.2 Scope

The Table of Contents provides the scope of this manual. The scope is a product of stakeholder input. Stakeholders include county MHPs and their designated staff members and DMH staff.

This manual is not intended to duplicate the content of the HIPAA Companion Guide.⁶ However, key concepts from that manual have been reiterated in this manual to explain the DMH/DHCS Mental Health Medi-Cal claiming process.

1.2 Program Background

Medicaid was established by the Federal government. The Medicaid program provides services to certain groups of people with limited income and resources and the aged, blind and disabled. Although the Federal government establishes general guidelines for the program and participates financially, States operate and administer Medicaid.

Each Federally-approved State plan must designate a single State agency responsible for administration of its State Medicaid Program plan. In the case of California's Medicaid program (known as Medi-Cal), the Department of Health Care Services (DHCS) is the single responsible State agency.

DHCS delegates administrative responsibility for specialty mental health services to DMH. However, there are some critical areas where DHCS retains responsibility for Medi-Cal operations affecting mental health clients. Examples include:

- Establishing Aid codes⁷
- Maintaining eligibility information technology systems such as the Medi-Cal Eligibility Determination System (MEDS)
- Adjudicating SD/MC Mental Health Medi-Cal claims
- Processing claims for Federal Financial Participation (FFP) payments

For services meeting FFP cost-sharing requirements, the cost of mental health services is paid through a combination of county, State, and Federal funds. The FFP sharing ratio is determined on an annual basis and known as the Federal Medical Assistance Program (FMAP) percentage. The county share is funded by a combination of State realignment funds, State managed care allocations, State General Fund (SGF) monies, local county funds and other sources such as local grants.

1.3 Authority

Authority for the Mental Health Medi-Cal program is governed by Federal and California statutes.

⁶ Cal. DMH (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

⁷ Retrieved July 1, 2008 from: https://mhitws.cahwnet.gov/docs/public/reference_information.asp

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Chapter 1: Introduction

1.3.1 *The Social Security Act*

Federal Social Security Act Title XIX⁸ provides the basis for development of each State's Medicaid plan.

1.3.2 *The Health Insurance Portability and Accountability Act of 1996*

The Code of Federal Regulations (CFR) provides statutory authority for the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II).⁹

1.3.3 *The Welfare and Institutions Code (W&I) Code*

The California Welfare and Institutions (W&I) Code provides statutory authority for the Mental Health Medi-Cal program and implements legislation.

1.3.4 *The California Code of Regulations (CCR)*

State regulations applicable to DMH are found in CCR, Title 9.¹⁰

1.4 **The DMH Medi-Cal Claims Customer Service Office**

The Medi-Cal Claims Customer Service Office provides counties with direct access to a central office to address claim payment issues, offer technical assistance on claim processing, and ensure accurate and timely submission and processing of claims.

For assistance, call (916) 651-3283 or email MedCCC@dmh.ca.gov.

⁸ Grants to States for Medical Assistance Programs, 42 U.S.C. § 1396-1396v, Subchapter XIX, Chapter 7 (1965).

⁹ Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d –1320d-8, Public Law 104-191, § 262 and § 264; also 45 C.F.R., Subchapter C, Parts 160, 162 and 164.

¹⁰ Cal. Code Regs., Title 9, Division 1, Chapters 1-14.

2. GETTING STARTED

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Chapter 2: Getting Started

2 Introduction

This chapter provides the requirements that must be met before submitting claims, including:

- [Enrolling in ITWS](#)
- [DMH Legal Entity and Provider Numbers and National Provider Identifiers](#)
- [Enrolling Providers and Certifying them for Medi-Cal](#)
- [Provider Data Files](#)
- [Online Provider System \(OPS\)](#)
- [HIPAA Testing and Certification](#)

2.1 Enrolling in ITWS

The DMH Information Technology Web Services (ITWS) is a collection of web applications that allow DMH business partners to access information securely over the Internet. Requests for access to specific areas of ITWS are approved by 'approvers' appointed by each county director.¹¹

For basic information related to ITWS enrollment and uploading claim files, a Virtual Tour is available.¹² For further information, please call ITWS Administration at (916) 654-3445 or use the ITWS contact pages.¹³

2.2 DMH Legal Entity and Provider Numbers, and National Provider Identifiers

All MHP providers must have both a DMH Legal Entity Number and a DMH Provider Number. DMH Provider Numbers are unique 4-digit numbers used to distinguish one or more of a Legal Entity's facilities that deliver both Medi-Cal and non-Medi-Cal mental health services. The DMH Provider File Update form (MH 3829) located on ITWS is used to request and update DMH Provider Numbers.¹⁴

Legal Entity is a corporation, individual, or county that owns a facility offering mental health services. DMH assigns unique 5-digit Legal Entity Numbers for cost reporting purposes. The Legal Entity File Update form (MH 3840) located on ITWS is used to request and update Legal Entity Numbers.¹⁵

Federal HIPAA regulations require that individual health care providers and organizations obtain a National Provider Identifier (NPI). DHCS maintains a website providing information about obtaining an NPI.¹⁶ Counties must identify by NPI the rendering provider and the billing and service facility provider locations in 837 health care claims transactions. Prior to NPI, DMH assigned a 4-digit DMH Provider Number for use in the SD/MC claiming system. Because the legacy SD/MC system only recognizes

¹¹ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/docs/public/authforms.asp>

¹² Retrieved July 1, 2008 from: https://mhhitws.cahwnet.gov/demo/How%20to%20Enroll_files/frame.htm

¹³ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/docs/public/contact.asp>

¹⁴ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

¹⁵ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

¹⁶ Retrieved July 1, 2008 from: <http://files.medi-cal.ca.gov/pubsdoco/npi/npi.asp>

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Chapter 2: Getting Started

the pre-NPI, 4-digit DMH Provider Number, DMH has built a crosswalk (cross-reference table) that converts the NPI on the 837 transaction into a 4-digit DMH Provider Number on the proprietary claim record processed by the SD/MC claim system.

Counties must submit to DMH the Service Facility Location NPI that corresponds to the 4-digit DMH Provider Number for each Medi-Cal provider. DMH enters the Service Facility Location NPI into the Online Provider System (OPS) and associates it with the 4-digit DMH Provider Number. Counties may access OPS via ITWS to verify that the NPI information was entered correctly.

2.3 Enrolling Providers and Certifying for Medi-Cal Services

Instructions for enrolling providers can be found on ITWS in the Provider/Legal Entity System Enrollment Guide¹⁷ and the Provider System Documentation manual.¹⁸ Additional information can be found in the Provider Pamphlet.¹⁹

The Medi-Cal Certification and Transmittal form is found on ITWS²⁰ and in the Provider System Documentation.²¹ The form is used for Mental Health Medi-Cal provider certification and DMH approval. This form also includes activation, termination and recertification dates. The information it contains is critical in determining not only when a provider may deliver services but also what services an MHP is allowed to bill through the SD/MC claiming system for that provider. Certifications for providers are specific to both Modes of Service and Service Function codes.

2.4 Provider Data Files

DMH maintains a Provider File that lists all MHP providers. The information in the Provider File includes the name, address, Modes of Service, Service Functions, Medi-Cal certification, and their associated NPI. These terms are defined on ITWS in the Provider File Information/Provider System Documentation.²²

To add a DMH Provider Number to the DMH Provider File, a provider must first have a Legal Entity Number listed in the Legal Entity File.

2.5 Online Provider System (OPS)

OPS²³ is a web-based system that provides authorized users real-time access to information about mental health providers and the Legal Entities that own those providers. To access OPS, a county must first enroll in ITWS, and then use the **Request**

¹⁷ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/docs/public/enrollmentGuides.asp>

¹⁸ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):
<https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

¹⁹ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

²⁰ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):
<https://mhhitws.cahwnet.gov/systems/cfrs/docs/private/forms.asp>

²¹ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):
<https://mhhitws.cahwnet.gov/systems/provider/docs/private/systemdocs.asp>

²² Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):
<https://mhhitws.cahwnet.gov/systems/provider/docs/private/systemdocs.asp>

²³ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/itws/Provider/>

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Chapter 2: Getting Started

Additional Membership link. Additional information about OPS is available through a DMH Information Notice.²⁴

2.6 HIPAA Testing and Certification

The HIPAA Companion Guide²⁵ provides the testing/certification steps required to meet HIPAA validation and SD/MC processing requirements. It also includes the necessary information for counties to format HIPAA compliant claims.

²⁴ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-15.pdf>

²⁵ Cal. DMH (2007, June). HIPAA Testing and Certification. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

3. CLIENT ELIGIBILITY

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Chapter 3: Client Eligibility

3 Introduction

This chapter includes information about the Medi-Cal eligibility. It includes:

- [Client Eligibility](#)
- [Aid Codes](#)

3.1 Client Eligibility

The sections below describe Medi-Cal Eligibility Determination and Medi-Cal Eligibility Review.

3.1.1 Eligibility Determination

Procedures for determining Medi-Cal eligibility are the responsibility of DHCS. The determination and collection of client eligibility data typically lies with the county social services department. Detailed information regarding eligibility criteria may be obtained through the DHCS website.²⁶ DHCS Provider Bulletins and manuals provide information for all Medi-Cal programs, including mental health care.²⁷

The following concepts regarding Medi-Cal eligibility are key to the management of Mental Health Medi-Cal claiming. Throughout this manual they will be discussed in different contexts:

- Medi-Cal eligibility is determined on a monthly basis. For this reason, Mental Health Medi-Cal claims processing requires the ongoing review and management of client Medi-Cal eligibility data.
- Verification of client Medi-Cal eligibility is often reviewed by external auditors after the claimed month of service. For this reason, MHPs must maintain proof of how client Medi-Cal eligibility was verified.
- Medi-Cal eligibility may require a client Share of Cost (SOC) be met before Medi-Cal will pay for any services. Medi-Cal SOC is discussed elsewhere in this manual.
- Clients who are eligible for Social Security Supplemental Security Income (SSI) are also Medi-Cal eligible. Information on SSI may be obtained through the Federal Social Security Administration website.²⁸
- Medi-Cal eligibility may be established retroactively through court hearings or decisions.
- California Healthy Families Program²⁹ eligibility is based on the Federal State Children's Health Insurance Program (SCHIP)³⁰ designed for children whose

²⁶ Retrieved July 1, 2008 from:

<http://www.dhs.ca.gov/mcs/mcpd/meb/ACLs/Index/2007ACWDLs/10thru19.htm>

²⁷ Retrieved July 1, 2008 from: <http://www.medi-cal.ca.gov/publications.asp>

²⁸ Retrieved July 1, 2008 from: <http://www.ssa.gov/pubs/11000.html>

²⁹ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-01.pdf>

³⁰ Retrieved July 1, 2008 from: <http://www.cms.hhs.gov/home/schip.asp>

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Chapter 3: Client Eligibility

family income is below a State-established level but above the level qualifying for Medi-Cal. California has incorporated Healthy Families Plan members into the Medi-Cal eligibility system through beneficiary Aid codes.

- The HIPAA 270/271 transactions are available from DHCS to verify client Medi-Cal eligibility³¹.

3.1.2 Eligibility Review

Once Medi-Cal eligibility is determined by DHCS procedures, beneficiary eligibility information may be reviewed through different methods. However, with few exceptions, the source of this eligibility verification information will always be from the DHCS Point of Service (POS) system³².

3.2 Aid Codes

Aid codes are codes assigned to Medi-Cal-eligible individuals during the application/enrollment process and indicate the program under which the individual qualifies for services.

The most current version of the DMH Aid code list can be found on ITWS.³³ It provides useful information in the following categories:

- Federal Financial Participation (FFP) percentage
- Aid code
- Type of benefits
- Share of Cost
- Code description
- Indication of reimbursement through the DHCS Fiscal Intermediary Management Division, Alcohol and Drug Programs (ADP),³⁴ Mental Health Programs, and/or EPSDT³⁵ programs.

³¹ Retrieved July 1, 2008 from: http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaaspecs_home.asp

³² Retrieved July 1, 2008 from: <https://www.medi-cal.ca.gov/Eligibility/Services.asp>

³³ Retrieved July 1, 2008 from: https://mhitws.cahwnet.gov/docs/public/reference_information.asp

³⁴ Retrieved July 1, 2008 from: <http://www.adp.ca.gov>

³⁵ Retrieved July 1, 2008 from: http://www.dmh.ca.gov/DMHDocs/docs/letters01/01-07_Enclosure_A.pdf

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Chapter 3: Client Eligibility

4. COVERED SERVICES AND LIMITATIONS

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Chapter 4: Covered Services and Limitations

4 Introduction

This chapter provides explanations of covered services and limitations related to Mental Health Medi-Cal claiming. It also explains key concepts about the way claims are processed. It includes:

- [Modes of Service](#)
- [Service Function Codes](#)
- [HIPAA: Converting Modes of Service/Service Function Codes](#)
- [HCPCS and CPT Codes Used to Bill Other Healthcare Payers](#)
- [Staffing Requirements](#)

4.1 Modes of Service

Mode of Service describes a classification of service types used for Client and Services Information system (CSI) and Cost Reporting. This allows any mental health service type recognized by DMH to be grouped with similar services. The Modes of Service used by Cost Reporting are:

- 00 (Administration)
- 05 (24 Hour Services)
- 10 (Less than 24 Hour Day Treatment Program Services)
- 15 (Outpatient Services)
- 45 (Outreach Services)
- 55 (Medi-Cal Administrative Activities)³⁶
- 60 (Client Support and Care)

Direct treatment Modes of Service used by both CSI and Mental Health Medi-Cal are:

- 05 (24 Hour Services)
- 10 (Less than 24 Hour Day Treatment Program Services)
- 15 (Outpatient Services)

For Mental Health Medi-Cal, these Modes of Service are mapped to Procedure and Revenue codes for the 837 transaction. Medi-Cal reimbursement in any other Mode of Service is through interim payment (MH1982 B and MH1982 C) or the Cost Reporting process.

4.1.1 Proprietary Billing Format

The proprietary SD/MC claiming system uses Medi-Cal Modes of Service. These Medi-Cal Modes of Service differ from the Cost Reporting Modes of Service. Since prior to

³⁶ Medi-Cal Administrative Activities (MAA) are billed and paid through a paper claim (MH1982D).

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Chapter 4: Covered Services and Limitations

HIPAA, county and state systems were designed to bill and adjudicate claims in their proprietary formats, the HIPAA Companion Guide³⁷ provides guidance on crosswalking the Medi-Cal Modes of Service to the related HIPAA 837 Service codes. The proprietary billing Modes of Service are defined as follows:

- 05, 07, 08, and 09 (24 Hour Services)
- 12 (Outpatient Hospital Services)
- 18 (Non-Residential Rehabilitative Treatment)

TABLE 4-1: MODES OF SERVICE

24-HOUR SERVICES DESCRIPTION	
These are services that provide a therapeutic environment of care and treatment within a 24-hour setting.	
MODE	SETTING(S)
05	Psychiatric Health Facility; Adult Crisis Residential; Adult Residential
07	Inpatient Hospital Services of an acute care general hospital
08	Psychiatric Hospital Services for individuals under 21
09	Psychiatric Hospital Services for individuals age 65 and older

NON 24-HOUR SERVICES DESCRIPTION	
These services provide short-term or sustained therapeutic intervention for beneficiaries experiencing acute and/or ongoing psychiatric distress.	
MODE	SETTING(S)
12	Outpatient Hospital Services
18	Non-Residential Rehabilitative Treatment

4.2 Service Function Codes

Service Function codes are used in CSI and Cost Report information systems and in the proprietary claiming system. They identify the specific type of service received under a Mode of Service. Service Function codes include any number from 01-99 (although codes 80 and 90 are not used). They are necessary for classifying county service and service cost data at a very specific level.

Examples for Mode of Service 15 (Outpatient Services) are:

- Service Function codes 60-69 represent Medication Support services
- Service Function codes 70-79 represent Crisis Intervention services

³⁷ Cal. DMH (2007, June). Chapter 6, Crosswalk Mappings and Other Tables. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

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Chapter 4: Covered Services and Limitations

Service Function codes are not used in 837 transactions. The HIPAA Companion Guide provides guidance on crosswalking Service Function codes to the related HIPAA 837 service procedure codes.

Table 4-2 lists the Mode of Service and Service Function codes. The associated Service Function code can be found in parenthesis below the Mode of Service. If viewing this manual in MS Word or PDF format, click on a hyperlinked Service Function in the list below to go directly to its definition.

TABLE 4-2: MODES OF SERVICE/SERVICE FUNCTION CODES

MODE	MODE OF SERVICE: 24-HOUR	
05, 07, 08, 09 (CSI & Cost Report 05)	Psychiatric Health Facility Adult Crisis Residential Adult Residential Inpatient Hospital Services of an acute care general hospital Psychiatric Hospital Services for individuals under 21 Psychiatric Hospital Services for individuals age 65 and older	
	(SF) RANGE	SERVICE FUNCTION (SF) TITLE
	10–18	Local Hospital Inpatient
	19	Hospital Administrative Days
	20–29	Psychiatric Health Facility
	40–49	Adult Crisis Residential
	65–69	Adult Residential
MODE	MODE OF SERVICE: DAY	
12, 18 (CSI & Cost Report 10)	Outpatient Hospital Services Non-Residential Rehabilitative Treatment	
	(SF) RANGE	SERVICE FUNCTION (SF) TITLE
	20–24	Crisis Stabilization – Emergency Room
	25–29	Crisis Stabilization – Urgent Care
	81–84	Day Treatment Intensive – Half Day
	85–89	Day Treatment Intensive – Full Day
	91–94	Day Rehabilitation – Half Day
	95–99	Day Rehabilitation – Full Day

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Chapter 4: Covered Services and Limitations

CODE	MODE OF SERVICE: OUTPATIENT	
12, 18 (CSI & Cost Report 15)	Outpatient Hospital Services Non-Residential Rehabilitative Treatment	
	(SF) RANGE	SERVICE FUNCTION (SF) TITLE
	01–09	Case Management/Brokerage (Targeted Case Management – TCM)
	10–18	Mental Health Services (MHS)
	19	MHS Professional Inpatient Visit
	30–38	MHS
	39	MHS Professional Inpatient Visit
	40–48	MHS
	49	MHS Professional Inpatient Visit
	50–57	MHS
	58	Therapeutic Behavioral Services
	59	MHS Professional Inpatient Visit
	60–68	Medication Support Services
	69	Medication Support—Professional Inpatient Visit
	70–78	Crisis Intervention
	79	Crisis Intervention—Professional Inpatient Visit

Most of the following Service Function definitions are taken from CCR, Title 9³⁸ with specific subsection references as provided with each definition.

4.2.1 Hospital Inpatient: Title 9, Section 1820.205

Hospital Inpatient services are provided in an acute psychiatric hospital or a distinct acute psychiatric part of a general hospital that is approved by DHCS to provide psychiatric services. These services must be medically necessary for diagnosis or treatment of a mental disorder.³⁹

³⁸ Cal. Code Regs., Title 9.

³⁹ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 2, Article 2, § 1820.205.

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Chapter 4: Covered Services and Limitations

4.2.2 Hospital Inpatient Administrative Day Services: Title 9, Section 1820.220

Administrative day services reimbursement criteria include the following:

During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services. There is no appropriate, non-acute treatment facility in a reasonable geographic area and the hospital documents contacts with a minimum of 5 appropriate, non-acute treatment facilities per week subject to the requirements stated in Title 9, Section 1820.220.⁴⁰

4.2.3 Psychiatric Health Facility: Title 9, Section 1810.236 & Title 22, Section 77001

A Psychiatric Health Facility is a facility licensed under the provisions of CCR, Title 22.⁴¹ For the purposes of this chapter, psychiatric health facilities that have been certified by DHCS as Medi-Cal providers of inpatient hospital services are governed by provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.⁴²

4.2.4 Psychiatric Health Facility Services: Title 9, Section 1820.205 & 1810.237

Psychiatric Health Facility Services are therapeutic or rehabilitative services provided in a psychiatric health facility *other than* a psychiatric health facility as defined above. These services are provided on an inpatient basis to beneficiaries who need acute care (care that meets criteria outlined in CCR, Title 9⁴³) and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.⁴⁴

4.2.5 Adult Crisis Residential Treatment Services: Title 9, Section 1820.208

Adult Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non-institutional residential setting that provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis that does not have medical complications requiring nursing care.

This category includes a range of activities and services that support beneficiaries in their effort to restore, maintain, and apply interpersonal and independent living skills and to access community support systems. Crisis Residential Treatment Service is available 24 hours a day, seven days a week. Activities may include (but are not limited to) assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.⁴⁵ Adult Crisis Residential Treatment Services are provided in Social Rehabilitation Facilities licensed under the provisions of CCR, Title 22,⁴⁶ and certified under the provisions of CCR, Title 9.⁴⁷

⁴⁰ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.220.

⁴¹ Cal. Code Regs., Title 22, Chapter 9, Division 5, § 77001.

⁴² Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.236.

⁴³ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 2, Article 2, § 1820.205.

⁴⁴ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.237.

⁴⁵ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 2, Article 2, § 1820.208.

⁴⁶ Cal. Code Regs., Title 22, Division 6, Chapter 2.

⁴⁷ Cal. Code Regs., Title 9, Division 1, Chapter 3, Article 3.5.

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4.2.6 *Adult Residential Treatment Services: Title 9, Section 1810.203*

Adult Residential Treatment Services are rehabilitative services provided in a non-institutional residential setting for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in a residential treatment program.

This service includes a range of activities and services that support beneficiaries in their effort to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.⁴⁸ Adult Residential Treatment Services are provided in Social Rehabilitation Facilities licensed under the provisions of CCR, Title 22,⁴⁹ and certified under the provisions of CCR, Title 9.⁵⁰

4.2.7 *Crisis Stabilization—Emergency Room: Title 9, Sections 1840.338, 1840.348*

Crisis Stabilization - Emergency Room is a service lasting less than 24 hours provided to (or on behalf of) a patient for a condition that requires a more timely response than a regularly scheduled visit. Service activities include (but are not limited to) assessment, collateral, and therapy. Crisis stabilization differs from crisis intervention in that stabilization is delivered by providers who meet contact, site, and staffing requirements for crisis stabilization described in CCR, Title 9, sections 1840.338⁵¹ and 1840.348.⁵²

Crisis Stabilization must be provided on site at a licensed 24-hour health care facility, as part of a hospital-based outpatient program, at a certified provider site certified to perform crisis stabilization.⁵³

The maximum allowance provided in CCR, Title 22⁵⁴ for 'crisis stabilization-emergency room' shall apply when the service is provided in a 24-hour facility, including a hospital outpatient department.⁵⁵

4.2.8 *Crisis Stabilization—Urgent Care: Title 9, Sections 1840.105*

Crisis Stabilization — Urgent Care follows the same guidelines as 'Crisis Stabilization — Emergency Room' above, except that the maximum allowance for this category shall apply when the service is provided at an appropriate site other than an emergency room.⁵⁶

⁴⁸ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.203.

⁴⁹ Cal. Code Regs., Title 22, Division 6, Chapter 2.

⁵⁰ Cal. Code Regs., Title 9, Division 1, Chapter 3, Article 3.5.

⁵¹ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.338.

⁵² Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.348.

⁵³ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.348.

⁵⁴ Cal. Code Regs., Title 22, Division 3, Chapter 3, Article 7, § 51516.

⁵⁵ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 1, § 1840.105.

⁵⁶ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 1, § 1840.105.

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4.2.9 *Day Treatment Intensive: Title 9, Section 1810.213*

Day Treatment Intensive is a structured, multi-disciplinary program of therapy, which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.⁵⁷

4.2.10 *Day Rehabilitation: Title 9, Section 1810.212*

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.⁵⁸

4.2.11 *Case Management/Brokerage: Title 9, Section 1810.249*

Case Management/Brokerage is a service that assists a patient to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to: communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient's progress; placement services; and plan development.⁵⁹

4.2.12 *Mental Health Services: Title 9, Section 1810.227*

Mental Health Services are individual or group therapy and intervention services designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.⁶⁰

4.2.13 *Mental Health Services — Professional Inpatient Visit*

Mental Health Services — Professional Inpatient Visit are the same as Mental Health Services, except they are provided in a Fee-For-Service inpatient setting (Inpatient Consolidation — IPC) by professional (former Fee-For-Service) staff.

⁵⁷ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.213.

⁵⁸ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.212.

⁵⁹ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.249.

⁶⁰ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.227.

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Chapter 4: Covered Services and Limitations

4.2.14 Medication Support Services: Title 9, Section 1810.25

Medication Support Services are those services that include prescribing, administering, dispensing and monitoring psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the patient.⁶¹

4.2.15 Medication Support — Professional Inpatient Visit

Medication Support Services — Professional Inpatient Visit are the same as Medication Support Services, except they are provided in a Fee-For-Service inpatient setting (IPC) by professional (former Fee-For-Service) staff.

4.2.16 Crisis Intervention: Title 9, Section 1840.338 & 1840.348

Crisis Intervention services last less than 24 hours, to or on behalf of a patient for a condition that requires more timely response than a regularly scheduled visit.

Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in CCR, Title 9 Articles 1840.338⁶² and 1840.348.⁶³

4.2.17 Crisis Intervention — Professional Inpatient Visit

Crisis Intervention — Professional Inpatient Visit services are the same services as Crisis Intervention except that the services are provided in a Fee-For-Service IPC setting by professional (former Fee-For-Service) staff.

4.3 HIPAA: Converting Modes of Service/Service Function Codes

See [Appendix C on Conversion of Local Data Sets](#) for information on this topic.

4.4 HCPCS and CPT Codes Used to Bill Other Healthcare Payers

Mental Health Plans are expected to bill other healthcare payers prior to billing Mental Health Medi-Cal for specialty mental health services. Valid Mental Health Medi-Cal HCPCS claiming codes are found in the HIPAA Companion Guide.⁶⁴

⁶¹ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 1, Article 2, § 1810.225.

⁶² Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.338.

⁶³ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.348.

⁶⁴ Cal. DMH (2007, June). Chapter 6, Crosswalk Mappings and Other Tables. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

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Chapter 4: Covered Services and Limitations

4.5 Staffing Requirements

Staffing requirements are found in CCR, Title 9.⁶⁵

⁶⁵ Cal. Code Regs., Title 9, Division 1, Chapter 3, Article 11.

5. OTHER MENTAL HEALTH CLAIMING

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Chapter 5: Other Mental Health Claiming

5 Introduction

This chapter covers claiming performed outside the SD/MC system. It includes:

- [Inpatient Psychiatric Facilities \(Non-Contract\)](#)
- [Outpatient Claiming](#)
- [AB 3632 Children's Services](#)
- [Administrative, Utilization Review, and Medi-Cal Administrative Activities Claiming](#)
- [Annual Year-end Cost Report](#)

5.1 Inpatient Psychiatric Facilities (Non-Contract)

This section is related only to those Psychiatric Inpatient Hospitals that do not contract with any MHP.

Psychiatric inpatient managed care Medi-Cal claiming continues to be processed through the DHCS Fiscal Intermediary Management Division. This process begins when a county-authorized representative approves a mental health inpatient provider's Treatment Authorization Request (TAR). The DHCS fiscal intermediary claiming system matches the claims to the TARs and adjudicates the claim. This system supports the submission, approval and payment of claims for Mental Health Medi-Cal Psychiatric Inpatient Fee-For-Service providers. TARs are governed by DHCS policy and procedures. See the Inpatient Mental Health Services Program section under the Medi-Cal Inpatient/Outpatient Provider Manual⁶⁶ for information on TARs⁶⁷ and related billing. Subsequently, the inpatient provider bills the DHCS Fiscal Intermediary Management Division for Medi-Cal reimbursement. This type of inpatient billing is never billed directly from a county through DMH.

5.2 Outpatient Claiming

Between November 1997 and July 1998 MHPs assumed responsibility for inpatient hospital and outpatient specialty mental health professional services. County representatives provide authorization for mental health outpatient services by external providers and bill DMH Mental Health Medi-Cal for reimbursement. This billing must conform to all DMH requirements.⁶⁸

5.3 AB 3632 Children's Services

Assembly Bill 3632 (AB 3632) Children's Services is relevant to this manual since counties must compile related AB 3632 Medi-Cal statistics for use in Cost Reporting to DMH.

⁶⁶ Retrieved July 1, 2008 from: http://files.medi-cal.ca.gov/pubsdoco/io_manual.asp.

⁶⁷ Retrieved July 1, 2008 from: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/tar_z01.doc.

⁶⁸ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 3, § 1840.304.

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Chapter 5: Other Mental Health Claiming

The Special Education Pupils (SEP) program⁶⁹ implements the Federal Individuals with Disabilities Education Act (IDEA)⁷⁰ that entitles disabled pupils to a free and appropriate public education in the least restrictive environment. The California Department of Education is responsible for SEP.

The original legislation for funding mental health services to SEP children (AB 3632) was passed in 1985. The final State regulations were adopted in 1999. The SEP program is codified in CCR, Division 9 of Title 2⁷¹ as dictated by U.S. Government Code (USC), Title 20, Chapter 33.⁷²

Special education pupils who require mental health services in any of 13 disability categories may receive services from county mental health programs. To be eligible to receive services, they must have a current Individualized Education Plan (IEP) on file. Services must align with the child's needs identified in the IEP so children will benefit from educational programs. They are free to all eligible students regardless of family income or resources. For additional information about this program, visit the California Department of Education website on Special Education services.⁷³ The National Dissemination Center for Children with Disabilities (NICHY)⁷⁴ is one source for additional programmatic information regarding IDEA/IEP program implementation.

County mental health departments may provide eligible special education pupils with mental health assessments, mental health service recommendations, and mental health services. Mental health services include: psychotherapy provided to the pupil individually or in a group, assessments, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management (when residential treatment is required). These services must be consistent with the IEP on file during the time of any related service delivery.

County mental health clients who are AB 3632-eligible may/may not be Medi-Cal-eligible. In cases of Medi-Cal eligibility there are no special Mental Health Medi-Cal claiming requirements. A Mental Health Medi-Cal 837 transaction has no embedded information that indicates the claim specifically relates to an AB 3632-eligible child. However, DMH CSI reporting does have specific requirements related to identifying AB 3632 children's services. See DMH CSI documentation related to CSI AB 3632 reporting requirements. For the Phase II Mental Health Medi-Cal claiming system, an indicator such as a Not to Exceed (NTE) field is under consideration for AB 3632 services to indicate the Mental Health service is being provided based on a child's IEP.

There are no requirements specific to processing an AB 3632 Mental Health Medi-Cal claim. Nevertheless, Cost Report settlement with SEP funding and California Senate Bill 90 (SB 90)⁷⁵ claims for state-mandated reimbursements require information on AB 3632 Medi-Cal costs and receivables. So each county must be able to distinguish AB 3632 Medi-Cal claims from other Medi-Cal claims information. This is required to maintain an

⁶⁹ Cal. Code Regs., Division 9, Title 2, § 60000.

⁷⁰ 20 U.S.C., Chapter 33, § 1400 et seq.

⁷¹ Cal. Code Regs., Division 9, Title 2, § 60000.

⁷² 20 U.S.C., Chapter 33, § 1400 et seq.

⁷³ Retrieved July 1, 2008 from: <http://www.cde.ca.gov/sp/se/>

⁷⁴ Retrieved July 1, 2008 from: <http://www.nichcy.org/training/contents.asp#toc>

⁷⁵ Property Tax Relief Act of 1972, SB 90, California State Legislature (1972).

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accurate classification of AB 3632 Mental Health Medi-Cal claims and to avoid improper claiming to SB 90 or DMH SEP funding.

5.4 Administrative, Utilization Review, and Medi-Cal Administrative Activities Claiming

Administrative, Utilization Review, and Medi-Cal Administrative Activities (MAA) claiming are part of overall county Medi-Cal claiming opportunities. However, they are not specifically claimed through the SD/MC 837 transaction claiming system.

Administrative and Utilization Review costs are not included in rate setting calculations for maximum Mental Health Medi-Cal reimbursement rates. Neither do the 837 transaction claims provide a vehicle for interim county funding of these costs. They are treated as separate costs to process apart from the actual SD/MC 837 transaction claim.

DMH provides counties interim funding for Administrative and Utilization Review costs related to service delivery through paper claim form submission. These paper claim forms are the MH1982 B (Administrative costs) and MH1982 C (Utilization Review costs). DMH Letters No.: 05-10⁷⁶ and 05-11⁷⁷ contain the most recent DMH directives on Administration and Utilization Review claiming.

A county may/may not submit MH1982 B and MH1982 C forms during a fiscal year in order to receive interim funding. In either case, settlement of actual Administrative or Utilization Review costs occurs during the fiscal end of year Cost Reporting process.

Activities claimed under MAA are activities necessary for the proper and efficient administration of the Medi-Cal program. They are found under Mode of Service 55 and are never part of an SD/MC 837 transaction claim. Invoices are submitted quarterly through paper claim submissions using the MH 1982D claim form. Instructions regarding county requirements for MAA planning development and claiming are found in the DMH MAA Instruction Manual maintained by the DMH Cost Reporting and Financial Support Unit.

5.5 Annual Year-end Cost Report

The annual year-end DMH Cost Report is required to be completed by all legal entities that contract with the MHP to provide community mental health services (Medi-Cal and non-Medi-Cal). The Cost Report serves multiple purposes including establishment of the MHP's cost settlement basis and subsequent DMH fiscal audit. The basis for both cost settlement and fiscal audit is established in the Cost Report process by determining the allowable costs and allocating those costs between direct service (i.e. unit cost by Mode of Service and Service Function code), Administrative, Utilization Review, Research and Evaluation and MAA cost centers.

Annual training is provided by DMH on the Cost Report process. In order to access complete instructions for the Cost Report process found in the Cost and Financial Reporting System Instruction Manual,⁷⁸ counties must enroll with DMH Information

⁷⁶ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-10.pdf>

⁷⁷ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-11.pdf>

⁷⁸ Retrieved July 1, 2008 from: https://mhitws.cahwnet.gov/systems/cfrs/docs/private/cfrs_manual.asp

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Technology Web Services (ITWS). An enrollment link and overview of the Cost and Financial Reporting System is available at:

<https://mhitws.cahwnet.gov/systems/cfrs/docs/public/default.asp>

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Chapter 5: Other Mental Health Claiming

6. SPECIALTY MENTAL HEALTH MEDI-CAL CLAIMS PROCESSING OVERVIEW

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Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

6 Introduction

This chapter provides an overview to claims processing and includes:

- [Claims Processing Overview](#)
- [High-level Mental Health Medi-Cal Claiming Views](#)
- [Mental Health Medi-Cal Claim Stages](#)
- [Claim Submission Deadlines](#)
- [Client Financial Liability and Mental Health Medi-Cal Eligibility Verification](#)
- [Uniform Method of Determining Ability to Pay \(UMDAP\)](#)
- [Medi-Cal Share of Cost \(SOC\)](#)
- [Title XXI Enhanced Services for Children](#)
- [Early and Periodic Screening, Diagnosis and Treatment \(EPSDT\)](#)
- [Mental Health Medi-Cal Service Claims Rates](#)
- [Federal Funding Ratios](#)
- [Mental Health Medi-Cal Claims Processing](#)
- [Claim Disallowance and Denied Replacement](#)
- [Mental Health Medi-Cal Reports](#)

6.1 Claims Processing Overview

Mental Health Medi-Cal claiming is a reimbursement system in which counties are provided an interim cash flow of State and Federal funding (pending cost settlement and audits) on a 'claim-in,' 'payment-out' basis. Funding is made available through the Federal Medicaid entitlement program⁷⁹ and California provides matching state and county funds.

Counties must meet claiming requirements in order for the State Controller's Office to make interim payments to county treasuries. This allows counties to obtain a percentage of the funding necessary to continue providing services to Mental Health Medi-Cal clients.

Counties must assure that claims submitted to DMH for mental health services to Medi-Cal eligible individuals have met all necessary requirements for Medi-Cal reimbursement of these services by certifying their costs in the year-end cost report. Year-end cost reports must be submitted by December 31 following the close of each fiscal year. This cost reporting requirement is discussed in Section 5.4.

Mental Health Medi-Cal is impacted by/integrated into other Federal/State/County fiscal and IT operations in many ways. The following sections provide an overview of various relationships to claim processing and provide information on claiming requirements.

⁷⁹ Grants to States for Medical Assistance Programs, 42 U.S.C. §1396-1396v, Subchapter XIX, Chapter 7 (1965).

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Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

6.2 High-level Mental Health Medi-Cal Claiming Overview

Figure 6-1 provides a visual perspective example of a claim as it relates to a broader funding process. Below is a description of this figure.

Amount Claimed: The amount claimed by the MHP (\$1.00) reflects an interim rate per unit of service based on either the actual cost incurred by the MHP based on a payment to a contract provider or the estimated cost of a county operated provider. The claim is sent by the MHP to DMH for adjudication.

Example: Approved Non-EPSTD: An approved non-EPSTD claim is reimbursed based on the appropriate Federal Medical Assistance Percentage (FMAP). This percentage represents the percentage of a claim for which the Federal government will pay Federal Financial Participation (FFP). State and/or county funds must then be used to pay for the balance of the claim. The example uses an FMAP of 50% so that a claim in the amount of \$1.00 would be reimbursed with \$.50 of FFP and \$.50 with State and/or county funds, which may include funding from:

- State realignment funds (see description below)
- State managed care allocations
- State General Fund monies for AB3632
- Mental Health Services Act (MHSA) funds
- Local county monies
- Other sources such as grants, etc.

Example: Approved EPSTD: An approved EPSTD claim is also reimbursed based on the FMAP of 50% so that an approved EPSTD claim in the amount of \$1.00 would be reimbursed with \$.50 of FFP and \$.50 with State and/or county funds, which may include funding from:

- State realignment funds (see description below)
- State managed care allocations
- State General Fund (SGF) monies distributed for EPSTD
- State General Fund monies for AB3632
- Mental Health Services Act (MHSA) funds
- Local county monies
- Other sources such as grants, etc.

Figure 6-1 shows that Mental Health Medi-Cal funding is composed of both Federal and non-Federal funds. Federal funds are reimbursements to the State under the Federal Medicaid program. Non-Federal funds may be any non-Federal funds not otherwise limited by matching restrictions. Federal funds may not be used to match other Federal funds.

- **Realignment Funds:** In FY 1991/92, California's State budget was 'realigned', placing the responsibility and a greater share of the risk for social services,

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Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

health and mental health programs on the counties. Under realignment, the county share of the cost for the realigned programs was funded by new sales tax revenue sources and vehicle license fees. The Local Revenue Fund contains a Sales Tax Account, Sales Tax Growth Account, Vehicle License Fee Account, Vehicle License Fee Growth Account, and several sub-accounts. The revenues deposited into these accounts are distributed by the State Controller's Office to all counties on a monthly basis according to various formulas found in statute.

- Examples of non-Federal funds used by counties include local county funds established by local taxes and other income. Other non-Federal funds include: State Realignment Funds, State Managed Care Allocations, State General Fund monies distributed for EPSDT, State General Fund monies distributed for children's services in accordance with AB3632, and Mental Health Services Act (MHSA) funds.

Money Flow:

- A. State Realignment Funds are paid monthly to the county by the State Controller's Office
- B. State Managed Care Allocations are paid to the county by DMH in accordance with Section 5778 of the W&I Code and the DMH/MHP contract.
- C. FFP is paid in arrears based on claims for actual provider expenses submitted to DMH by the county for reimbursement
- D. EPSDT SGF is paid based on monthly SD/MC approved claims adjusted for each individual county's baseline match as outlined in DMH Letters 98-03 and 98-12, a 10% county contribution on growth in State and local match since FY 2001/02 as outlined in the October 23, 2002 All County Mental Health Director's Letter, and a 95% adjustment to allow for potential variability in claims and cost settlement.

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Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

FIGURE 6-1: EXAMPLE OF A MENTAL HEALTH MEDI-CAL CLAIM PAYMENT

Amount Claimed	Approved Non-EPSDT Claim	Approved EPSDT Claim
\$1.00	\$1.00	\$1.00

State and/or County Funds may include:

- State Realignment Funds
- State Managed Care Allocation
- Local County monies for EPSDT
- Other sources such as grants, etc.

Money Flow:

- A. State Realignment Funds are paid monthly to the county by the State Controller's Office
- B. State Managed Care Allocations are paid to the county by DMH as an advance in accordance with Section 5778 of the W&I Code and the DMH/MHP contract.
- C. FFP is paid in arrears based on claims for actual provider expenses submitted to DMH by the county for reimbursement.
- D. EPSDT SGF is paid based on monthly SD/MC approved claims adjusted for each individual county's baseline match as outlined in DMH Letters 98-03 and 98-12, a 10% county contribution on growth in State and local match since FY 2001/02 as outlined in the October 23, 2002 All County Mental Health Director's Letter, and a 95% adjustment to allow for potential variability in claims and cost settlement.

Processing:

FFP is paid by DMH Accounting based on the SD/MC Approved Services Report and Explanation of Balances (EOB) data. DHCS reviews the payment information and establishes Federal Funding for the payment.

Funding Sources:

1. FFP represents Federal Funds.
2. State Realignment Funds, State Managed Care Allocation, and EPSDT SGF distributions are paid by State monies, such as state tax revenues and revenues for the State General Fund.
3. County Funds represent local taxes and other income.

MENTAL HEALTH MEDI-CAL BILLING MANUAL

Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

Figure 6-2 represents another high-level view of the Mental Health Medi-Cal claims processing system and illustrates various processes including:

- Claim submission by the Mental Health Medi-Cal service provider to the MHP
- Claim submission by MHPs to DMH
- DMH claim translation and claim processing
- DHCS claim adjudication and processing
- State Controller's Office (SCO) claim payment to the local county treasurer

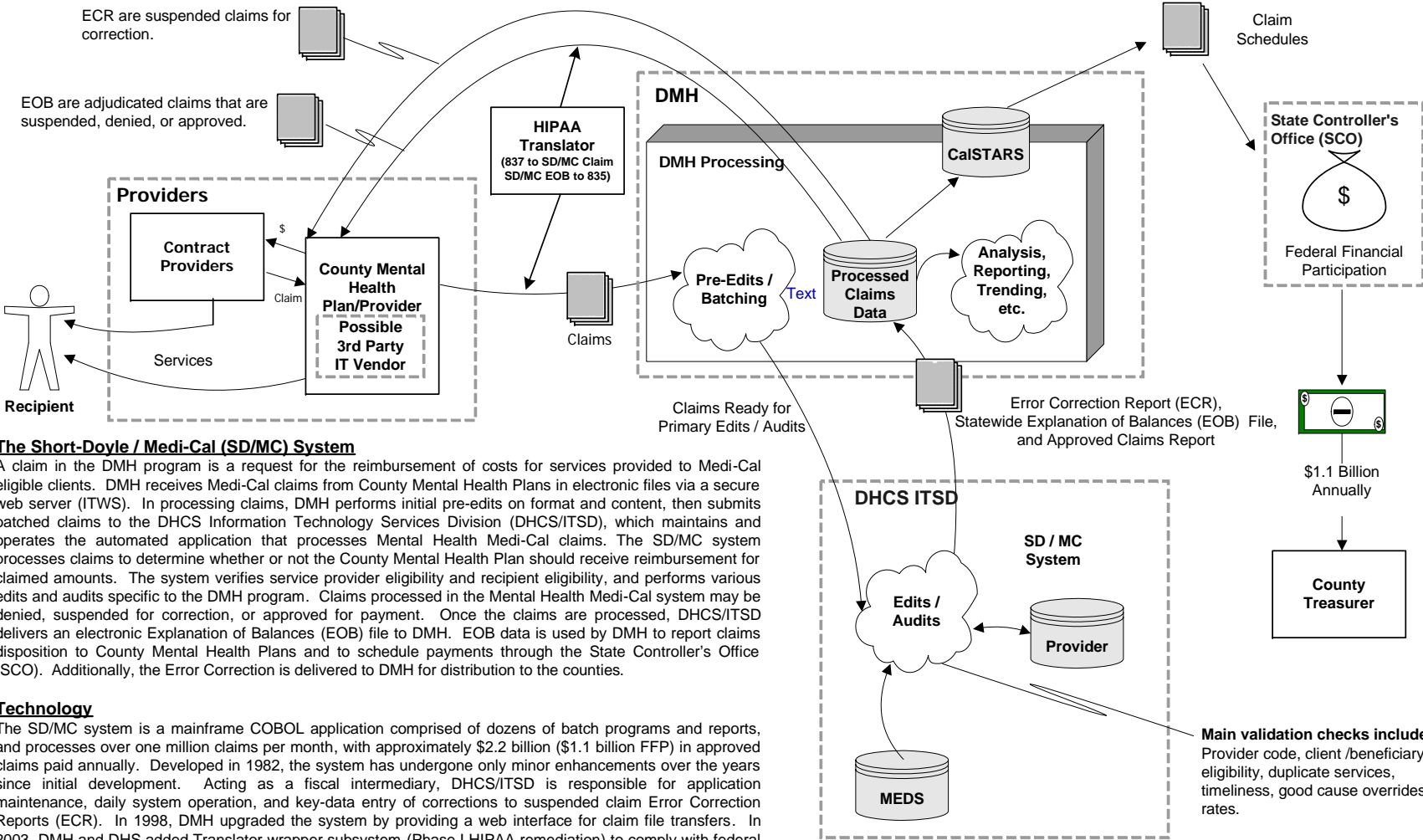
Arrows from local counties to DMH indicate SD/MC 837 transaction claim submissions.

Arrows from DMH to counties indicate EOB and [Error Correction Report \(ECR\)](#) data. EOB information is also sent in a HIPAA 835 health care claim payment advice transaction. In the near future, the EOB information will only be available through the 835 transaction.

Mental Health Medi-Cal claims submitted by counties to DMH include both mental health outpatient and inpatient service-related claims. Background information on Specialty Mental Health Medi-Cal is described on DMH websites.

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 Chapter 6: Specialty Mental Health Medi-Cal Claims Processing Overview

FIGURE 6-2: SD/MC HIGH-LEVEL CLAIMS PROCESSING SYSTEM FLOW



The Short-Doyle / Medi-Cal (SD/MC) System

A claim in the DMH program is a request for the reimbursement of costs for services provided to Medi-Cal eligible clients. DMH receives Medi-Cal claims from County Mental Health Plans in electronic files via a secure web server (ITWS). In processing claims, DMH performs initial pre-edits on format and content, then submits batched claims to the DHCS Information Technology Services Division (DHCS/ITSD), which maintains and operates the automated application that processes Mental Health Medi-Cal claims. The SD/MC system processes claims to determine whether or not the County Mental Health Plan should receive reimbursement for claimed amounts. The system verifies service provider eligibility and recipient eligibility, and performs various edits and audits specific to the DMH program. Claims processed in the Mental Health Medi-Cal system may be denied, suspended for correction, or approved for payment. Once the claims are processed, DHCS/ITSD delivers an electronic Explanation of Balances (EOB) file to DMH. EOB data is used by DMH to report claims disposition to County Mental Health Plans and to schedule payments through the State Controller's Office (SCO). Additionally, the Error Correction is delivered to DMH for distribution to the counties.

Technology

The SD/MC system is a mainframe COBOL application comprised of dozens of batch programs and reports, and processes over one million claims per month, with approximately \$2.2 billion (\$1.1 billion FFP) in approved claims paid annually. Developed in 1982, the system has undergone only minor enhancements over the years since initial development. Acting as a fiscal intermediary, DHCS/ITSD is responsible for application maintenance, daily system operation, and key-data entry of corrections to suspended claim Error Correction Reports (ECR). In 1998, DMH upgraded the system by providing a web interface for claim file transfers. In 2003, DMH and DHS added Translator wrapper subsystem (Phase I HIPAA remediation) to comply with federal HIPAA laws.

Future Changes

In 2007, the SD/MC Phase II HIPAA remediation project began which includes changes to accommodate adjustments to paid claims, completion of a fully compliant 835, and addition of the 276/277 claims inquiry and response transactions. Phase II is scheduled for completion in 2009.

Main validation checks include:
 Provider code, client /beneficiary eligibility, duplicate services, timeliness, good cause overrides, rates.

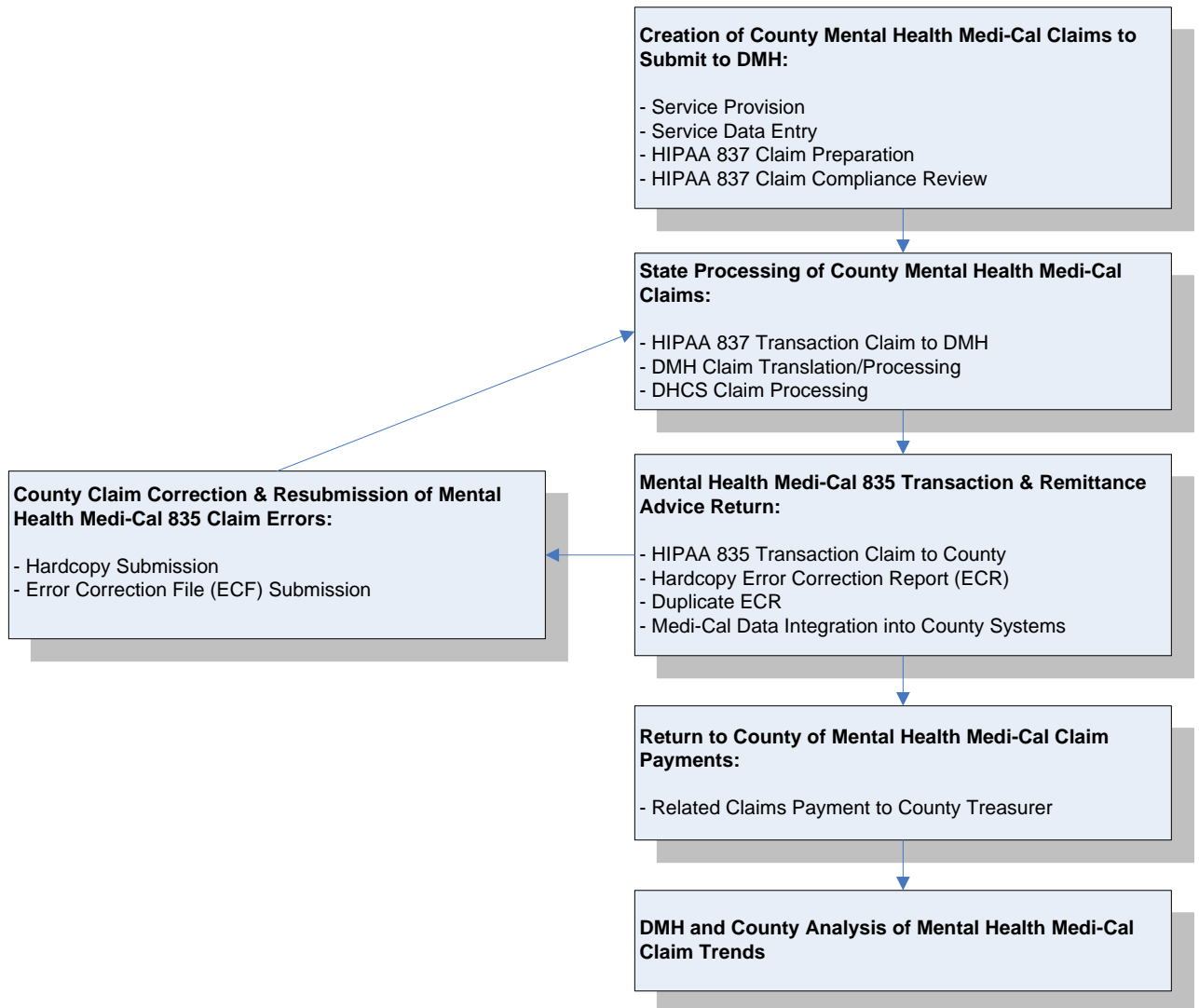
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6.3 Mental Health Medi-Cal Claim Stages

Mental Health Medi-Cal claiming is categorized by stages of the claiming process. Each stage may be monitored or analyzed for efficiency, improvements, or throughput. The following chart summarizes these claiming stages.

FIGURE 6-3: MENTAL HEALTH MEDI-CAL CLAIM STAGES



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6.4 Claim Submission Deadlines

The timeline for initial county submission of a Mental Health Medi-Cal claim is critical. Counties have up to 6 months from the month of service to initially submit a claim.⁸⁰

Submission of a claim between 7 and 12 months from service month requires inclusion in the claim of an approved Good Cause reason.⁸¹

Good Cause reason codes are included in 837 transactions. These codes are represented by claim Delay Reason codes in claim element CLM20. See the HIPAA Companion Guide⁸² for the correct code to use.

Initial submission of a claim after 12 months from service month will result in claim denial.^{83 84} Exceptions to the 12 month deadline may occur in the case of court or State hearing decisions.⁸⁵

6.5 Client Financial Liability and Mental Health Medi-Cal Eligibility Verification

6.5.1 Coordination of Benefits

The SD/MC claiming system does not perform coordination of benefits through various payer sources. Each source must be billed separately by the MHP.

One example is Medicare/Medi-Cal dual-eligible clients (referred to as Medi/Medi clients). The MHP will bill Medicare prior to Medi-Cal. A Medicare intermediary processing the county MHP will not coordinate the subsequent billing to Medi-Cal. Instead, claim adjudication by the Medicare intermediary will result in claim payment information returned to the MHP. The MHP may submit an 837 transaction to the Mental Health Medi-Cal system with the Medicare payment information included.

6.6 Uniform Method of Determining Ability to Pay (UMDAP)

For information on the Uniform Method of Determining Ability to Pay (UMDAP), see DMH Information Notice No. 98-13.⁸⁶

6.7 Medi-Cal Share of Cost (SOC)

County mental health clients may also have a Medi-Cal SOC. Mental health IT systems are required to indicate Medi-Cal SOC payments per the guidelines found in the HIPAA

⁸⁰ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 1, § 1840.110.

⁸¹ Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, § 51008.5.

⁸² Cal. DMH (2007, June). Table F, Delay Reason Code Crosswalk. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

⁸³ Retrieved July 1, 2008 from: http://a257.g.akamaitech.net/7/257/2422/16nov20071500/edocket.access.gpo.gov/cfr_2007/octqtr/42cfr447.45.htm

⁸⁴ Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, § 51008.5.

⁸⁵ Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 1.3, § 51008.5.

⁸⁶ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices98/98-13.pdf>

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Companion Guide,⁸⁷ which are consistent with the Federal HIPAA 837 Implementation Guides. They are used in the HIPAA 837 transaction to assist DMH in determining the claim's net billed amount (see DMH Information Letter 07-05⁸⁸).

DHCS Inpatient/Outpatient Medi-Cal Manual contains SOC information.⁸⁹ This DHCS manual provides additional information about:

- Who determines SOC
- How to determine if a recipient must pay SOC
- Obligating SOC payment
- Certifying SOC
- Eligibility Verification Confirmation (EVC) numbers

6.8 Title XXI Enhanced Services for Children

The State Children's Health Insurance Program (SCHIP)⁹⁰ was established under Title XXI of the Social Security Act. The purpose of this program is to enable States to initiate and expand child health assistance to uninsured, low-income children. The FFP provides an enhanced match for all services funded under Title XXI. In California, assistance is provided primarily through either or both of two methods:

- (1) Establishment of the Healthy Families Program (HFP), which provides a basic health benefit package (provided by HFP health plans), that includes a mental health benefit for children assessed with serious emotional disturbances (SED)⁹¹ provided by the county mental health departments.
- (2) Expanding eligibility for children under the State's Medicaid (Medi-Cal) Child Health Plan (known in California as MCHIP), which provides enhanced Medicaid match under Title XXI for health and mental health service expenditures for 'optional targeted low-income children.' They are defined in Federal law as targeted low-income children who would not qualify for Medicaid.

The related eligibility Aid codes for Healthy Families and enhanced Medi-Cal match (paid under Title XXI funding) are included in the DMH and ADP Aid Codes Master Chart⁹² on ITWS.

⁸⁷ Cal. DMH (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from:

http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

⁸⁸ Retrieved July 1, 2008 from: http://www.dmh.ca.gov/DMHDocs/docs/letters07/07-05_Letter.pdf

⁸⁹ Retrieved July 1, 2008 from: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

⁹⁰ Retrieved July 1, 2008 from: <http://www.cms.hhs.gov/home/schip.asp>

⁹¹ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

⁹² Retrieved July 1, 2008 from: https://mhitws.cahwnet.gov/docs/public/reference_information.asp

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6.8.1 Healthy Families Program (HFP)

Established in 1998, HFP⁹³ provides low-cost insurance for children under the age of nineteen whose families do not have insurance, do not qualify for no-cost Medi-Cal, and whose income is at or below 250% of the Federal poverty level. Eligible children may be U.S. citizens, U.S. non-citizen nationals, or eligible-qualified immigrants. HFP insurance covers health, dental, and vision services. Most covered services are provided by health plans under contract with the Managed Risk Medical Insurance Board (MRMIB),⁹⁴ the State agency that administers HFP.

HFP provides 'basic' mental health services per CCR, Title 10.⁹⁵ However, if a child is thought to be Seriously Emotionally Disturbed (SED) per W&I Section 5600.3,⁹⁶ the HFP enrollee is referred to his or her local county MHP for an SED assessment. If the MHP determines that the child meets the SED criteria, it assumes responsibility for the provision and payment of treatment of the SED condition(s), with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HFP health, plan. When a mental health department assumes responsibility for the treatment of the HFP enrollee's SED condition, it claims for the services via the SD/MC claiming system.

HFP claims are distinguished by a client's Aid code classification. Therefore, county claims with Aid codes of '7X,' '9H' or '9R' are processed as Healthy Families claims. For further information on HFP, including applicable Federal Financial Participation Rates and Inpatient Provider numbers, see DMH Information Notice No.: 07-01⁹⁷ and the HIPAA Companion Guide.⁹⁸

6.9 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is Medicaid's benefit for individuals under 21 years of age. It was included as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation⁹⁹ and has been a part of Medicaid since its inception. In California, the EPSDT benefit includes comprehensive health, mental health, dental, hearing and vision care services for Medi-Cal eligible children/youth less than 21 years of age.¹⁰⁰

EPSDT mental health services were expanded in 1995 by DHCS in accordance with federal regulations and statutes that require States to not only provide and pay for any medically-necessary health treatment services, but also provide and pay for any mental health treatment services needed to correct or ameliorate the mental health condition of a full-scope Medi-Cal-eligible beneficiary under 21 years of age. Part of the impetus for

⁹³ Retrieved July 1, 2008 from: <http://www.healthyfamilies.ca.gov/hfhome.asp>

⁹⁴ Retrieved July 1, 2008 from: <http://www.mrmib.ca.gov/>

⁹⁵ Cal. Code Regs., Title 10, Chapter 5.8, § 2699.6700.

⁹⁶ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3.

⁹⁷ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-01.pdf>

⁹⁸ Cal. DMH (2007, June). Chapter 3.11.1, Segment and Data Element Description. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

⁹⁹ Omnibus Budget Reconciliation Act of 1989, P.L. 101-239.

¹⁰⁰ Retrieved July 1, 2008 from: http://www.dmh.ca.gov/DMHDocs/docs/letters01/01-07_Enclosure_A.pdf

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this expansion was a lawsuit, *T.L. vs. Belshé*¹⁰¹ that put forth the position that California had not fully complied with these Federal regulations and statutes.

In order to fund the expansion of EPSDT specialty mental health services, DHCS estimated the amount of additional SGF dollars and FFP dollars needed after a county baseline was established. This baseline represents the county's responsibility to maintain their mental health services funding levels prior to EPSDT expansion, and is derived from the FY 1994/95, Mental Health Medi-Cal Cost Report settlement amounts adjusted for cost of living (home health market basket indicator).

As a result of the expansion discussed above, funding for EPSDT specialty mental health services is governed by a complex set of rules applicable to each county's program funding that includes baseline funding, expansion funding above the baseline and a 10% county match for growth in the SGF matching requirement for the cost of EPSDT services above the FY 2001/02 level. Due to the complexity of the EPSDT DMH/County programs, all applicable DMH Information Notices and Letters should be reviewed.

The relationship between TBS and EPSDT should also be considered.¹⁰² In July 1999, following the preliminary injunction in the *Emily Q. vs. Belshé* lawsuit,¹⁰³ MHPs became responsible for providing or arranging for TBS as an EPSDT supplemental specialty mental health service. TBS allows for the provision of intensive one-to-one services for children/youth with SED¹⁰⁴ who are experiencing a stressful transition or life crisis when additional short-term support is needed to prevent placement in or transition from high-level group homes or locked facilities. In order to be eligible for these services, the child or youth must be EPSDT-eligible,¹⁰⁵ a member of the certified class under the *Emily Q. vs. Belshé* lawsuit, and meet the need criteria.¹⁰⁶

Estimation of statewide EPSDT claiming data requires access to relevant data for EPSDT services claimed through Mental Health Medi-Cal. EPSDT services may be delivered to a beneficiary by the county of origin (the county where Medi-Cal eligibility is established) or by another county. DMH provides regular updates to services provided to a beneficiary by a host county. Access to this County of Fiscal Responsibility data is available through ITWS.¹⁰⁷

EPSDT specialty mental health services are restricted to full-scope Medi-Cal eligible parties under 21 years of age who meet the medical necessity criteria. Full-scope Medi-Cal eligibility is indicated by the Medi-Cal Aid code assigned during Medi-Cal application, and eligibility intake processes conducted by county social services departments. These Aid codes may be found in the DMH and ADP Aid Codes Master Chart on ITWS.¹⁰⁸

¹⁰¹ T. L. v. Belshe, No. CV-S-93-1782 LKKPAN, (E. D. Cal., 1995)

¹⁰² Retrieved July 1, 2008 from:

http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

¹⁰³ *Emily Q. v. Belshe*, No. CV-98-4181-WDK (C.D. Cal., May 5, 1999)

¹⁰⁴ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

¹⁰⁵ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/letters99/99-03.pdf>

¹⁰⁶ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3.

¹⁰⁷ Retrieved July 1, 2008 from: <https://mhhitws.cahwnet.gov/>

¹⁰⁸ Retrieved July 1, 2008 from: https://mhhitws.cahwnet.gov/docs/public/reference_information.asp

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A county's EPSDT SGF settlement is based on information from settled Cost Report data for Mental Health Medi-Cal, Mental Health Medi-Cal and EPSDT approved claims data from the DMH Medi-Cal Epidemiology and Forecasting Support Unit, and paid claims information from DMH Accounting. A final EPSDT settlement letter that includes the calculations used to generate the final settlement amount is sent to each county with a copy provided to DMH Accounting.

6.10 Mental Health Medi-Cal Service Claim Rates

Local mental health plans and contract providers set their usual and customary charge. The Statewide Maximum Allowances (SMA) rates are set annually by DMH through DMH Letters and Notices. DMH Letter No.: 07-10¹⁰⁹ and DMH Information Notices 07-22,¹¹⁰ 07-23,¹¹¹ and 07-24¹¹² demonstrate maximum Mental Health Medi-Cal rates established by DMH for FY 07/08.

6.11 Federal Funding Ratios

Mental Health Medi-Cal and Healthy Families services are paid through Federal, County and State funding. However, Federal and State sharing ratios are subject to change.

Federal regulations 42CFR447.50 through 42CFR447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.¹¹³

Federal reimbursement is determined annually and released as Federal Medicaid Assistance Percentages (FMAP).^{114,115} Subsequently, DMH notifies county mental health departments of FMAP changes through correspondence such as DMH Letter No.: 06-06.¹¹⁶

Mental Health Medi-Cal claim payments are settled by county-submitted Cost Reports and subsequent DMH audits. Therefore FMAP historical data is useful to maintain.

Historical FMAP data may be found on the United States Assistant Secretary for Planning and Evaluation (ASPE) website.¹¹⁷

¹⁰⁹ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/letters07/07-10.pdf>

¹¹⁰ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-22.pdf>

¹¹¹ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-23.pdf>

¹¹² Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-24.pdf>

¹¹³ Retrieved July 1, 2008 from: http://a257.g.akamaitech.net/7/257/2422/16nov20071500/edocket.access.gpo.gov/cfr_2007/octqtr/42cfr447.50.htm

¹¹⁴ Retrieved July 1, 2008 from: http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=69209

¹¹⁵ Retrieved July 1, 2008 from: <http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-20264.pdf>

¹¹⁶ Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices05/05-07.pdf>

¹¹⁷ Retrieved July 1, 2008 from: <http://aspe.hhs.gov/health/fmap.htm>

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6.12 Mental Health Medi-Cal Claims Processing

To submit Mental Health Medi-Cal claims, counties and their billing service vendors must fulfill certain requirements as discussed in this section. These requirements include obtaining ITWS usage authorization/enrollment; Medi-Cal certification of providers; conversion of local data sets into DMH-approved claim data sets; processing of 837 and 835 transactions; and completion of any related hardcopy claim forms, i.e., MH1982 A, MH1982 B, or MH1982 C.

6.12.1 Mental Health Medi-Cal Claim Submission Dates

All county MHP Mental Health Medi-Cal claims submitted to DMH are batched for DHCS processing. Claim submission deadline dates govern which county claims will be included in a batch. Each year's claim submission schedule may be found on ITWS.¹¹⁸ The claim submission date is the cutoff date.

6.12.2 Mental Health Medi-Cal Claim 837 Transactions

Mental Health Medi-Cal health care claim 837 transactions are submitted electronically via ITWS, the portal for online DMH applications, by selecting **Short-Doyle/Medi-Cal Claims – EOB (for DMH)** from the **Systems** menu. To upload a file or files, select **Upload** under **Function** and follow the prompts. Unusual or very complex claims are sometimes submitted in hard copy format.

The structure and contents of 837 transactions are defined in the HIPAA Companion Guide.¹¹⁹ Additional requirements are outlined by DMH Notices and Letters. For example, DMH Letter No.: 07-05¹²⁰ details the requirement that 837 transactions include gross cost of service and related other payer payments and/or adjustments.

Figure 6-2 illustrates this concept, showing that DMH uses a Translator to change data from the HIPAA-compliant 837 transaction into the SD/MC proprietary claim format. The SD/MC proprietary claim data is then forwarded to DHCS for adjudication.

The HIPAA Companion Guide should be consulted for specific details on processing DMH 837 transactions.

6.12.3 Mental Health Medi-Cal 835 Transaction Processing

Counties can download their 835 health care claim payment advice records from ITWS by selecting **Short-Doyle/Medi-Cal Claims – EOB (for DMH)** from the **Systems** menu.

¹¹⁸ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

<https://mhitws.cahwnet.gov/systems/sdmc/docs/private/referenceinfo.asp>

¹¹⁹ Cal. DMH (2007, June). Chapter 3, Health Care Claim Files. In Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from:

http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

¹²⁰ Retrieved July 1, 2008 from: http://www.dmh.ca.gov/DMHDocs/docs/letters07/07-05_Letter.pdf

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The HIPAA Companion Guide¹²¹ should be consulted for specific details on processing 835 transactions.

6.12.4 MH1982 A

A completed copy of the MH1982 A form, DMH Short-Doyle/Medi-Cal Monthly Claim for Reimbursement-Treatment Cost must accompany each claim file, whether it is submitted through ITWS or on paper. A signed MH1982 A form is usually faxed to DMH for further processing. DMH Information Notice No.: 03-10¹²² outlines this requirement. Form MH1982 A is available on ITWS for authorized users.¹²³ After logging on to ITWS, select the **Systems** tab, select **Short-Doyle/Medi-Cal Claims – EOB (for DMH)**, select the **SDMC–DMH Information** tab and select **Claim Forms**.

6.12.5 Claim Errors and Claims in Suspense

Currently Mental Health Medi-Cal claims can be placed in suspense while the county determines if the claim errors causing the suspense claim status may be corrected. ITWS provides a listing of the possible types of errors returned for county review.¹²⁴ Claims in suspense can be automatically moved to denial status if the claim remains in suspense for greater than 97 days without further attempts by a county to correct the claim error.¹²⁵ If a county has attempted to correct the suspense claim error through error correction procedures, the claim may remain in suspense status if it is reprocessed and continues to fail the edits. The appendix containing the Error Correction Report Handbook describes procedures for correcting claims in suspense.

6.13 Claim Disallowance and Denied Replacement

[PLACEHOLDER – PENDING SD/MC PHASE II]

6.14 Transition from Disallow Claims System to Void and Replace Transaction

[PLACEHOLDER – PENDING SD/MC PHASE II]

6.15 Mental Health Medi-Cal Reports

6.15.1 Historical Overview of Mental Health Medi-Cal Claim Reports

As discussed previously, DMH Mental Health Medi-Cal claim processing was based on usage of a SD/MC proprietary claim format. Counties, using this format, submitted their

¹²¹ Cal. DMH (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from:

http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

¹²² Retrieved July 1, 2008 from: <http://www.dmh.ca.gov/DMHDocs/docs/notices03/03-10.pdf>

¹²³ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

<https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/ClaimForms.asp>

¹²⁴ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

<https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/referenceinfo.asp>

¹²⁵ Cal. Code Regs., Title 9, Division 1, Chapter 11, Subchapter 4, Article 1 § 1840.110

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claims as unformatted text files to DMH. DMH then batches and forwards the claims to DHCS. DHCS processes the claims and returns the EOB, Edit Error Correction Report (EECR), and Duplicate Error Correction Report (DECR) to DMH. DMH then forwards the EOB and the error reports to the counties. The EOB is in an unformatted text file format and includes the Approved, Denied, and Suspended claims.

6.15.2 *Current Overview of Mental Health Medi-Cal Claim Reports*

Currently, as required by HIPAA, DMH is providing counties with 835 payment advice transactions that indicate approved, denied, or suspended claims submitted via 837 health care claim transactions. [Error Correction Reports \(ECR\)](#) are currently provided to most counties in hardcopy format via the EECR and the DECR.

Additionally, through ITWS, counties are continuing to receive approved, denied, and suspended claims data via a downloadable EOB file. This data is provided so that counties (that so choose) can update the database of a DMH-supplied Microsoft Access application¹²⁶ or update their proprietary billing systems.

6.15.3 *County of Fiscal Responsibility Files (CFR) Subsystem*

DMH provides an electronic Excel file through ITWS that contains Mental Health Medi-Cal claims data provided by counties other than the county of beneficiary. This data is needed to analyze statewide Mental Health Medi-Cal claims relevant to the county of beneficiary and is important to county MHPs. A county or MHP may combine this data with its own billing system data for statewide reporting purposes. For example they might generate reports on expectant EPSDT reimbursement or potential accounts payable due to other counties. ITWS provides information related to this file.¹²⁷

6.15.4 *County Multi-Year Mental Health Medi-Cal Report*

DMH provides counties with statewide adjudicated claims data since Fiscal Year 1999/2000 via Excel pivot tables on ITWS.¹²⁸ This report contains claims trend information. The data may be queried by several descriptors, including County Code, Service Period, and Approved/Denied Period.

6.15.5 *County Approved Claims Report*

DMH provides each county with monthly approved claims reports for each fiscal year since Fiscal Year 2002/2003 via Excel workbooks on ITWS.¹²⁹ This report contains claim approval summary and detail information including total approved amounts by program for FFP and SGF.

¹²⁶ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

https://mhitws.cahwnet.gov/systems/sdmc/docs/private/eob-eecr_application_database_v3.3.asp

¹²⁷ Retrieved July 1, 2008 from: <https://mhitws.cahwnet.gov/itws/transfer.asp?SysID=1>

¹²⁸ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

https://mhitws.cahwnet.gov/systems/sdmc/docs/private/anomaly_reports.asp

¹²⁹ Retrieved July 1, 2008 from (if you cannot access this link, check with your ITWS approver):

<https://mhitws.cahwnet.gov/itws/transfer.asp?SysID=1>

7. DUPLICATE CLAIMS, MAXIMUM SERVICE TIMES, LOCKOUTS AND OVERRIDES

7 Introduction

This chapter provides an overview to edit, lockouts and overrides and includes:

- [Duplicate Claims, Maximum Service Times, Lockouts and Overrides](#)
- [Duplicate Claims](#)
- [Maximum Service Times and Lockouts](#)
- [Duplicate Service Error Messages](#)
- [Discharge Day](#)
- [Institutional Limitation](#)
- [Time of Service Limitation](#)

7.1 Duplicate Claims, Maximum Service Times, Lockouts and Overrides

Claims that have passed the edits in the SD/MC system and are suitable for payment are edited against other incoming claims and the history file of approved claims. Table 7-1 provides a graphic illustration of the multiple-service edits. Table 7-2 provides billing scenarios depicting sequences of service claims and the resulting claim approval or denial, depending on the values of the eight duplicate criteria fields, duplicate override code, and admission date. Below are the related definitions of the duplicate claims, maximum service times, and lockouts edits.

7.2 Duplicate Claims

A duplicate service claim in the Short-Doyle / Medi-Cal (SD/MC) is defined as the second and all subsequent claims that match all of the following eight criteria:

- Person
- Provider (Service Facility Location)
- Date of service
- Mode of service
- Service function
- Units of service
- Units of time
- Net Billed amount

The subsequent claim will be suspended for duplicate correction (error code 27) unless the claim has a duplicate override code that has been placed on the claim by the county. This code is used by the county to certify that the county has verified the identified service is not an actual duplicate claim for reasons such as: different time of service, procedure, or rendering provider. Use of the override is predicated on the review of client records by a licensed clinician and that the services were appropriate and medically necessary.

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Chapter 7: Edits, Lockouts and Overrides

7.2.1 Duplicate Service Override Codes

The allowable override codes are listed below and in 'Table E – Duplicate Payment Override Code Crosswalk' of the HIPAA Companion Guide.¹³⁰

59 - Distinct Procedural Service

76 - Repeat Procedure by Same person (rendering provider)

77 - Repeat Procedure by Different person (rendering provider)

7.2.2 837 Claim Fields Related to the Duplicate Edit

The eight duplicate service criteria are created by translation of certain fields in the 837 claim. These 837 fields are listed below so that billing providers are aware of the relationship between the 837 claim and the SD/MC duplicate edit.

- Subscriber
- Provider (Service Facility Location)
- Date of service
- Procedure Code, Modifier, Place of Service, Taxonomy, Units

HIPAA Companion Guide 'Table K – Crosswalk 837P To SD/MC Mode Of Service And Service Functions' describes how 837 procedure codes, modifiers, place of service, provider taxonomy, and units will be used to create the current SD/MC mode of service and service function codes that will be used for claim processing. The modifier is also the field to use for placing a duplicate override, if applicable.

A duplicate override code may be necessary even if claims have different values for the procedure code, modifier, place of service, taxonomy, or units since they may be translated into the same mode of service and service function.

7.2.2.1 Units

The Units field on the 837 corresponds to the units of time for all but 24 hour services, in which case it corresponds to units of service. See the HIPAA Companion Guide for more information on the Units field and its use in the service procedure crosswalks.

7.2.2.2 Line Item Charge Amount

The Line Item Charge Amount field on the 837 may not match the Line Item Charge Amount field on the 835 because the gross amount coming in on the 837 is adjusted to create the Net Billed Amount in the SD/MC system, which is reported in the Line Item Charge Amount field on the 835. The Net Billed Amount is the value used as one of the criteria in the SD/MC system duplicate service evaluation. Refer to the HIPAA Companion Guide for the calculations used to create the Net Billed Amount.

¹³⁰ California Department of Mental Health (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide for the 837 Professional and Institutional Health, retrieved July 1, 2008 from: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

7.3 Maximum Service Times and Lockouts

Table 7-1 describes maximum service times and lockout conditions for a specific recipient and date of service.

Lockouts (L) are claims for mutually exclusive activities, which are services that should never occur on the same day for the same recipient and will not be approved for reimbursement. Some claims for services may occur on the day of admission (A) but are lockouts on other days.

Multiple Services are claims for services for the same day and recipient that are approved for reimbursement, up to the maximum accumulation of units of time for each Service Category and subject to the Statewide Maximum Allowance (SMA), or maximum payment allowed per unit of time for each Service Category. For inpatient claims, the discharge day (day the patient is leaving the hospital) will not be counted since there is no service on that day. Services for the same day for the same recipient may be approved for reimbursement with an indicated appropriate override code.

7.4 Duplicate Service Error Messages

The duplicate service error messages and codes are listed in 'Table J – SD/MC Error Code Crosswalk' of the HIPAA Companion Guide. These errors and their descriptions are listed below. Service claims that may result in SD/MC error code '27' may be prevented by indicating the appropriate duplicate override code in the originally submitted claim so long as the accumulated service time does not exceed the listed maximums. If the lockout conditions are met, the related services will be suspended with a duplicate error '26', which cannot be corrected with an override code.

7.4.1.1 SD/MC Error Code 26 'DUPLICATE SERVICE – NO OVERRIDE'

This indicates the SD/MC system has found a duplicate service for which this service has no possible overrides. This is the case where the services are listed as a lockout ('A' or 'L') in the SD/MC Table of Multiple-Service Billing Edits. The service on the Duplicate ECR may only be corrected so that the claim no longer meets the lockout condition or by deleting the claim.

7.4.1.2 SD/MC Error Code 27 'MULTIPLE SERVICE – OVERRIDE OK'

This indicates the SD/MC system found a duplicate service for which this service may be corrected with an override code, if appropriate, or deleted if the service is not for an appropriate documented duplicate service.

7.4.1.3 SD/MC Error Code 23 'UNITS > ALLOWED'

This indicates the SD/MC system has found a service, when added to previously approved claim(s), exceeds the maximum amount of time allowed. Correct the appropriate fields or delete the claim. There is no override possible for this error. If other fields are not in error, correct the units. Be sure to use leading zeros, that is, if the units are '2' enter '0002.'

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Chapter 7: Edits, Lockouts and Overrides

7.5 Discharge Day

The day of discharge for an inpatient hospital day is not Medi-Cal reimbursable unless the date of discharge and the date of admission are the same.

7.6 Institutional Limitation

Case Management/Brokerage services are limited when a recipient is receiving inpatient services. These limitations may be found and disallowed during audits.

7.7 Time of Service Limitation

Services that should never occur during the same time may be found and disallowed during audit.

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TABLE 7-1: SD/MC TABLE OF MULTIPLE-SERVICE BILLING EDITS¹³¹

Mode of Service	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	12, 18	05	05	12, 18	12, 18	07-09	07-09	05
Service Function	10-19, 30-59	60-69	01-09	85-89	81-84	95-99	91-94	65-79	40-49	70-79	20-29	10-18	19	20-29
	MH/TBS Services (5)	Med Support (1)	CM / Brokerage (4)	DT Intensive Full Day	DT Intensive Half Day	DT Rehab Full Day	DT Rehab Half Day	Adult Residntl	Adult Crisis Residntl	Crisis Intvntn (2)	Crisis Stabilizn ER & UC (3)	Hospital Inpatient	Hospital Inpatient Admin Day (6)	PHF
MH/TBS Services (5)				T	T	T	T	T	A		T	A	L	A
Med Support (1)											T	A	L	A
CM/Brokerage (4)												I	I	I
DT Intensive Full Day	T			L	L	L	L		A		T	A	L	A
DT Intensive Half Day	T			L	L	L	L		A		T	A	L	A
DT Rehab Full Day	T			L	L	L	L		A		T	A	L	A
DT Rehab Half Day	T			L	L	L	L		A		T	A	L	A
Adult Residential	T							L	A		T	A	L	A
Adult Crisis Residential	A			A	A	A	A	A	L	A	A	A	L	A
Crisis Intervention (2)									A		T	A	L	A
Crisis Stabilizn ER&UC(3)	T	T		T	T	T	T	T	A	T	T	A	L	A
Hospital Inpatient	A	A	I	A	A	A	A	A	A	A	A	L	L	A
Hosp Inpatient Administrative Day (6)	L	L	I	L	L	L	L	L	L	L	L	L	L	L
PHF	A	A	I	A	A	A	A	A	A	A	A	A	L	L

I Institutional Limitations - Audit
L Lockout - Services that may not occur on the same day
A Lockout except for day of admission
T Lockout during actual time service is provided - audit, not a computer edit
 Multiple services may be allowed on the same day, limited by the maximum time allowed.

(1) Maximum of 4 hours (240 Minutes) per day
(2) Maximum of 8 hours (480 minutes) per day
(3) Maximum of 20 hours per 24 hour period
(4) Maximum of 24 hours (1440 minutes) per day
(5) Maximum of 2878 minutes per day
(6) An Administrative Day may not be billed on the day of admission

¹³¹ Lockout specifics are contained in Cal. Code Regs., Title 9, Division 1, Chapter 11.

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Chapter 7: Edits, Lockouts and Overrides

TABLE 7-2: DUPLICATE AND MULTIPLE SERVICE BILLING SCENARIOS

Duplicates that fail the edits

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C1234567A	6701	2/2/2005	18	10	1	50	\$122.00			
C1234567A	6701	2/2/2005	18	10	1	50	\$122.00		Failed the duplicate edit	

When two or more records LOOK like duplicates, an override code will allow them to pass the duplicate edit. This might occur when two clinicians at the same provider provide concurrent services.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C3334567A	6702	2/2/2005	18	10	1	50	\$122.00			
C3334567A	6702	2/2/2005	18	10	1	50	\$122.00	Y	Passed the edits - due to Override	

Any number of claims for service may be approved for the same recipient on the same day, up to the maximum time allowed for that type of service. This is an example with several claims, from different providers, with the last one exceeding the maximum.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C7636163A	6701	4/3/2005	18	60	1	30	\$135.30		Cumulative # of minutes = 30	
C7636163A	6702	4/3/2005	18	60	1	120	\$541.20		Cumulative # of minutes = 150	
C7636163A	6733	4/3/2005	18	60	1	30	\$135.30		Cumulative # of minutes = 180	
C7636163A	6740	4/3/2005	18	60	1	10	\$45.10		Cumulative # of minutes = 190	
C7636163A	6745	4/3/2005	18	60	1	40	\$180.40		Cumulative # of minutes = 230	
C7636163A	6745	4/3/2005	18	60	1	30	\$135.30		Failed the Maximum Time Allowance edit since the cumulative # of minutes exceeded the 240 minutes allowed per day	

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Any number of claims for service may be approved for the same recipient on the same day, up to the maximum time allowed for that type of service. This is an example with two claims, with the second one exceeding the maximum.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C9914939A	6790	4/11/2005	18	70	1	360	\$1,306.80		Cumulative # of minutes = 360	
C9914939A	6792	4/11/2005	18	70	1	180	\$653.40		Failed the Maximum Time Allowance edit since the cumulative # of minutes exceeded the 480 minutes allowed per day	

Any number of claims for service may be approved for the same recipient on the same day, up to the maximum time allowed for that type of service. This is an example with a claim which exceeds the maximum.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C7755544A	6790	4/10/2005	18	20	1	23	\$2,033.66		Failed the Maximum Time Allowance edit of 20 hours per 24 hour period	

Claims that exceed the Statewide Maximum Allowance (SMA) for the current fiscal year will be adjusted to reflect the SMA.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C3312456A	6790	4/15/2005	18	10	1	100	\$290.00		Exceeded the SMA, approved amount will reflect the SMA of \$2.44 per staff minute, or \$244.00.	

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Chapter 7: Edits, Lockouts and Overrides

Only one Day Treatment service may be provided to the same beneficiary on the same day.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C6157894A	6790	4/16/2005	18	81	1	1	\$134.81			
C6157894A	6792	4/16/2005	18	91	1	1	\$78.64		Failed the edit limit of only one Day Treatment Service	

Only one Hospital Inpatient or Hospital Inpatient Administrative Day service may be provided to the same beneficiary on the same day.

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C6198742A	6790	4/20/2005	07	10	1	1	\$913.58			
C6198742A	6792	4/20/2005	07	19	1	1	\$236.82		Failed the edit limit of only one Hospital Inpatient or Hospital Inpatient Administrative Day on one day.	

Outpatient services are allowed on the day of Admission, subject to the other edits (such as SMA and Maximum Time Allowed).

Client	Provider	Date of Service	Mode of Service	Service Function	Units of Service	Units of Time	Net Billed Amount	Duplicate Override	Comments	Admission Date
C8167742A	6790	4/10 to 4/18/2005	07	10	9	0	\$8,222.22		Hospital Inpatient	4/10/2005
C8167742A	6790	4/19 to 4/21/2005	07	19	2	0	\$473.64		Hospital Administrative Days - discharged on 4/21/05	4/10/2005
C8167742A	6701	4/10/2005	18	10	1	30	\$73.20			
C8167742A	6783	4/10/2005	18	60	1	45	\$202.95			
C8167742A	6705	4/10/2005	18	84	1	1	\$134.81			
C8167742A	6701	4/10/2005	18	20	1	4	\$353.92			
C8167742A	6792	4/10/2005	18	01	1	45	\$85.05			

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Appendix A: Glossary

APPENDIX A: GLOSSARY

837/835	HIPAA transactions are commonly referred to by their transaction set/version. Common names used in this manual are: 837I (Institutional) transactions, 837P (Professional) transactions, and 835 (Health Care Claim Payment/Advice) transactions
AB	Assembly Bill
ADP	Department of Alcohol and Drug Programs
Beneficiary	A client who is receiving financial benefit from a funding source such as Medi-Cal Medicare, insurance, etc.
CCR	California Code of Regulations
CFR	Code of Federal Regulations; also, County of Financial Responsibility
CFRS	Cost and Financial Reporting System
CIMH	California Institute for Mental Health
CIN	Client Index Number (first 9 digits of the Beneficiary Identification Card).
Client	Anyone who is receiving mental health services (even a one-time initial assessment).
CMHDA	California Mental Health Directors Association
CMS	Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services)
Crosswalk	Cross-reference table
CSI	Client Services Information System
DCS	Disallow Claims System
DHCS	Department of Health Care Services (formerly DHS)
DHS	Department of Health Services
DMH	Department of Mental Health
ECR	Error Correction Report
EOB	Explanation of Balance
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EVC	Eligibility Verification Confirmation numbers
FAQs	Frequently Asked Questions
FFP	Federal Financial Participation
FFS	Fee for Service
FMAP	Federal Medicaid Assistance Percentages

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Appendix A: Glossary

FY	Fiscal Year
GF	General Fund
HFP	Healthy Families Program
HIPAA, Title II	Health Insurance Portability and Accountability Act of 1996
HIPAA Transaction Standards	<p>HIPAA transaction standards have five parts. Example: ASC X12N 837 004010 X098</p> <p>ASC – Source of a standard; in this case, the standard comes from the American National Standards Institute (ANSI) Accredited Standards Committee (ASC). This is occasionally shown as ‘ANSI ASC’ or just ‘ASC.’</p> <p>X12N – A subcommittee of the ANSI ASC X12 committee; the X12N subcommittee defines EDI standards used in the insurance industry.</p> <p>837 – A transaction set; in the case of the 837 transaction, Institutional, Professional, and Dental variations exist.</p> <p>004010 – Version of the X12 standard; this is usually referred to as ‘version 4010.’ It identifies version 4 of the standard, Release 1, sub release 0.</p> <p>X098 – Internal reference numbers; in the case of the 837 transaction, three versions exist: 837I (Institutional), 837P (Professional), and 837D (Dental). Reference numbers X096, X097, and X098 identify these, respectively.</p>
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan
IPC	Inpatient Consolidation
ITWS	Information Technology Web Services
Legal Entity (LE)	Each county mental health department or agency and the corporations, partnerships, or agencies, providing public mental health services under contract with the county mental health department or agency.
MAA	Medi-Cal Administrative Activities
Medi-Cal	California’s Medicaid program
MEDS	Medi-Cal Eligibility Data System
MHP	Mental Health Plan
NICHY	National Dissemination Center for Children with Disabilities
NPI	National Provider Identifier
NTE Field	Not to Exceed Field
OBRA '89	Omnibus Budget Reconciliation Act of 1989
OPS	Online Provider System

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Appendix A: Glossary

POS	Point of Service
Provider	A supplier of mental health services in California that are used by county mental health programs.
Provider File	Lists all providers of mental health services in California that are used by county mental health programs.
PRV	Provider System
SB	Senate Bill
Mental Health Medi-Cal	Another name for the program which oversees Short-Doyle / Medi-Cal claiming
SCHIP	State Children's Health Insurance Program
SED	Seriously Emotionally Disturbed
SEP	Special Education Pupils
SGF	State General Funds
SMA	Statewide Maximum Allowances
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
TAR	Treatment Authorization Request
TBS	Therapeutic Behavioral Services
Title 9	Portion of California Code of Regulations Community Mental Health Services
UMDAP	Uniform Method of Determining Ability to Pay
UR	Utilization Review
USC	U.S. Government Code (USC)
VCR	Void, Correction, and Replacement
W&I Code	Welfare and Institutions Code

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Appendix A: Glossary

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Appendix B: Existing SGF and FFP Claims Payment Overview Process Flow

APPENDIX B: EXISTING SGF AND FFP CLAIMS PAYMENT OVERVIEW PROCESS FLOW

The following figure illustrates the shapes and color coding associated with the process flow.

PROCESS FLOW LEGEND

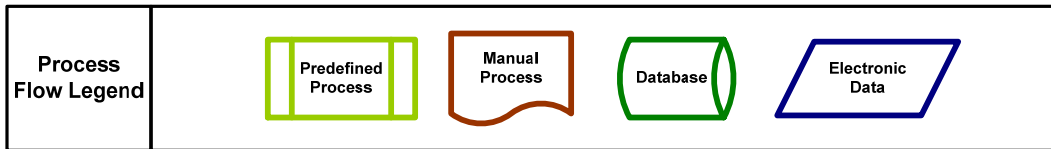
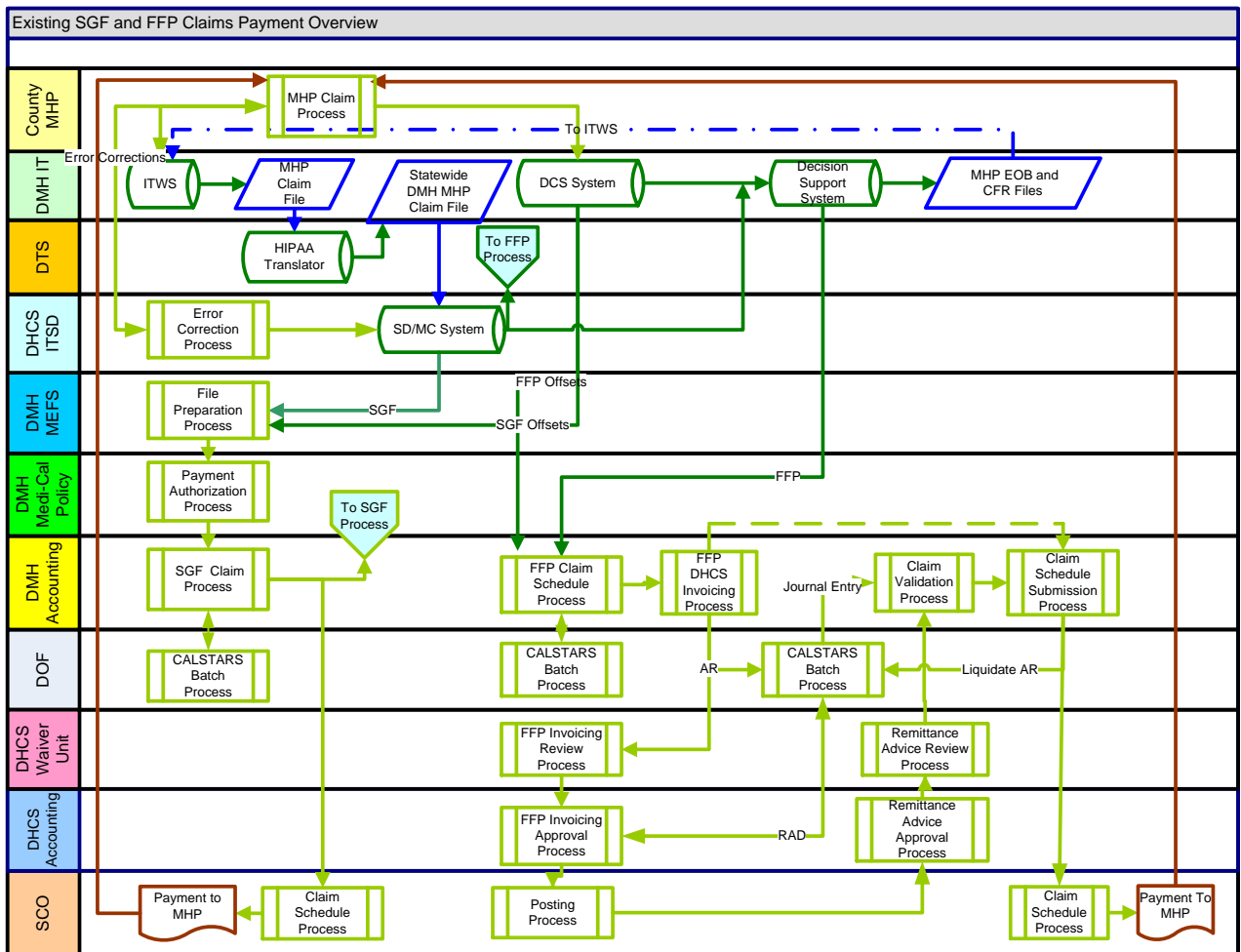


FIGURE 7-1: SGF AND FFP CLAIMS PAYMENT OVERVIEW PROCESS FLOW



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Appendix B: Existing SGF and FFP Claims Payment Overview Process Flow

MENTAL HEALTH MEDI-CAL BILLING MANUAL

Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

APPENDIX C: CONVERSION OF LOCAL DATA SETS IN DMH APPROVED CLAIM DATA SETS

Local county mental health operations vary in the way their service staff code mental health services. Local coding may be in the form of HCPCS or CPT codes, DMH Mode of Service/Service Function codes, or a unique set of codes, which is linked to HCPCS, CPT, or DMH Mode/Service Function codes through crosswalk tables. In all cases local county operations must conform or translate their local codes to those 837 transaction coding requirements found in the HIPAA Companion Guide.¹³²

Critical to understanding Mental Health Medi-Cal claiming is the fact that the DMH 837 health care claim transaction format does not use the Mode of Service and related Service Function codes. Instead it uses different codes to represent similar information. These codes include Procedure codes, Place of Service codes, Taxonomy codes, and Modifier codes. Further discussion of this concept is found in Chapter 4 of this manual.

DMH 837 transaction Procedure codes are required by national HIPAA 837 transaction code standards. The HIPAA Companion Guide must be referenced to fully understand the related full and correct coding of Mental Health Medi-Cal claims.

Tables 7.3 through 7.9 illustrate key Mode of Service/Service Function crosswalks concepts that are integrated into the HIPAA Companion Guide. All of these tables have the same basic format. Columns A through D represent key Cost Report and/or CSI coding. Columns F through H represent key coding found in the SD/MC proprietary claim format (used prior to 837 transaction claiming). Columns J through O represent key coding found in 837 transaction claiming. This format describes the various coding constructs which will provide a more comprehensive knowledge of the scope of County/DMH/DHCS claims processing. Review of this format facilitates comparison and contrast of claiming by Modes of Service.

Table 7-3 represents the Mode of Services and Service Function information related to MAA by a county MHP. MAA activities can not be claimed through Mental Health Medi-Cal. Chapter 5 of this manual provides information regarding county Medi-Cal reimbursement relative to administration and utilization review.

Table 7-4 represents the Modes of Services and Service Function information related to 24 Hour Services by a county MHP. This table demonstrates how a particular Mode of Service may have services that are billable to Mental Health Medi-Cal as well as services not billable to Mental Health Medi-Cal. This table also shows how some Mode of Service/Service Function codes were translated to the prior DMH SD/MC proprietary claim. It demonstrates how the same Mode of Service/Service Function codes are represented as a Procedure code in the SD/MC 837 transaction claim format.

The following is an example using 24 Hour Services billable for Mental Health Medi-Cal and the related applicable to the Modes of Service. A description by row/column is used to explain table concepts.

Line 4 of Table 7-4 shows detail for Local Hospital Inpatient (age 21 to 64) SD/MC 837 transaction claiming.

¹³² Cal. DMH (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from:
http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

Line 4, Column B is the Cost Reporting Mode of Service 05 (which represents the mode of 24 Hour-type services).

Line 4, Column C shows a range of Service Function codes used by counties in Cost Reporting (10 to 18). Counties have their own rationale for how or why they utilize Service Function codes, but their choices must be within the allowable range. For example, a county that has two separate Local Hospital Inpatient facilities might show costs as follows:

- Facility 1: Mode 05, Service Function 10
- Facility 2: Mode 05, Service Function 11

Line 4, Column D shows the type of Units of Service to be represented on the Cost Report.

Line 4, Column F shows the Mode of Service, i.e., 07, specific to the SD/MC proprietary claim. The different Modes of Service represent the type of Hospital Inpatient (either a general hospital or a psychiatric hospital). The psychiatric hospital was further delineated for those over age 64 and under age 21. Psychiatric hospitals are considered institutes for mental disease by the Federal Government, and for clients aged 21-64 there is no FFP reimbursement.

The SD/MC proprietary claim Mode of Service 07 in this example demonstrates the difference between this claiming Mode of Service and the cost reporting Mode of Service 05. Review of the other tables shows the same concept for all the Modes of Service.

The complete set of SD/MC proprietary claim codes available were:

- Mode 05 for 24-Hour non-Hospital Services
- Mode 07 for General Hospital Inpatient
- Mode 08 for Psychiatric Hospital Inpatient (Under 21 years of age)
- Mode 09 for Psychiatric Hospital Inpatient (Over 64 years of age)
- Mode 12 for Outpatient Hospital Services
- Mode 18 for Non-Residential Rehabilitative Treatment

Line 4, Column G represents the Service Function codes to the SD/MC proprietary claim Mode of Service, 07. These Service Function codes are identical to those found in their corresponding Cost Reporting Mode of Service. This is always true when comparing other table lines.

Line 4, Column H shows the type of Cost Units upon which the costs are determined. Cost Units may be units of service or units of time.

Line 4, Columns J and K demonstrate there are no equivalent Mode of Service and Service Function codes in a SD/MC 837 transaction. As stated before, the SD/MC 837 transaction requires other code constructs. Because of this fundamental difference in

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

approach between the SD/MC 837 transactions and prior SD/MC proprietary claim formats, relevant crosswalks are found throughout the HIPAA Companion Guide.¹³³

Line 4, Column K shows the HCPCS Procedure code of H2015, Comprehensive Community Support Services, per 15 minutes.¹³⁴ HCPCS Procedure codes are required in SD/MC 837 transaction claims. CMS maintains background information on HCPCS and CPT codes.¹³⁵

The implementation of HCPCS codes in DMH 837 transaction claims may affect the ability to directly relate Cost Reporting Mode of Service/Service Function codes to the DMH SD/MC adjudicated claim Mode of Service/Service Function data. This may occur because DMH 837 transaction claims must currently be translated back to the prior SD/MC proprietary claim format used by DMH/DHCS claiming systems. This is the role of the current Translator. Since the DMH 837 transaction claim does not have the original Mode of Service/Service Function descriptors, specific Service Function detail may be unavailable. The following discussion exemplifies this.

Example Service Function Detail Loss

County A provides both an Assessment and a Collateral service to the same client in the same day. County A computer systems track this through internal codes representing Mode of Service 15 (Outpatient) with:

- Collateral local coding is equal to Service Function 10
- Assessment local coding is equal to Service Function 30

When the county creates an 837 transaction claim for each of these services, the result is that both of these services will be represented by Procedure code H2015. A review of **TABLE 7-6** demonstrates the Procedure code H2015 mapping.

When the DMH SD/MC Translator receives the county's related 837 transaction claim, the Translator does not translate the 837 transaction claim back to the county's local code. Since Procedure code H2015 is always considered a Mental Health Service to DMH, the DMH Translator converts the county 837 transaction claim data to Service Function 30 (Mental Health Service).

The crosswalk tables provided in Tables 7.3 through 7.9 describe which Modes of Service and Service Function combinations are acceptable to include on an SD/MC 837 transaction claim. The tables also show all the current Modes of Service and Service Function combinations.

¹³³ Cal. DMH (2007, June). Short Doyle/Medi-Cal Claims Processing System HIPAA Trading Partner Companion Guide, retrieved July 1, 2008 from:

http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

¹³⁴ Retrieved July 1, 2008 from: <http://www.icd9data.com/>

¹³⁵ Retrieved July 1, 2008 from: <http://www.cms.hhs.gov/MedHCPCSGenInfo>

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-3: ADMINISTRATION RELATED CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L	M	N
Cost Reporting Information					SD/MC Proprietary Claim					SD/MC 837 Transaction			
Programs	Mode Code	Service Function code	Cost Units										
Administration Support	20	-	-										
Research and Evaluation	25	-	-										
Formal Training Programs	40	-	-										
Contract Administration	41	-	-										
Utilization Review	42	-	-										
NOTE: The DMH 837 transaction does not contain any service or taxonomy coding to directly bill Interim Mental Health Medi-Cal for these related program costs.													

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-4: 24 HOUR SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L	M
Cost Reporting Information					SD/MC Proprietary Claim				SD/MC 837 Transaction			
Programs	Mode Code	Service Function Code	Cost Units		Mode Code	Service Function Code	Cost Units		Revenue Code	Procedure Code	Modifier 2	Cost Units
Local Hospital IP/General Hospital IP	05	10 to 18	Day		07	10 to 18	Day		0100	H2015		Day
Local Hospital IP/Psychiatric Hosp IP-under age 21	05	10 to 18	Day		08	10 to 18	Day		0100	H2015	HA	Day
Local Hospital IP/Psychiatric Hosp IP-over age 64	05	10 to 18	Day		09	10 to 18	Day		0100	H2015	HC	Day
Local Hospital Admin Day/General Hospital IP	05	19	Day		07	19	Day		0101	H0046		Day
Local Hospital Admin Day/Psychiatric Hosp IP-under age 21	05	19	Day		08	19	Day		0101	H0046	HA	Day
Local Hospital Admin Day/Psychiatric Hosp IP-over age 64	05	19	Day		09	19	Day		0101	H0046	HC	Day
Psychiatric Health Facility (PHF)	05	20 to 29	Day		05	20 to 29	Day		-	H2013		Day
SNF Intensive	05	30 to 34	Day		-	-	-		-	-		-
IMD Basic (No Patch)	05	35	Day		-	-	-		-	-		-
IMD Patch	05	36 to 39	Day		-	-	-		-	-		-
Adult Crisis Residential	05	40 to 49	Day		05	40 to 49	Day		-	H0018	HB or HC	Day
Jail Inpatient	05	50 to 59	Day		-	-	-		-	-		-
Residential Other	05	60 to 64	Day		-	-	-		-	-		-
Adult Residential	05	65 to 79	Day		05	65 to 79	Day		-	H0019	HB or HC	Day
Semi - Supervised Living	05	80 to 84	Day		-	-	-		-	-		-
Impendent Living	05	85 to 89	Day		-	-	-		-	-		-
MH Rehab Centers	05	90 to 94	Day		-	-	-		-	-		-

MENTAL HEALTH MEDI-CAL BILLING MANUAL

Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-5: DAY SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L	M	N
Cost Reporting Information					SD/MC Proprietary Claim				SD/MC 837 Transaction				
Programs	Mode Code	Service Function code	Cost Units		Mode Code	Service Function code	Cost Units		Procedure Code	Modifier 2	Place of Service	Cost Units	Taxonomy Code
Crisis Stabilization - ER	10	20 to 24	Hour		12	20 to 24	Hour		S9484	TG	23	Hour	282N00000X, 283Q00000X
Crisis Stabilization - Urgent Care	10	25 to 29	Hour		12	25 to 29	Hour		S9484	TG	20	Hour	282N00000X, 283Q00000X
Vocational Services	10	30 to 39	-		-	-	-		-			-	
Socialization	10	40 to 49	-		-	-	-		-			-	
SNF Augmentation	10	60 to 69	-		-	-	-		-			-	
Day TX Intensive half day	10	81 to 84	1/2 day		12	81 to 84	1/2 day		H2012	TG		4 hours	282N00000X, 283Q00000X
Day TX Intensive full day	10	85 to 89	Day		12	85 to 89	Day		H2012	TG		6 hours	282N00000X, 283Q00000X
Day Rehabilitation half day	10	91 to 94	1/2 day		12	91 to 94	1/2 day		H2012			4 hours	282N00000X, 283Q00000X
Day Rehabilitation full day	10	95 to 99	Day		12	95 to 99	Day		H2012			6 hours	282N00000X, 283Q00000X
Crisis Stabilization - ER	10	20 to 24	Hour		18	20 to 24	Hour		S9484	TG	23	Hour	
Crisis Stabilization - Urgent Care	10	25 to 29	Hour		18	25 to 29	Hour		S9484	TG	20	Hour	
Vocational Services	10	30 to 39	-		-	-	-		-			-	
Socialization	10	40 to 49	-		-	-	-		-			-	
SNF Augmentation	10	60 to 69	-		-	-	-		-			-	
Day TX Intensive half day	10	81 to 84	1/2 day		18	81 to 84	1/2 day		H2012	TG		4 hours	
Day TX Intensive full day	10	85 to 89	Day		18	85 to 89	Day		H2012	TG		6 hours	
Day Rehabilitation half day	10	91 to 94	1/2 day		18	91 to 94	1/2 day		H2012			4 hours	
Day Rehabilitation full day	10	95 to 99	Day		18	95 to 99	Day		H2012			6 hours	
Crisis Stabilization - Urgent Care	10	25 to 29	Hour		18	25 to 29	Hour		S9484	TG	20	Hour	

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

Vocational Services	10	30 to 39	-	-	-	-	-	-			-	
Socialization	10	40 to 49	-	-	-	-	-	-			-	
SNF Augmentation	10	60 to 69	-	-	-	-	-	-			-	
Day TX Intensive half day	10	81 to 84	1/2 day	18	81 to 84	1/2 day	H2012	TG			4 hours	
Day TX Intensive full day	10	85 to 89	Day	18	85 to 89	Day	H2012	TG			6 hours	
Day Rehabilitation half day	10	91 to 94	1/2 day	18	91 to 94	1/2 day	H2012				4 hours	
Day Rehabilitation full day	10	95 to 99	Day	18	95 to 99	Day	H2012				6 hours	

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-6: OUTPATIENT SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L	M
Cost Reporting Information					SD/MC Proprietary Claim				SD/MC 837 Transaction			
Programs	Mode Code	Service Function code	Cost Units		Mode Code	Service Function code	Cost Units		Procedure Code	Place of Service	Cost Units	Taxonomy Code
Linkage/Brokerage (Targeted Case Management (TCM))	15	01 to 09	minutes		12	01 to 09	minutes		T1017		minutes	282N00000X, 283Q00000X
Collateral	15	10 to 18	minutes		12	10 to 18	minutes		H2015		minutes	282N00000X, 283Q00000X
Professional Inpatient Visit - Collateral	15	19	minutes		12	19	minutes		H2015	21 or 51	minutes	282N00000X, 283Q00000X
Mental Health Services	15	30 to 57	minutes		12	30 to 38	minutes		H2015		minutes	282N00000X, 283Q00000X
Professional Inpatient Visit Mental Health Services	15	19,39,49,59	minutes		12	39	minutes		H2015	21 or 51	minutes	282N00000X, 283Q00000X
Therapeutic Behavioral Services	15	58	minutes		12	58	minutes		H2019		minutes	282N00000X, 283Q00000X
Medication Support	15	60 to 68	minutes		12	60 to 68	minutes		H2010		minutes	282N00000X, 283Q00000X
Professional Inpatient Visit - Medication Support	15	69	minutes		12	69	minutes		H2010	21 or 51	minutes	282N00000X, 283Q00000X
Crisis Intervention	15	70 to 78	minutes		12	70 to 78	minutes		H2011		minutes	282N00000X, 283Q00000X
Professional Inpatient Visit Crisis Intervention	15	79	minutes		12	79	minutes		H2011	21 or 51	minutes	282N00000X, 283Q00000X
Linkage/Brokerage (Targeted Case Management (TCM))	15	01 to 09	minutes		18	01 to 09	minutes		T1017		minutes	
Collateral	15	10 to 18	minutes		18	10 to 18	minutes		H2015		minutes	
Professional Inpatient Visit - Collateral	15	19	minutes		18	19	minutes		H2015	21 or 51	minutes	
Mental Health Services	15	30 to 57	minutes		18	30 to 38	minutes		H2015		minutes	
Professional Inpatient Visit Mental Health Services	15	19,39,49,59	minutes		18	39	minutes		H2015	21 or 51	minutes	
Therapeutic Behavioral Services	15	58	minutes		18	58	minutes		H2019		minutes	
Medication Support	15	60 to 68	minutes		18	60 to 68	minutes		H2010		minutes	
Professional Inpatient Visit -	15	69	minutes		18	69	minutes		H2010	21 or	minutes	

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Medication Support										51		
Crisis Intervention	15	70 to 78	minutes		18	70 to 78	minutes		H2011		minutes	
Professional Inpatient Visit Crisis Intervention	15	79	minutes		18	79	minutes		H2011	21 or 51	minutes	

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-7: OUTREACH SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L
Cost Reporting Information					SD/MC Proprietary Claim				SD/MC 837 Transaction		
Programs	Mode Code	Service Function code	Cost Units								
Mental Health Promotion	45	10 to 19	Hours								
Community Client Services	45	20 to 29	Hours								
NOTE: The DMH 837 transaction does not contain any service or taxonomy coding to directly bill Interim Mental Health Medi-Cal for these related program costs.											

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-8: MEDI-CAL ADMINISTRATIVE ACTIVITIES SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L	
Cost Reporting Information					SD/MC Proprietary Claim					SD/MC 837 Transaction		
Programs	Mode Code	Service Function code	Cost Units									
Medi-Cal Outreach	55	01 to 03	Hours									
Medi-Cal Eligibility Intake	55	04 to 06	Hours									
Medi-Cal Contract Administration	55	07 to 09	Hours									
Crisis Referral	55	11 to 13	Hours									
MHS Contract Administration	55	14 to 16	Hours									
Discounted MH Outreach	55	17 to 19	Hours									
SPMP Case Management	55	21 to 23	Hours									
SPMP Program Planning	55	24 to 26	Hours									
SPMP MAA Training	55	27 to 29	Hours									
Non-SPMP Case Management	55	31 to 34	Hours									
Non-SPMP Program Management	55	35 to 39	Hours									
<p>NOTE: The DMH 837 transaction does not contain any service or taxonomy coding to directly bill Interim Mental Health Medi-Cal for these related program costs.</p>												

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Appendix C: Conversion of Local Data Sets in DMH Approved Claim Data Sets

TABLE 7-9: SUPPORT SERVICES CROSSWALKS

A	B	C	D	E	F	G	H	I	J	K	L
Cost Reporting Information					SD/MC Proprietary Claim				SD/MC 837 Transaction		
Programs	Mode Code	Service Function code	Cost Units								
Conservatorship Investigation	60	20 to 29	Hours								
Conservatorship Administration	60	30 to 39	Hours								
Life Support/ Board and Care	60	40 to 49	Hours								
Case Management Support	60	60 to 69	Hours								
Client Housing Support Expenditures	60	70	-								
Client Housing Operating Expenditures	60	71	-								
Client Flexible Support Expenditures	60	72	-								
Non Medi-Cal Capital Assets	60	75	-								
Other Non Medi-Cal Client Support Expenditures	60	78	-								
<p>NOTE: The DMH 837 transaction does not contain any service or taxonomy coding to directly bill Interim Mental Health Medi-Cal for these related program costs.</p>											

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Appendix D: Hyperlinks to Materials Referenced in This Manual

APPENDIX D: HYPERLINKS TO MATERIALS REFERENCED IN THIS MANUAL

Centers for Medicare & Medicaid Services (CMS) EPSDT Information:

<http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/>

Centers for Medicare & Medicaid Services (CMS) HCPCS Code Set:

<http://www.cms.hhs.gov/MedHCPCSGenInfo>

Centers for Medicare & Medicaid Services (CMS) HIPAA Information:

<http://www.cms.hhs.gov/HIPAAGenInfo/>

Centers for Medicare & Medicaid Services (CMS) Medicaid Information:

<http://www.cms.hhs.gov/home/medicaid.asp>

Code of Federal Regulations, Title 42, Volume 4:

http://a257.g.akamaitech.net/7/257/2422/16nov20071500/edocket.access.gpo.gov/cfr_2007/octqtr/42cfr447.45.htm

DHCS Bulletins & Manuals:

<http://www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx>

DHCS Inpatient/Outpatient Medi-Cal Manual: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

DHCS Letters: <http://www.dhcs.ca.gov/formsandpubs/Pages/Letters.aspx>

DHCS Medi-Cal Eligibility Branch:

<http://www.dhs.ca.gov/mcs/mcpd/meb/ACLs/Index/2007ACWDLs/10thru19.htm>

DHCS Provider Point of Service (POS) System: www.medi-cal.ca.gov

DMH Website: <http://www.dmh.ca.gov>

DMH - ADT Aid Codes Master Chart:

https://mhhitws.cahwnet.gov/docs/public/reference_information.asp

DMH Approved, Denied, Error Correction MS Access Database:

https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/eob-eecr_application_database_v3.3.asp

DMH Cost and Financial System Reporting Manual:

https://mhhitws.cahwnet.gov/systems/cfrs/docs/private/cfrs_manual.asp

DMH County Multi-Year Mental Health Medi-Cal Excel Pivot Tables:

https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/anomaly_reports.asp

DMH County of Fiscal Responsibility Files (CFR) Subsystem Excel File:

<https://mhhitws.cahwnet.gov/itws/transfer.asp?SysID=1>

DMH EPSDT Therapeutic Behavioral Services:

http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

DMH Explanation of Balances and Electronic Error Correction Report (EOB-eECR

v3.3.2): https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/eob-eecr_application_database_v3.3.asp

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DMH Information Notice 03-10 (New Claim Submission Procedures and HIPAA Testing and Certification for SD/MC): <http://www.dmh.ca.gov/DMHDocs/docs/notices03/03-10.pdf>

DMH Information Notice 05-07 (Rates for Inpatient Hospital Services Contracts): <http://www.dmh.ca.gov/DMHDocs/docs/notices05/05-07.pdf>

DMH Information Notice 07-01 (Healthy Families Program): <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-01.pdf>

DMH Information Notice 07-22 (Revised Maximum Rate Limits for Mental Health Medi-Cal Services): <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-22.pdf>

DMH Information Notice 07-23 (Revised Maximum Rate Limits for Mental Health Medi-Cal Services): <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-23.pdf>

DMH Information Notice 07-24 (Revised Maximum Rate Limits for Mental Health Medi-Cal Services): <http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-24.pdf>

DMH Information Notice 98-13 (UMDAP Brief): <http://www.dmh.ca.gov/DMHDocs/docs/notices98/98-13.pdf>

DMH Letters & Information Notices: <http://www.dmh.ca.gov/DMHDocs>

DMH Letter No.: 05-10 (Short-Doyle/Medi-Cal Administrative Cost Claims): <http://www.dmh.ca.gov/dmhdocs/docs/letters05/05-10.pdf>

DMH Letter No.: 05-11 (Requirements for Mental Health Medi-Cal Claims for Costs of Quality Assurance): <http://www.dmh.ca.gov/dmhdocs/docs/letters05/05-11.pdf>

DMH Letter 07-05 (Changes to Mental Health Medi-Cal): http://www.dmh.ca.gov/DMHDocs/docs/letters07/07-05_Letter.pdf

DMH Letter 07-10 (Instructions for completing the Legal Entity File Update Form MH3840): <http://www.dmh.ca.gov/DMHDocs/docs/letters07/07-10.pdf>

DMH Letter 99-03: Therapeutic Behavioral Services: <http://www.dmh.ca.gov/DMHDocs/docs/letters99/99-03.pdf>

DMH Medi-Cal Mental Health Policy: Consolidation and Managed Care: http://www.dmh.ca.gov/Medi_Cal/Consolidation.asp

DMH Provider File Update Form (3829) and Legal Entity Update Form (3840): <https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

DMH Provider/Legal Entity System Enrollment Guide: <https://mhhitws.cahwnet.gov/docs/public/enrollmentGuides.asp>

DMH Provider System Documentation Manual: <https://mhhitws.cahwnet.gov/systems/provider/docs/private/information.asp>

EPSDT/Therapeutic Behavioral Services (TBS): http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

Federal Medical Assistance Percentages (FMAP): <http://aspe.hhs.gov/health/fmap.htm>

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Federal Register Volume 71, Number 230:

<http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/E6-20264.pdf>

http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2006_register&position=all&page=69209

HIPAA Companion Guide: http://www.dmh.ca.gov/hipaa/docs/DMH_CompanionGuide-061807.pdf

HIPAA Implementation Guide: I:\ProjDocs\HIPAA\Implementation Guides\4010 Implementation Guides

HIPAA Trading Partner Agreement:

Healthy Families Program website: <http://www.healthyfamilies.ca.gov/hf/hfhome.jsp>

ICD9 Medical Codes: <http://www.icd9data.com/>

IPC/134 - Inpatient Consolidation (IPC) RF-0-134 Report:

https://mhhitws.cahwnet.gov/systems/IPC_134/docs/public/in-patient_consolidation_file_134.asp

ITWS Anomaly Reports (if you cannot access this link, check with your supervisor):

https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/anomaly_reports.asp

ITWS Approver Forms: <https://mhhitws.cahwnet.gov/docs/public/authforms.asp>

ITWS Contact Page: <https://mhhitws.cahwnet.gov/docs/public/contact.asp>

ITWS Enrollment form: <https://mhhitws.cahwnet.gov/enroll/default.asp?Page=1>

ITWS Error Correction Report Handbook:

<https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/referenceinfo.asp>

ITWS Mental Health Medi-Cal Reference Information (if you cannot access this link, check with your supervisor):

<https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/referenceinfo.asp>

ITWS Transfer Files: <https://mhhitws.cahwnet.gov/itws/transfer.asp?SysID=1>

ITWS Web Portal: <https://mhhitws.cahwnet.gov>

ITWS Virtual Tour:

https://mhhitws.cahwnet.gov/demo/How%20to%20Enroll_files/frame.htm

Medi-Cal Certification and Transmittal Form:

<https://mhhitws.cahwnet.gov/systems/cfrs/docs/private/forms.asp>

Medi-Cal HIPAA: ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications: http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaaspecs_home.asp

Medi-Cal Inpatient/Outpatient Manual:

<http://www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx>

Medi-Cal Publications: <http://www.medi-cal.ca.gov/publications.asp>

Medi-Cal Share of Cost: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc

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Mental Health Medi-Cal Claim Submission Schedule:

<https://mhhitws.cahwnet.gov/systems/sdmc/docs/private/referenceinfo.asp>

National Dissemination Center for Children with Disabilities (NICHCY):

<http://www.nichcy.org/training/contents.asp#toc>

National Provider Identifier: <http://files.medi-cal.ca.gov/pubsdoco/npi/npi.asp>

Online Provider System (OPS): <https://mhhitws.cahwnet.gov/itws/Provider/>

Social Security Supplemental Security Income Website:

<http://www.ssa.gov/pubs/11000.html>

Stop Medi-Cal Fraud website: <http://www.stopmedi-calfraud.dhs.ca.gov/>

Treatment Authorization Request (TAR): <http://files.medi->

[cal.ca.gov/pubsdoco/publications/masters-mtp/part1/tar_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/tar_z01.doc)

United States Assistant Secretary for Planning and Evaluation:

<http://aspe.hhs.gov/health/fmap.htm>

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Appendix E: Error Correction Report Handbook

APPENDIX E: ERROR CORRECTION REPORT HANDBOOK



Error Correction Report Handbook

JULY 17, 2008

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Appendix E: Error Correction Report Handbook

1. INTRODUCTION

1 What is an ECR?

Claims are submitted to the California State Department of Mental Health for Short-Doyle/Medi-Cal and for SED¹³⁶-Healthy Families. Claims that do not meet edit/eligibility requirements are either denied or suspended. Claims that are suspended end up on the Edit Error Correction Report (ECR report). The ECR process is what a county uses to fix errors so that a corrected claim may be processed for payment.

The format of the ECR is always the same. There is a row of data that provides information on the specific claim. It includes BILLED MO/YR, PATIENT NAME, PATIENT RECORD NUMBER, SERVICE MO/YR, SERVICE DAYS, MODE OF SERVICE, SERVICE FUNCTION, UNITS/TIME, SERVICE UNITS, WELFARE ID/SSN and BILLED AMOUNT. Below this claim listing are the errors that have been identified. The listing of errors may include a box for an OVERRIDE CODE. It will always have a FIELD NUMBER, and BOXES to enter corrected information. It will also describe the FIELD IN ERROR; give the current value for that field, and an error message.

The ECR corrections received are entered by key data entry into the Medi-Cal Short-Doyle (MSD) system. The new values and/or overrides replace what is currently in suspense. The claim is then processed again going through the same edits. If it is not corrected properly, it will come out on the next ECR as an error. Corrections, when done incorrectly, may cause the process to deny the claim rather than suspend it.

The following is a listing of error messages that may appear on the ECR. An error message can appear related to a number of fields that are incorrect. The number in brackets is the number of the error message as it relates to codes on the electronic EOB (Explanation of Balance). The complete listing of FIELD numbers is in Table E4-1: Short-Doyle/Medi-Cal Claim Record Field Names and Conditions located in the reference information section of this handbook.

1.1 Error Messages

BLANK (01)

The identified field was left blank but is required for the edit process. Fill in the required information using the correct format for the specific field.

CONFLICTS WITH ELIGIBILITY FILE (10)

This happens when the incorrect SSN or Welfare ID is used. The edit tries to match SSN, name, age, and sex. The fix is to use the correct SSN or to delete the record. However, it may be an error in the YEAR OF BIRTH (Field 11), SEX (Field 12) or PATIENT NAME (Field 8) that keeps the edit from matching on the required fields.

Check the SSN. If it is correct make sure that the other items (YEAR OF BIRTH, SEX, PATIENT NAME) are correct. The YEAR OF BIRTH field must have the 'century' and 'year' the client was born, NOT the month and year. A client born in '1976' would be entered as '976'.

11 9 7 6

¹³⁶ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

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DATE RANGE NOT ALLOWED (22)

This relates to TREATMENT DATE (Field 16). This indicates that days-billed are in error. If the time billed is for an inpatient stay, this can be shown as a range of days (e.g., '0520'- admit date on the 5th of the month to discharge on the 20th of the month). If the time billed is for an outpatient visit on the 5th of the month, then it should be shown as '0505', which means it is for the same day.

INELIGIBLE IN MO/YR (09)

This error indicates the recipient was not eligible for Medi-Cal services during the billed month and year of service. This message is also used if recipient has a Share-of-Cost (SOC) obligation to meet. Provider is prohibited from billing Medi-Cal for services used to meet the beneficiary's SOC. When the SOC has been obligated, the balance above the SOC amount and all subsequent services for that month may be billed to Medi-Cal. There are two ways to correct this error:

If the total amount of services during the month is below the SOC amount, place an 'X' in the override code to cancel the claim from Medi-Cal, or

If the amount of services provided during the month is above the SOC amount, the total amount of services must be SOC certified using the Proof of Eligibility (POE) machine, in order to bill Medi-Cal. Once certified, on the ECR report, enter the complete Welfare ID number in field 10.

INVALID CODE (03)

There are a number of errors related to 'Invalid Code.'

SERVICE FUNCTION CODE (FIELD 18).

This is an indication that an incorrect code was entered. Verify the type of service provided, and write the correct number.

Medication Support for example.

	18	6	0
--	----	---	---

SSN ERROR (FIELD 10)

This error indicates that there was no match found in the Medi-Cal Eligibility Determination System (MEDS). Providers are responsible for verifying that the following numbers are correct:

Welfare Identification (ID) (14 digits)

Social Security Numbers (SSN) (9 digits) (must not start with an 8 or a 9)

Swipe Card (first 9 digits are the CIN)

Pseudo SSN (9 digits) (must start with an 8 or 9 and end with the letter 'P')

Client Index Number (CIN) (9 digits)

Note: Any groups of numbers that are different from 9 digits or 14 digits will fail the edit. Only use the first 9 digits on the BIC card. They are the CIN number. Do not include the CIN check digit (10th digit following the CIN).

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Appendix E: Error Correction Report Handbook

1.2 Corrections:

If the SSN indicated in the report is **wrong**, write the correct SSN in the correction field. **Leave the override code space blank.** Do not include dashes. Left justify the entry.

10 5 6 3 6 0 1 2 3 4

If the **14 digit Welfare ID** indicated on the report is **wrong**, write in the correct Welfare ID. **Leave the override code space blank.**

10 1 9 3 8 5 5 5 5 5 5 2 7 7

1.3 Other Messages Pertaining to Field 10:

1. Invalid Code: This message may occur because the first **10**-digits on the **swipe card** were used. Enter only the first **9** digits in the correction field. Or a pseudo SSN that requires a 'P.' Leave the override code blank. The preferred ID is the CIN.
2. Ineligible in Month/Year
3. Not On Eligibility File
4. No Secondary Match

DISCHARGE (FIELD 17)

This error indicates that a discharge code has been placed improperly. In the correction space, enter a lower case 'b' with a slash through it.

17 b/

DIAGNOSTIC CODE (FIELD 14)

This is an indication that the Diagnostic Code was not within the Mental Health section of the ICD-9-CM.

14 V 6 1 1

14 2 9 0 0

14 3 1 1

14 3 0 3 0 0

INVALID DRUG CODE (21)

Relates to Drug Medi-Cal only.

INVALID SERVICE FUNCTION CODE (19)

Correct the service function code.

LATE SUBMISSION (04)

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There are three possible errors.

1. The billing was not timely and may be subject to a 'Good Cause' code.
2. The claim was submitted more than a year after the month of service and is not subject to 'Good Cause' override.
3. The date is in error and needs to be corrected.

If the date used in the initial billing is verified to be correct then you may only override this error for 'Good Cause'. The codes are used to explain why the claim was not sent timely. Failure to use a 'Good Cause' code will result in rejection of the claim being corrected.

If the claim was submitted more than one year after the month of service the 'Good Cause' override code will not work as the claim is more than a year old. Place an 'X' in the override box to delete the claim.

If the date is found to be incorrect, then write the correct date in the correction field.

MEDICARE COVERAGE PART __, HIC # _____ (31)

This error message relates to the XOVER INDICATOR (Field 22). It indicates that the client is a Medicare beneficiary. Claims to Short-Doyle/Medi-Cal for services provided to a Medicare beneficiary should be claimed only after Medicare reimbursement/denial documentation has been received. There are a number of corrections and edits possible. The edits involve either deleting the claim ('X' in the override box) or a specific code in the 'XOVER INDICATOR' box and a change in the dollar amount. See 'XOVER INDICATOR' table.

If a client has Medicare coverage but the claiming **provider has not been certified as a Medicare provider**, place an 'H' in the correction space in Field 22 (**not the override space**). In Field 21 enter the amount to bill Medi-Cal only if it is different from the amount shown.

22 H

21 .

If the claim is an **X** crossover claim, meaning the **client is eligible for Medicare**, then the provider needs to verify whether or not Medicare has been billed.

If Medicare has not been billed, then **deny** the claim by putting an '**X**' in the override code. The provider must then bill Medicare. Upon receipt of Medicare payment or denial the claim may be resubmitted.

X 22

21 .

If Medicare has been billed but there is **no response** from Medicare, then **deny** the claim by putting an '**X**' in the override code. Upon receipt of Medicare payment or denial the claim may be resubmitted.

X 22

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21 .

If Medicare was billed but **payment was denied** to the provider, then **bill Medi-Cal** by putting an 'X' in Field 22 (**not the override space**). In Field 21 change the amount only if incorrect on the ECR.

22

21 .

If Medicare was billed and **payment was made** to the provider, then put an 'X' in Field 22 (**not the override space**). In Field 21 enter the amount billed net of the Medicare payment. Example: If the amount billed was \$100.20 and Medicare paid \$25.50, enter \$74.70 in Field 21.

22
21 .

If the claim is an **N** crossover claim, which means **the client was Medicare eligible but the service was not**, place an 'N' in the correction space in Field 22 (**not the override space**). In Field 21 write in the amount to be billed to Medi-Cal only if it is different from what is on the ECR. If it is the same, leave the field blank.

22

21 .

MO/YR OF SERVICE GREATER THAN RECEIPT DATE (16)

The receipt date is entered by State Department of Mental Health. This error indicates that the service was provided after the claim was received. Enter the correct date.

MODE NOT AUTHORIZED (08)

Message indicates that the wrong MODE OF SERVICE (Field 6) has been used. Verify the mode of service being provided (e.g., 18 – Outpatient Services).

MODE NOT AUTHORIZED IN MO/YR (14)

Enter the correct mode. The provider information submitted to DMH may need to be updated.

NO SECONDARY MATCH (15)

This error message usually goes with 'Conflicts with Eligibility File'. Since the SSN/Welfare ID/CIN is incorrect, all the related information is also incorrect. Use the correction field to enter all the correct information (i.e., name and year of birth).

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NOT NUMERIC (06)

This message might appear in any of seven different fields. There may be letters or spaces instead of numbers in the field.

NOT ON ELIGIBILITY FILE (11)

This error message indicates that an incorrect Welfare ID/SSN/CIN was entered. Verify the correct CIN of the client and if he was eligible during the month of service, leave the override code blank, and use the correction field to enter the correct CIN. Do not use the check digit with the CIN. The CIN is the preferred identifier to use for claiming. It will be mandatory for SD/MC Phase II.

NOT ON PROVIDER FILE (12)

This message indicates that the provider number is wrong or not on current provider listing. Provider numbers that include letters must be in upper case. Providers should contact their county mental health program to make sure the provider number is on the Medi-Cal Provider File prior to resubmission of the ECR.

NOT VALID DATE (02)

Date is not valid for the specific field. For example, Date the Claim is Submitted (Field 4) is 'CCYYMM'. Outpatient treatment Dates would be 'First Day' (01-31) 'Last Day' (01-31), for example, '0505'. Inpatient would be a range of days, for example, '0615'.

OTHER COVERGE IND - (32)

This indicates that other health coverage has been found on the MEDS system.

If the claim is a **P** crossover claim, meaning the **client has private insurance**, the provider needs to verify if the private insurance has been billed.

If private insurance has not been billed, then **deny** the claim by putting an '**X**' in the override code. The provider must then bill the private insurance. Upon receipt of insurance payment the claim may be submitted again for the balance.

22

21 .

If private insurance has been billed but there is **no response** from the insurance company, then **deny** the claim by putting an '**X**' in the override code. Upon receipt of insurance payment or denial the claim may be submitted again.

22

21 .

If private insurance was billed but **payment was denied** to provider, then **bill Medi-Cal** by putting a '**P**' in Field 22 (**not the override space**). In Field 21 write the billed amount only if it is different from the amount shown on the ECR.

22 P

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21 .

If private insurance was billed and **payment was made** to the provider, then put a 'P' in Field 22 (**not the override space**). In Field 21 enter the amount billed net of the insurance payment. Example: If the amount billed was \$100.20 and insurance paid \$25.50, enter \$74.70 in Field 21.

22 P

21 7 4 . 7 0

Other Coverage Indicator code of '9' means that client has **Healthy Families** coverage. Place an 'X' in the override Code and resubmit as a Healthy Families claim, if SED.¹³⁷ There is no other correction.

X 22

21 .

PROGRAM NOT AUTHORIZED (13)

Enter the correct program code.

SERVICE FUNCTION NOT AUTHORIZED (29)

Enter the correct service function code.

SERVICE FUNCTION NOT AUTHORIZED IN MO/YR (30)

Enter the correct service function code.

TO DAY > FROM DAY (24)

This indicates that the end date is greater than the start date. Please enter the correct dates.

UNITS NOT EQUAL TO DAYS (25)

Units claimed are not equal to the days claimed (Inpatient only), that is, the number of units is greater than the number of days possible based on the 'from' and 'to' dates. Please correct the dates or units.

UNITS/SERVICE IS NOT <=UNITS/TIME (20)

UNITS OF SERVICE (Field 20) must be equal to or less than UNITS OF TIME (Field 19).

ZERO CLAIMED (07)

¹³⁷ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

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UNITS OF TIME (Field 19) and UNITS OF SERVICE (Field 20) must be equal to or greater than zero, depending on the service. TOTAL BILLED AMOUNT (Field 21) must be greater than zero. Enter the correct amount.

1.4 Things to Remember

- ECR's must be corrected using GREEN ink.
- A signature, date and provider telephone number must be on the first page of each batch. For multiple pages the signer has the option to use a stamp pad wherein the signer's name and telephone number is provided.
- Welfare Identification Number has 14 digits.
- Social Security Number (SSN) has 9 digits and is left justified in the Welfare Identification Number field. The number on the plastic swipe card is a CIN number followed by the check digit and the issue date; the date is in a Julian format.
- Client Index Number (CIN). This number can be found on the BIC and on the MEDS screen. Use only the first 9 digits, do not include the check digit or for the BIC the Julian issue date.
- 'X' override code will delete a record for both Edit and Duplicate ECR's.
- The correction field is used for amending incorrect information only. Do not recopy data that is correct.
- Anytime a correction is being made, leave the override code field blank.
- The State Department of Mental Health Accounting Section must receive the batch within 60 days of the Run Date.

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2. DUPLICATE ERROR CORRECTION REPORT

2 Duplicate Error Correction Report (DECR)

The purpose of this report is to inform the provider of service lines that were suspended from approval because of duplicate or multiple service claiming errors. For more information refer to the Mental Health Medi-Cal Billing Manual at Chapter 7: Duplicate Claims, Maximum Service Times, Lockouts and Overrides.

The claim in error is grouped with the approved claims that identified the error and with a correction box. This group of information is printed as follows: The first line of each group is the suspended claim. The next line(s) is the approved claim(s) that caused the claim in the first line to suspend. The approved claim(s) is preceded or followed by two asterisks as an aid in identifying the approved claim(s) from the error claim. The suspended and approved claim lines display the same information with the exception of 'Billed Amount' and 'Approved Amount' and 'Patient Number' and 'Appr Date.' The suspended claim displays 'Patient Number' and 'billed amount' and the approved record displays 'Apprv Date' and 'Approved Amount.' The last item in the group is the correction boxes. These boxes are used by the providers to either override the duplicate error or to correct the claim. The first three boxes consist of:

CLAIM ID – Supplied by the computer program. The claim id from the claim in error.

O/R – Enter the override code 'Y' to approve the claim, or 'X' to delete the claim from suspense.

FIELD – Always '99'. This identifies the correction as a duplicate error correction.

The remaining correction boxes are only entered if NOT overriding the claim, i.e., to correct an error that made the claim appear to be a duplicate. Only fields that need changing should be entered in their appropriate boxes.

MO/YR SERV – Month and year the recipient received the service. (enter leading zeros)

DAYS SERV – The first and last day of treatment. (enter leading zeros)

UNITS TIME – Units of time provided. (right justified, leading zeros not required)

UNITS SV – Units of service provided. (right justified, leading zeros not required)

BILLED AMOUNT – Total amount billed for services provided.

DUPLICATE ERROR MESSAGE – Supplied by the program based on the type of error.

2.1 Duplicate Error Messages

The duplicate error messages are listed below.

SD/MC Error Code 26 'DUPLICATE SERVICE – NO OVERRIDE'

This indicates the SD/MC system has found a duplicate service for which this service has no possible overrides. This is the case where the services are listed as a lockout ('A' or 'L') in the SD/MC Table of Multiple-Service Billing Edits. The service on the Duplicate ECR may only be corrected so that the claim no longer meets the lockout condition or by deleting the claim.

Verify the submitted claim information. If the claim information is correct,

1. either deny the claim with an "X" override, or
2. take no action, which will age deny the claim in 96 days from when it was added to suspense.

If the claim information is incorrect, make the correction(s) in the supplied correction boxes.

SD/MC Error Code 27 'MULTIPLE SERVICE – OVERRIDE OK'

This indicates the SD/MC system found a duplicate service for which this service may be corrected with an override code, if appropriate, or deleted if the service is not for an appropriate documented duplicate service.

Verify the submitted claim information. If the claim information is correct, follow the established county procedure to obtain clinician certification of the service as appropriate and medically necessary. Upon notification of clinician certification, enter the override code "Y" in the override code field for that claim, and sign and date the DECR at the bottom. If the claim information is incorrect, make the correction(s) to the claim information in the appropriate correction boxes.

SD/MC Error Code 23 'UNITS > ALLOWED'

This indicates the SD/MC system has found a service, when added to previously approved claim(s), exceeds the maximum amount of time allowed. Correct the appropriate fields or delete the claim. There is no override possible for this error. If other fields are not in error, correct the units. Be sure to use leading zeros, that is, if the units are '2' enter '0002.'

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3. HEALTHY FAMILIES

3 Healthy Families

3.1 Healthy Families Beneficiary ID

The Beneficiary ID must be 14 places on the form = BC9H99NNNNNNNA, where:

BC = Beneficiary County (two digit numeric);

9H=Healthy Families;

9 = Filler and;

CIN = 9NNNNNNNA (where N is a numeric and A is a letter. CIN = Client Index Number and is unique in the system).

3.2 Error Codes and Healthy Families Program (HFP) Claims

Error Code 03 – Invalid Code. This code is set for many situations such as invalid gender code, invalid CIN, etc. For HFP this code will appear if the aid code is equal to '9H' and the CIN is not in a valid format. It would also be set if the '9H' is present but there is no county code.

Error Code 09 – Ineligible in Mo/Yr. This error code is set for the following reasons:

1. If no HFP is found for the date of service (if the 14 character HFP formatted beneficiary ID code was used for billing) then regular FFP eligibility checks are conducted. If no FFP aid code is found, the 09 error is done otherwise the found FFP aid code will be placed in the approved aid code field.
2. HFP clients must be certified as SED¹³⁸ to bill SD/MC. The method of certification is to use the 14 byte beneficiary ID (Beneficiary County code, 9H aid code, '9', and CIN). If only the SSN or CIN are used the system will check for regular FFP eligibility.

For HFP this code will also be set for the following reasons:

3. No HFP or Medi-Cal eligibility was found for the Date of Service but the ID is found on MEDS and the secondary matches on name, date of birth, and gender agree.
4. The HFP claim Date of Service is before the date of eligibility for HFP. Unlike Medi-Cal, HFP eligibility is day-specific (not month-specific). A child with an effective date of coverage in HFP of 5/20/08 is not eligible for HFP services prior to that date.

¹³⁸ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

3.3 EOB and ECR Changes Related to Error Code 32 – Other Coverage Ind

If the HFP claim was submitted as SD/MC but the person has HFP coverage there will be error code '32 – Other Coverage Ind 9'. This means that HFP coverage was found.

How to Resubmit using EOB

As the system is showing this as a SD/MC claim and not a HFP claim, the counties can resubmit the claim as a new HFP claim if the child is SED.¹³⁹

How to Resubmit Using ECR

This error cannot be corrected using the ECR. You can mark the ECR with 'X' to have it deleted and then resubmit a new HFP claim if the child is SED.

¹³⁹ Cal. Welf. & Inst. Code, Division 5, Part 2, Chapter 1, § 5600.3

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4. REFERENCE INFORMATION

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TABLE E4-1: SHORT-DOYLE/MEDI-CAL CLAIM RECORD FIELD NAMES AND CONDITIONS

Description	Conditions	Field Number
Claim ID		
Provider code	non-blank	3
Date the claim is submitted		4
Program code	01	5
Mode of service	05, 07, 08, 09, 12, 18	6
Patient Name		8
Patient record number		
Beneficiary ID	Format controls	10
Year of Birth	numeric or blank	11
Sex code		12
Race/Ethnic code		13
DSM IV Diagnostic code	non-blank	14
Century/Year/Month that service is provided	Non-blank and numeric	15
Treatment (service) dates		16
Discharged code		17
Service Function		18
Units of Time	Numeric => zero	19
Units of Service	Numeric => zero	20
Total billed amount	Numeric => zero	21
Late billing override code		
Duplicate payment override code		
Admission Date		
County use field		
Crossover indicator		22
Total Service Charge		23
Medicare/OHC amount		

The information above shows the relationship between the elements on the claim (Description), minimum conditions and the field number shown on the ECR. For example, Provider Code must be non-blank, and the field on the ECR would be 3.

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TABLE E4-2: 'XOVER INDICATOR' EDIT LOGIC TABLE

County		State System			
Recipient's Eligibility	Xover Indicator	Recipient's MEDS Eligibility	Action	EOB Xover Error Code	Error Correction Report Message
No Medicare	blank	No Medicare	Approve	--	---
No Medicare	blank	Medicare	Suspend	31	Medicare Part __, HIC#
Medicare	X	Medicare	Approve	--	---
Medicare	X	No Medicare	Approve	--	---
Medicare	blank	No Medicare	Suspend	10	Conflicts with Eligibility.
Medicare	N	Medicare	Approve	--	---
Medicare	N	No Medicare	Approve	--	---
Medicare	blank	No Medicare	Suspend	10	Conflicts with Eligibility.
Medicare	H	Medicare	Approve	--	---
Medicare	H	No Medicare	Approve	--	---
Medicare	blank	No Medicare	Suspend	10	Conflicts with Eligibility.
No Other Coverage.	blank	No Other Coverage	Approve	--	---
No Other Coverage.	blank	Other Coverage	Suspend	32	Other Coverage __
Other Coverage	P	No Other Coverage	Approve	--	---
Other Coverage	blank	No Other Coverage	Suspend	10	Conflicts with Eligibility.
Other Coverage.	P	Other Coverage	Approve	--	---
Other Coverage.	P	Medicare	Suspend	31	Medicare Part __, HIC#
----	None Above	---	Suspend	03	Invalid Code

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TABLE E4-3: BATCH TRANSMITTAL FOR ERROR CORRECTION REPORTS

TO: STATE DEPARTMENT OF MENTAL HEALTH DATE SENT TO SDMH
ACCOUNTING SECTION
1600 NINTH STREET, RM. 150 _____
SACRAMENTO, CA 95814

DATE SENT TO SDHS

EDIT ECR _____
DUPLICATE ECR _____

County Code _____

BATCH NUMBER
(State Use Only)

LINE COUNT
(Total Green Corrections)

M- ___/___/___/___/___/___

___/___/___/___

REPORT DATE _____

RUN DATE _____

INSTRUCTIONS

There may be no more than **260 corrections/line count** in a batch. (A correction is considered one revised field item including the 'X' in the override bracket. Therefore, one page may contain more than one correction). In addition, no batch may have more than **30 pages**.

A **Batch Transmittal Form** must be completed and attached to the ECR with the following data elements:

DATE SENT TO SDMH – date of submission to the State Department of Mental Health

DATE SENT TO SDHS – Leave blank.

EDIT ECR/DUPLICATE ECR – Check the box. Do not mix types of ECR's.

LINE COUNT – number of corrected fields/lines in a batch (no more than 260 corrections).

REPORT DATE (MM-DD-YY) – the date found in the center of the ECR.

RUN DATE/CURRENT DATE (MM-DD-YY) – the date found on the upper right hand corner of the ECR.

BATCH NUMBER – For State DMH use only.

Staple (do not paperclip) each Batch Transmittal Form on top of every ECR batch in the upper left hand corner.

The State Department of Mental Health Accounting Section must receive the batch within **60 days** of the Run Date.