DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
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Private Hospital Directed Payment Program
CY 2023
Encounter File Review Toolkit
March 2024

California Department of Health Care Services
Capitated Rates Development Division
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State of California
Gavin Newsom, Governor

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Summary

The Department of Health Care Services (DHCS) is implementing the CY 2023 Private Hospital Directed Payment (PHDP) program, applicable to qualifying services during each six-month service period. The federal Centers for Medicare & Medicaid Services (CMS) approved the PHDP program for CY 2023 on March 18, 2024. The PHDP program provides supplemental reimbursement to participating private hospitals based on the actual utilization of qualifying services, as reflected in Medi-Cal managed care encounter data submitted to DHCS.

To assist the ongoing PHDP implementation efforts, DHCS will periodically provide encounter detail files (tab-delimited data files) to participating private hospitals and Medi-Cal managed care plans (Plans) for Medi-Cal managed care utilization associated with the National Provider Identifiers (NPIs) reported by the hospitals. The encounter detail files are intended to facilitate reconciliation between hospitals and plans to ensure the accuracy and completeness of the encounter data.

Purpose

The purpose of this document is to provide the information needed to interpret and evaluate the encounter detail files, such as data definitions and logic, as well as guidance related to reviewing encounter data, contracting relationships, and information about PHDP policy overall. The toolkit will be updated as necessary, and updates will be recorded in a change log (see Appendix E). This toolkit will be posted on DHCS' public website: Directed Payments Program.

Additional resources, including a Statewide Directory of hospital and plan contacts, are also posted on DHCS' public website at the same location and will be updated periodically.

Encounter Detail Files

DHCS will save your organization's encounter detail file(s) on a Secure File Transfer Protocol (SFTP) site accessible through this link: SFTP

Follow the steps below to retrieve your organization's encounter detail files(s):

1. Have your organization's designated SFTP Contact(s) log in to the SFTP site using their assigned user login and selected password.
2. If accessing the SFTP site for the first time using the temporary password provided by DHCS, immediately change the temporary password to a unique password.
3. In the upper left corner of the front page, click "Folders".
4. Click to open the "DHCS-CRDD-HospitalFinancing" folder.
5. Click to open either the "District Hospitals" folder (for Hospitals only) or the "Health Plans" folder (for Plans only).
6. Click to open folder(s) corresponding to your organization.
7. Transfer the files(s) to your organization's servers. The files contain:
    a. Encounter-level detail data including Protected Health Information in tab-delimited format (see Appendix B).
        i. Includes Medi-Cal managed care utilization for the applicable service period associated with your organization based on the NPIs reported by hospital.

DHCS anticipates providing encounter detail files on a quarterly basis; the current encounter detail file release schedule is outlined in Appendix A.

Review Steps for Hospitals

If you identify material differences between the data/service counts reflected in your encounter detail files and your anticipated data/service counts, follow these steps:

1. Are the differences related to plans (see Appendix D) with which you were contracted (either directly or indirectly through a delegated arrangement) to provide qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for PHDP payments.
    b. If yes, proceed to step 2.
2. Are you comparing utilization for the same service period covered by the encounter detail files?
    a. If no, align to the service period covered by the encounter detail files.
    b. If yes, proceed to step 3.

3. Is your service logic aligned with the encounter detail file logic (see Appendix C)?
    a. If no, align to DHCS' encounter detail file logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.
4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's exclusions.
    b. If yes, proceed to step 5.
5. Are the differences related to NPIs that are missing from the encounter detail files?
    a. If no, proceed to step 6.
    b. If yes, verify the NPI is not related to an excluded provider type (i.e. CBRC, FQHC, IHCP, or RHC).
        i. If there is still a variance, notify DHCS at PrivateDP@dhcs.ca.gov in order to report the missing NPI(s) and troubleshoot the issue.
        ii. Once you have notified DHCS, proceed to step 6 for NPIs that are included in the encounter detail files.
6. Are your anticipated service counts still materially different from the service counts reflected on your encounter detail files?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.
7. Work with your affected plan partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected plan partner(s) able to identify and resolve the data deficiencies?
    a. If no, proceed to step 8.
    b. If yes, no further action is needed.

Note: Discrepancies may be due to multiple factors such as: (i) the plan did not receive encounters (or required data was missing); (ii) the plan did not submit encounters to DHCS; or (iii) encounters were rejected by DHCS' system edits.

8. Contact DHCS at PrivateDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Review Steps for Plans

If you identify material differences between the data/service counts reflected in your encounter detail files and your anticipated data/service counts, follow these steps:

1. Are the differences related t hospitals with which you were contracted (either directly or indirectly through a delegated arrangement) for qualifying services during the applicable service period?
    a. *If no, do not proceed, as these services are not eligible for PHDP payments.*
    b. If yes, proceed to step 2.
2. Are you comparing utilization for the same service period covered by the encounter detail files?
    a. If no, align to the service period covered by the encounter detail files.
    b. If yes, proceed to step 3.
3. Is your service logic aligned with DHCS' encounter detail file logic (see Appendix C)?
    a. If no, align to DHCS' encounter detail file logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

Note: The encounter detail file logic is not the same as the Rate Development Template (RDT) logic.

4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS' exclusions.
    b. If yes, proceed to step 5.
5. Are the differences related to NPIs that are missing from the encounter detail files?
    a. If no, proceed to step 6.
    b. If yes, notify the hospital that the NPI is not included in the encounter detail files, and then proceed to step 6 for NPIs that are included.
6. Are your anticipated service counts still materially different from the service counts reflected on your encounter detail files?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your hospital partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected hospital partner(s) able to identify and resolve the data deficiencies?
    a. If no, proceed to step 8.
    b. If yes, no further action is needed.

Note: Discrepancies may be due to multiple factors such as: (i) the plan did not receive encounters (or required data was missing); (ii) the plan did not submit encounters to DHCS; or (iii) encounters were rejected by DHCS' system edits.

8. Contact DHCS at PlanDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Background

On May 6, 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which at the time was the first major update to federal managed care regulations concerning Medicaid and CHIP in more than a decade. [1] Among other changes, the final rule prohibited states from directing payments to providers through managed care contracts except under specified circumstances. Broadly, the final rule limited allowable direction of managed care payments to instances of:

- Value-based purchasing models (e.g., pay-for-performance, bundled payments);
- Delivery system reform or performance improvement initiatives; and
- Minimum/maximum fee schedules, or uniform dollar/percentage increases.

[1] See Federal Register Document Number 2016-09581, available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

Existing hospital pass-through payments, as defined by the final rule, were deemed an unallowable direction of payment, and were required to be phased out over a period of no more than 10 years. Additionally, on January 18, 2017, CMS issued another final rule that capped existing hospital pass-through payments at levels in effect as of July 5, 2016.[2]

In response to the new federal regulations, SB 171 (Chapter 768, Statutes of 2017) effectuated multiple new directed payment programs intended, in part, to continue support for providers in order to maintain access and improve quality of care for Medi-Cal beneficiaries.

- Welfare and Institutions Code (WIC) section 14197.4(b) requires DHCS to direct Plans to increase reimbursements, on a uniform dollar and/or percentage basis, to private hospitals for contracted services.
- The directed payment program, PHDP, implements a uniform dollar increase to reimbursements to private hospitals for contract services. For the CY 2023 service period, PHDP is expected to result in supplemental payments to private hospitals totaling $5.4 billion.

This toolkit, and the associated encounter detail files, are applicable only to PHDP.

PHDP: Structure and Policy

Final PHDP payments will be implemented using a statewide pool approach, with separate sub-pools for:

- Inpatient (IP) services
- Hospital Outpatient (OP) and Emergency Room (ER) services

Due to implementation considerations, the CY 2023 pool is subdivided into two equal halves:

- CY 2023 pool:
    - Phase I, for the service period of January 1, 2023 through June 30, 2023
    - Phase II, for the service period of July 1, 2023 through December 31, 2023

[2] See Federal Register Document Number 2017-00916, available at https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery

Additionally, final PHDP payments will be based on the actual utilization of contracted services as reflected in the Medi-Cal managed care encounter data received by DHCS. Therefore, while DHCS will initially develop proxy per-member-per-month (PMPM) rate add-on amounts for PHDP based on projected CY 2023 expenditures, pursuant to the PHDP proposal approved by CMS, these proxy PMPMs will not be paid. For the final PHDP payments, DHCS will recalculate the rate add-on amounts based on the actual distribution of IP and OP/ER utilization.

Note: Only contracted services are eligible for PHDP payments. (See Contract Services for details).

Exclusions

The following are excluded from PHDP:

- Inpatient services provided to enrollees with Medicare Part A, and non-inpatient services provided to enrollees with Medicare Part B.
- Services provided to enrollees with Other Health Coverage.
- Services provided by the following:
    - Cost-Based Reimbursement Clinics (CBRCs)
    - Indian Health Care Providers (IHCPs)
    - Federally Qualified Health Centers (FQHCs)
    - Rural Health Clinics (RHCs)
- State-only abortion services. [3]

Where a hospital and CBRC, FQHC, IHCP, or RHC share the same NPI, all service counts except for inpatient and emergency room encounters are zeroed out because of the NPI.

To help identify any erroneously excluded services due to a shared NPI between excluded clinics and hospitals, there is a column labeled FQ_Check that is populated

[3] State-only abortion services are identified as services where:
- procedure code is within 01964, 01966, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, S0190, S0191, S0199, X7724, X7726, Z0336 or,
- diagnosis code is within O045, O046, O047, O0480, O0481, O0482, O0483, O0484, O0485, O0486, O0487, O0488, O0489, Z332 or,
- inpatient surgical code is within 10A00ZZ, 10A03ZZ, 10A04ZZ, 10A07Z6, 10A07ZW, 10A07ZX, 10A07ZZ, 10A08ZZ, 10D18Z9

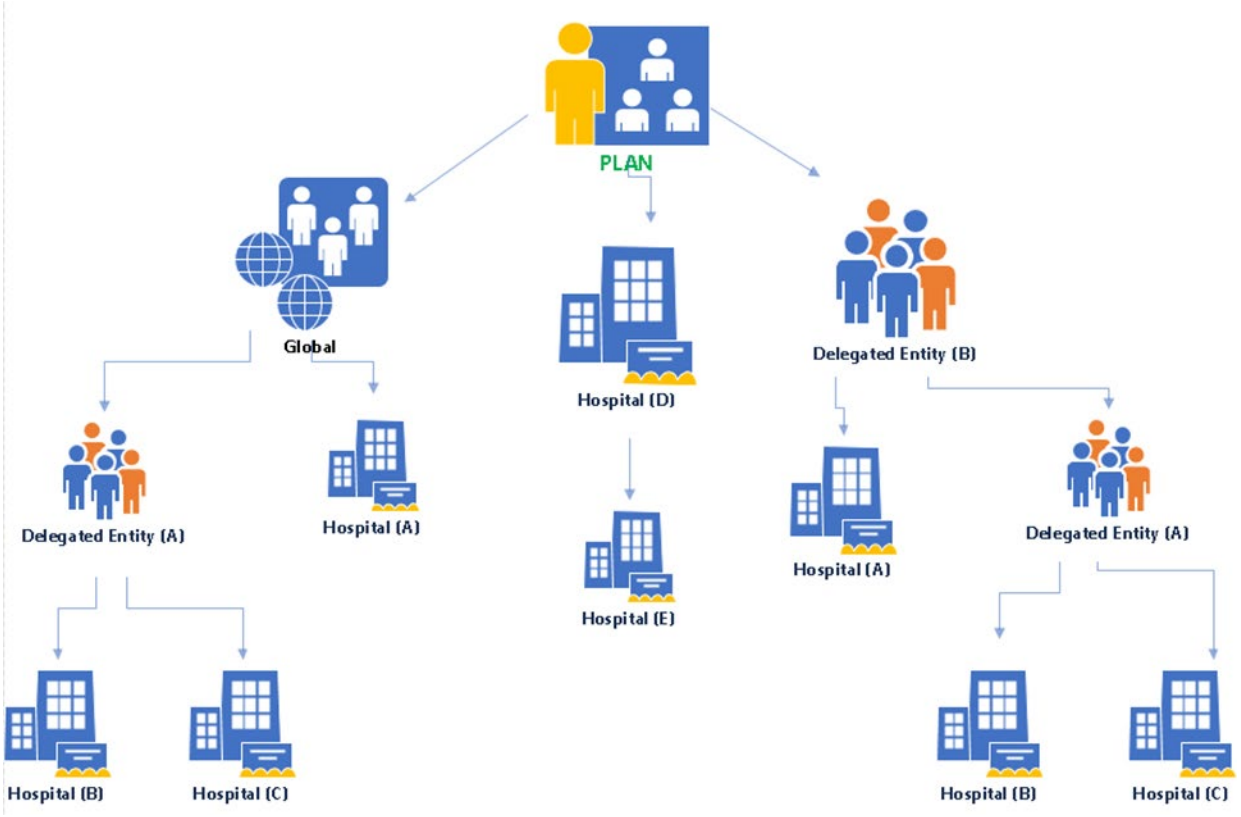
with an X for private hospitals for utilization being removed. Plans can delete these X's to indicate that these encounters should not be counted as an FQ/RHC encounter.

Contract Services

For the purposes of PHDP, a contract service is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Plan by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in APL 19-001 Attachment A. DHCS will start leveraging the Managed Care Provider Network data as described in APL 16-019 to identify if services are contracted or non-contracted.

Furthermore, for a delegated arrangement, there must be a demonstrable "unbroken contracting path" between the Plan and the provider for the service rendered and the member receiving the service. An "unbroken contracting path" means a sequence of contracts (as defined above) linking a health plan and a direct subcontractor or a series of subcontractors to the provider.

To assist DHCS' provider data quality improvement initiative, Managed Care Provider Network 274 data as outlined in APL 16-019 will be included in data releases. Medi-Cal managed care health plans submit their provider network to DHCS broken out by each county they operate in on a monthly basis. The MCP's submission is mapped to DHCS network adequacy standards as described in APL 19-002.



Contracting Examples

- **Example 1:** Hospital A has a full-risk capitation agreement with a plan to care for a specific population. Hospital A also has a contract with Hospital B to provide quaternary care to that population when the service is not available at Hospital A. Hospital B receives payment directly from Hospital A for treating this population.
    - If Hospital B is not contracted with the plan, are they considered a network provider when providing quaternary services for this population?
        - **Yes**, for the specific population and for quaternary services.
    - If Hospital B is contracted with the plan, but for a different population, are they considered a network provider when providing quaternary services for this population?
        - **Yes**, for the specific population and for quaternary services.

- **Example 2:** Hospital A has a contract with an Independent Physicians Association (IPA) to provide ancillary services. If a patient from the IPA presents to the hospital's emergency room and is ultimately admitted as an inpatient for treatment, is Hospital A considered a network provider?
    - **No** for inpatient services.
    - **Yes** for ancillary services.

- **Example 3:** Hospital A has a contract with IPA A to treat their patient population with a plan. Hospital A does not have a contract with IPA B to treat their population with the plan. Is Hospital A considered a network provider when they treat members of IPA B?
    - **No**. Hospital A is contracted for IPA A's population only.

- **Example 4:** Hospital A has a one-year contract (as defined above) with a plan to care for a specific population. Hospital A terminates the contract after 90 days. Does this contract meet the requirements under the contracting definition?
    - **Yes**. The term of the agreement was for a period of at least 120 days. However, only services provided during the 90 days under contract would be counted.

- **Example 5:** Hospital A has a direct contract with a plan. A beneficiary of the plan assigned to IPA B for professional services was seen by a specialist at Hospital A. IPA B is financially responsible for the beneficiary's professional services. IPA B does not have a contract with Hospital A. Does this qualify as an unbroken contracting chain?
    - **No**, this would not qualify. For professional services, there must be a contract between IPA B and Hospital A that meets the contracting definition.

PHDP: Implementation Timeline

For the CY 2023 program period, in order to meet federal timely claim filing deadlines, DHCS must make PHDP payments to plans no later than March 31, 2025 for Phase 1, and no later than September 30, 2025 for Phase 2. Therefore, considering both encounter system delays and processing time needed to perform calculations, any additional or revised encounter data must be received by DHCS **no later than June 30, 2024 for Phase 1**, and **no later than December 31, 2024 for Phase 2**, to be considered during the calculation of final PHDP payments. Encounter data must be

submitted through existing, established processes, as DHCS is unable to accept data submitted through a supplemental process.

Note: DHCS anticipates plans will establish encounter data submission deadlines for hospitals that are earlier than the due dates noted above. Hospitals and plans are expected to work together to determine these specific deadlines.

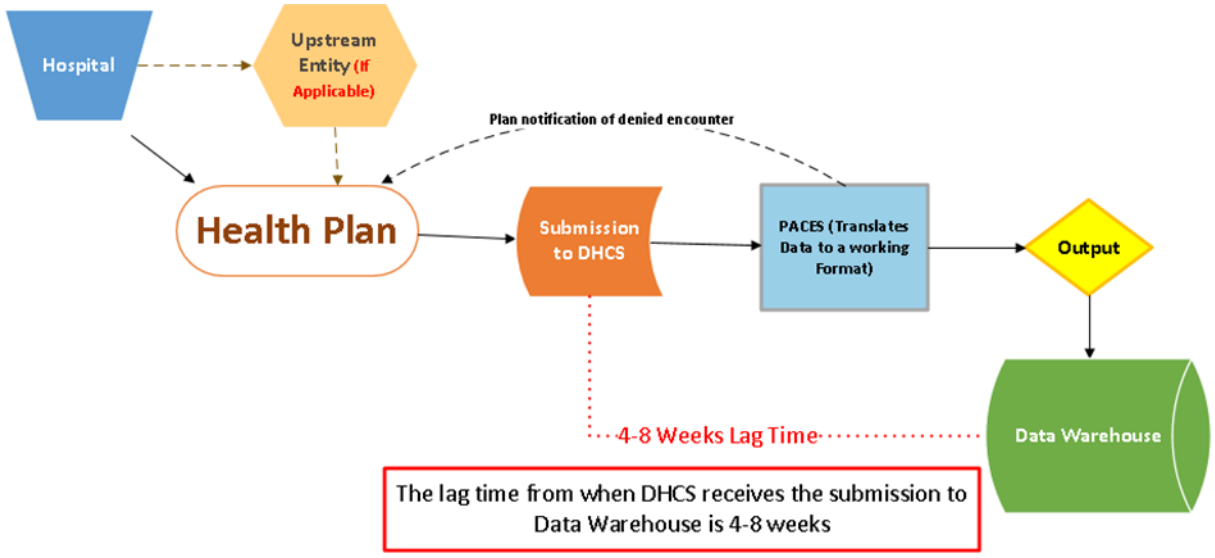
See the graphic below for an overview of the PHDP implementation timeline.

CY 2023:

	Activity	CY 2024 Q2	CY 2024 Q3	CY 2024 Q4	CY 2025 Q1	CY 2025 Q2	CY 2025 Q3
CY 2023 Phase 1 (January 1, 2023 – June 2023)	Deadline for encounter data submission to health plans	Exact due dates are plan specific					
	Deadline for encounter data submission to DHCS	June 30, 2024					
	Final encounter data pull for payment calculation		September 2024				
	Development of add-ons			CY 2024 Q4			
	Finalization of add-ons				January 1, 2025		
	Notice of draft payment amounts				January 2025		
	Projected payment to plans (cash month)				March 2025		
CY 2023 Phase 2 (July 2023 – December 2023)	Deadline for encounter data submission to health plans			Exact due dates are plan specific			
	Deadline for encounter data submission to DHCS			December 31, 2024			
	Final encounter data pull for payment calculation				March 2025		
	Development of add-ons					CY 2025 Q2	
	Finalization of add-ons						July 1, 2025
	Notice of draft payment amounts						July 2025
	Projected payment to plans (cash month)						September 2025

Encounter Data Flow

Encounters are generated by the provider of the service and transmitted, either directly or indirectly through an upstream entity, to the plan. Once encounters are received, the plan applies appropriate system edits and submits accepted encounters to DHCS, where the encounter system translates the incoming encounters into a working format that can be queried and used for statistical analysis and reporting. See the chart below for a visual representation of encounter data flow.



There is an approximate 4–8 week processing period between the time plans submit encounter data to DHCS and the time DHCS is able to query the encounter data for inclusion in the encounter detail file. As a result, encounter data submitted to DHCS within approximately 8 weeks of the date of the encounter detail file data release likely will not be reported.

For further background information, please see the Standard Companion Guide Transaction Information released by DHCS, which details how encounter data is transacted once received in DHCS' systems: Standard Companion Guide Transaction Information and Additional Resources

For information on DHCS' contracts with MCPs, please view DHCS' managed care contract boilerplates.

Counting Logic

Services are counted in accordance with the logic described in Appendix C subject to the caveats indicated below.

Inpatient Hospital days are equal to the discharge date (INPAT_DISCHARGE_DT) minus the service from date (SVC_FROM_DT). If the two fields contain the same date, the day count is set to equal 1. If INPAT_DISCHARGE_DT is blank, the service to date (SVC_TO_DT) is used instead.

For inpatient stays that span the beginning or end of either six-month phase, only the portion of "earned days" occurring during the service period are counted. If the discharge date falls after the phase end date, add 1.

For example, for CY 2023 Phase 2:

Service From Date	Discharge Date	Day Difference	Service Count
07/01/2023	07/01/2023	0	1
07/01/2023	07/02/2023	1	1
07/01/2023	07/03/2023	2	2
06/30/2023	07/01/2023	1	0
06/29/2023	07/02/2023	3	1
12/30/2023	01/01/2024	2	2
12/27/2023	12/30/2023	3	3

Multiple Same-Day Outpatient Visits: This logic applies to multiple OP visits occurring on the same day.

- Use individual provider NPI, if available, to differentiate same-day OP visits with the same billing/facility NPI, but continue to remove counts if the billing/facility NPI is identified as a FQHC, RHC, CBRC, or IHCP.

For **delivery-related inpatient stays**, the service count is equal to one of the following:

- If INPAT_DAYS_STAY is less than or equal to the difference between the start and end/discharge dates ("day difference"), then SVC_CNT is equal to the lesser of:
    - INPAT_DAYS_STAY multiplied by 2; or
    - The day difference plus 1 day (for vaginal deliveries) or plus 3 days (for cesarean deliveries)

- If INPAT_DAYS_STAY is greater than the day difference, then SVC_CNT is equal to the lesser of:
    - INPAT_DAYS_STAY; or
    - The day difference multiplied by 2

To mitigate potential under-or over-counting at the extremes, in all cases SVC_CNT will be no less than 2 days and no greater than the day difference multiplied by 2.

Delivery-related inpatient stays are identified as follows:

- PROC_CD is equal to one of the following: 01961, 01968, 59510, 59514, 59515, 59525, 59618, 59620, 59622, 01960, 01967, 57022, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59610, 59612, 59614, 59899, Z1002, Z1006, Z1010, Z1014, Z1024, Z9800

  OR

- REVENUE_CD is equal to one of the following: 0112, 0122, 0132, 0142, 0152, 0232, 0720, 0721, 0722, 0724, 0729

  OR

- PRIMARY_DIAG_CD_ICD10 is equal to one of the following: O7582, O82, O010, O011, O019, O020, O0281, O0289, O029, O1002, O1012, O1022, O1032, O1042, O1092, O151, O2402, O2412, O2432, O24420, O24424, O24429, O2482, O2492, O252, O2662, O2672, O6010X0, O6010X1, O6010X2, O6010X3, O6010X4, O6010X5, O6010X9, O6012X0, O6012X1, O6012X2, O6012X3, O6012X4, O6012X5, O6012X9, O6013X0, O6013X1, O6013X2, O6013X3, O6013X4, O6013X5, O6013X9, O6014X0, O6014X1, O6014X2, O6014X3, O6014X4, O6014X5, O6014X9, O6020X0, O6020X1, O6020X2, O6020X3, O6020X4, O6020X5, O6020X9, O6022X0, O6022X1, O6022X2, O6022X3, O6022X4, O6022X5, O6022X9, O6023X0, O6023X1, O6023X2, O6023X3, O6023X4, O6023X5, O6023X9, O610, O611, O618, O619, O620, O621, O622, O623, O624, O628, O629, O630, O631, O632, O639, O640XX0, O640XX1, O640XX2, O640XX3, O640XX4, O640XX5, O640XX9, O641XX0, O641XX1, O641XX2, O641XX3, O641XX4, O641XX5, O641XX9, O642XX0, O642XX1, O642XX2, O642XX3, O642XX4, O642XX5, O642XX9, O643XX0, O643XX1, O643XX2, O643XX3, O643XX4, O643XX5, O643XX9, O644XX0, O644XX1, O644XX2, O644XX3, O644XX4, O644XX5, O644XX9, O645XX0, O645XX1,

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OR

- Uses an inpatient ICD 10 surgical code equal to one of the following: 0HQ9XZZ, 0JCB0ZZ, 0JCB3ZZ, 0KQM0ZZ, 0U7C7ZZ, 0UJD7ZZ, 0UQ90ZZ, 0UQ93ZZ, 0UQ94ZZ, 0UQ97ZZ, 0UQ98ZZ, 0UQC0ZZ, 0UQC3ZZ, 0UQC4ZZ, 0UQC7ZZ, 0UQC8ZZ, 0US90ZZ, 0US94ZZ, 0US9XZZ, 0W8NXZZ, 0WQNXZZ, 10900ZC, 10903ZC, 10904ZC, 10907ZA, 10907ZC, 10908ZA, 10908ZC, 10D00Z0, 10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10D17Z9, 10D17ZZ, 10D18Z9, 10D18ZZ, 10E0XZZ, 10E0XZZ, 10H003Z, 10H00YZ, 10J07ZZ, 10P003Z, 10P00YZ, 10P073Z, 10P07YZ, 10S07ZZ, 10S0XZZ, 3E053VJ

If the delivery utilizes a procedure code within (01961, 01968, 59510, 59514, 59515, 59525, 59618, 59620, 59622) or a primary ICD10 diagnosis code within (O7582, O82), the delivery is classified as cesarean. All other deliveries are considered vaginal deliveries.

For non-Inpatient/LTC services, a visit is counted for each unique combination of patient (AKA_CIN), provider (NPI), and date of service (service from date).

- For Emergency Room, Specialty Physician, Primary Care Physician, and Other Medical Professional services, the header-level date of service (SVC_FROM_DT) on the encounter record is used.
- For Outpatient Facility and Mental Health Outpatient services, the detail-level date of service (DTL_SVC_FROM_DT) on the encounter record is used. This is intended to account for recurring visits where multiple visits are reported on one claim or encounter, such as for a series of physical therapy visits.

Questions

For questions, please contact:

- Private Hospitals – PrivateDP@dhcs.ca.gov
- Plans – PlanDP@dhcs.ca.gov

Appendix A: Encounter Detail File Data Release Schedule

Encounter Detail File Data Release Date	CY 2023 Phase 1	CY 2023 Phase 2
June 9, 2023	1	
September 8, 2023	2	
December 8, 2023	3	1
March 8, 2024	4	2
June 14, 2024	5©	3
September 13, 2024	6©	4
December 13, 2024		5©
March 14, 2025		6©

© indicates a data release for the purpose of contract status reporting. Future dates are tentative and subject to change.

Appendix B: Encounter Detail File Elements

- **ADJ_IND** – indicates type of adjustment applied to claim

Code	Description
	Not an adjustment
1	Positive Supplemental
2	Negative Supplemental (negative only)
3	Refund to Medi-Cal (negative only)
4	Positive side of void and reissue
5	Negative side of void and reissue
6	Cash disposition (obsolete)

- **ADMIT_FAC_NPI** – admitting facility NPI
- **AGE -** age
- **AKA_CIN** – actual non-masked CIN (Client Index Number)
- **BENE_FIRST_NAME** – beneficiary's first name
- **BENE_LAST_NAME** – beneficiary's last name
- **BENE_BIRTH_DT** – beneficiary's birth date
- **BILL_TYPE_CD** – billing type code
- **BIRTH_DT** – birth date
- **CCN** – Claim Control Number (CCN), uniquely identifies any processed claims within a specific plan code
- **CHECK_DT** – approximate date warrant was mailed in payment of claim
- **CLAIM_FORM_IND** – indicates if the claim form used is a UB-92 or a HCFA-1500 form

- **CLINIC_TYPE** – generated field to identify excluded provider types
    - **FQ** – Federally Qualified Health Centers
    - **RH** – Rural Health Clinics
    - **IH** – Indian Health Services
    - **CB** – Cost Based Reimbursement Clinics
    - **NA** – not an excluded provider type

- **DTL_SVC_FROM_DT** – detail level service from date

- **DTL_SVC_TO_DT** – detail level service to date

- **ENCRYPTED_AKA_CIN** – encrypted CIN

- **FI_CLAIM_TYPE_CD** – claim type

Code	Description
	Unknown
01	Pharmacy
02	Long Term Care
03	Hospital Inpatient
04	Outpatient
05	Medical/Allied
06	Code not used at DHCS
07	Vision
09	Code not used at DHCS
5	Unknown
55	Unknown
AP	Advanced Payment (No Provider) (IHSS)
CC	Contract County Provider (IHSS)
IP	Individual Provider (IHSS)
RM	Restaurant & Meals (No Provider) (IHSS)

- **FI_PROV_TYPE_CD** – classification of the provider rendering health/medical services

Code	Description
	UNKNOWN
0	UNKNOWN
001	ADULT DAY HEALTH CARE CENTERS
002	ASSISTIVE DEVICE AND SICK ROOM SUPPLY DEALERS
003	AUDIOLOGISTS
004	BLOOD BANKS
005	CERTIFIED NURSE MIDWIFE
006	CHIROPRACTORS
007	CERTIFIED NURSE PRACTIONER
008	CHRISTIAN SCIENCE PRACTIONER
009	CLINICAL LABORATORIES
010	GROUP CERTIFIED NURSE PRACTITIONER
011	FABRICATING OPTICAL LABORATORY
012	DISPENSING OPTICIANS
013	HEARING AID DISPENSERS
014	HOME HEALTH AGENCIES
015	COMMUNITY OUTPATIENT HOSPITAL
016	COMMUNITY INPATIENT HOSPITAL
017	LONG TERM CARE FACILITY
018	NURSE ANESTHETISTS
019	OCCUPATIONAL THERAPISTS
020	OPTOMETRISTS
021	ORTHOTISTS
022	PHYSICIANS GROUP
023	GROUP OPTOMETRISTS
024	PHARMACIES/PHARMACISTS
025	PHYSICAL THERAPISTS
026	PHYSICIANS
027	PODIATRISTS
028	PORTABLE X-RAY
029	PROSTHETISTS
030	GROUND MEDICAL TRANSPORTATION
031	PSYCHOLOGISTS

032	CERTIFIED ACUPUNTURIST
033	GENETIC DISEASE TESTING
034	MEDICARE CROSSOVER PROVIDER ONLY
035	RURAL HEALTH CLINICS/FEDERALLY QUALIFIED HEALTH CENTER
036	UNKNOWN
037	SPEECH THERAPISTS
038	AIR AMBULANCE TRANSPORTATION SERVICES
039	CERTIFIED HOSPICE
040	FREE CLINIC
041	COMMUNITY CLINIC
042	CHRONIC DIALYSIS CLINIC
043	MULTISPECIALTY CLINIC
044	SURGICAL CLINIC
045	CLINIC EXEMP FROM LICENSURE
046	REHABILITATION CLINIC
047	UNKNOWN
048	COUNTY CLINICS NOT ASSOCIATED WITH HOSPITAL
049	BIRTHING CENTER SERVICES
050	OTHERWISE UNDESIGNATED CLINIC
051	OUTPATIENT HEROIN DETOX CENTER
052	ALTERNATIVE BIRTH CENTERS - SPECIALTY CLINIC
053	EVERY WOMAN COUNTS
054	EXPANDED ACCESS TO PRIMARY CARE
055	LOCAL EDUCATION AGENCY
056	RESPIRATORY CARE PRACTITIONER
057	EPSDT SUPPLEMENTAL SERVICES PROVIDER
058	HEALTH ACCESS PROGRAM
059	HOME AND COMMUNITY BASED SERVICES NURSING FACILITY
060	COUNTY HOSPITAL INPATIENT
061	COUNTY HOSPITAL OUTPATIENT
062	GROUP RESPIRATORY CARE PRACTITIONERS
063	LICENCED BUILDING CONTRACTORS
064	EMPLOYMENT AGENCY
065	PEDIATRIC SUBACUTE CARE/LTC
066	PERSONAL CARE AGENCY

067	RVNS INDIVIDUAL NURSE PROVIDERS
068	HCBC BENEFIT PROVIDER
069	PROFESSIONAL CORPORATION
070	LICENSED CLINICAL SOCIAL WORKER INDIVIDUAL
071	LICENSED CLINICAL SOCIAL WORKER GROUP
072	MENTAL HEALTH INPATIENT SERVICES
073	AIDS WAIVER SERVICES
074	MULTIPURPOSE SENIOR SERVICES PROGRAM
075	INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT
076	DRUG MEDI-CAL
077	MARRIAGE AND FAMILY THERAPIST INDIVIDUAL
078	MARRIAGE AND FAMILY THERAPIST GROUP
080	CCS/GHPP NON-INSTITUTIONAL
081	CCS/GHPP INSTITUTIONAL
082	LICENSED MIDWIVES
084	INDEPENDENT DIAGNOSTIC TESTING FACILITY XOVER PROV ONLY
085	CLINICAL NURSE SPECIALIST X-OVER PROVIDER ONLY
086	MEDICAL DIRECTORS
087	LICENSED PROFESSIONALS
089	ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM
090	OUT OF STATE
092	RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)
093	CARE COORDINATOR (CCA)
095	PRIVATE NON-PROFIT PROPRIETARY AGENCY
096	TRIBAL FQHC PROVIDERS
098	MISCELLANEOUS
099	DENTIST

- **FQ_Check -** DHCS derived field that allows plans to blank out the indicator for DMPH non- FQHC (or other excluded clinic) outpatient services. DMPH outpatient services flagged as possibly being associated with an excluded clinic type, that do not have a revenue code of '0521', are marked with indicator "X." Plans should remove the indicator "X" if the service was not rendered by an excluded provider type.

- **HOSPITAL_NAME** – hospital name

- **HOSPITAL_TYPE** – hospital type (private, public, or district)
- **INPAT_ADMISSION_DT** – date the patient was admitted to the hospital (Inpatient/LTC claims only)
- **INPAT_DAYS_STAY** – length of patient stay (Inpatient/LTC claims only)
- **INPAT_DISCHARGE_DT** – date the patient was discharged (Inpatient/LTC claims only)
- **INPAT_DISCHARGE_DT_FLAG** – If = 1, the originally blank INPAT_DISCHARGE_DT was populated with SVC_TO_DT.
- **MAIN_SGMNT_ID_NO** – claim line number
- **MC_HDR_MEDI_CAL_PAID_AMT** = header level Medi-Cal paid amount
- **MC_STAT_A** – status and funding source for beneficiary's Medicare Part A Coverage
- **MC_STAT_B** – status and funding source for beneficiary's Medicare Part B Coverage

Code	Description
	No coverage
0	No coverage
1	Paid for by beneficiary
2	Paid for by State buy-in
3	Free (Part A only)
4	Paid by state other than California
5	Paid for by pension fund
6	UNKNOWN
7	Presumed eligible
8	UNKNOWN
9	Aged alien ineligible for Medicare

- **Full Duals must meet both criteria:**
  - MC_STAT_A – 1, 2, 3, 4, or 5
  - MC_STAT_B – 1, 2, 4, or 5

- **MC_STAT_D** – indicates beneficiary's Medicare Part D coverage status

- **MEDICARE_STATUS** – derived field
  - **Full_Dual** – both Medicare Parts A and B
  - **MC_Part_A** – just Medicare Part A
  - **MC_Part_B** – just Medicare Part B
  - **MCal_Only** – no Medicare

- **MEDI_CAL_REIMB_AMT** – detail level Medi-Cal paid amount

- **NPI** = billing provider's National Provider Identifier number

- **OC_CD** – identifies the other health coverage circumstances for each beneficiary

Code	Description
	No Coverage
2	Provident Life and Accident (no longer in use)
3	Principal Financial Group (no longer in use)
4	Pacific Mutual Life Insurance (no longer in use)
6	AARP (no longer in use)
9	Healthy Families
A	Any Carrier (includes multiple coverage), pay and chase
B	Blue Cross (no longer in use)
C	CHAMPUS Prime HMO
D	Medicare Part D
E	Plans Limited to Vision Coverage
F	Medicare Part C
G	CDCR Medical Parolee Plan (formerly American General)
H	Multiple Plans Comprehensive
I	Public Institution Coverage (formerly Metropolitan Life)
K	Kaiser
L	Dental only policies
M	Two or more carriers (no longer in use)
N	No Coverage

O	Override - Used to remove cost avoidance OHC codes posted by DHS Recovery or data matches (OHC Source is H, R, or T). Changes OHC to A.
P	PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified
Q	Pharmacy Plans Only(Non-Medicare)
R	Ross Loos (no longer in use)
S	Blue Shield (no longer in use)
T	Travelers (no longer in use)
U	Connecticut General (no longer in use)
V	Any carrier other than above, includes multiple coverage (formerly Variable)
W	Multiple Plans Non-Comprehensive
X	Blue Shield (no longer in use)
Y	Blue Cross North (no longer in use)
Z	Blue Cross South (no longer in use)

- **PAT_CTL_NBR** – Patient Control Number, identifies client or client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment

- **PLAN_CD** – health plan code

- **PLAN_CAP_AID_CD** – health care plan capitation aid code

- **PLAN_NAME** – health plan name

- **POS_CD** – place of service code

POS_CD	Description
0	Emergency Room
1	Inpatient Hospital
2	Outpatient Hospital
3	Nursing Facility, Level A/B
4	Home
5	Office, Lab, Clinic
6	ICF-DD
7	Other

- **PRIMARY_DIAG_CD** – primary diagnosis code (ICD-9)

- **PRIMARY_DIAG_CD_ICD10** – primary diagnosis code (ICD-10)
- **PROC_CD** – procedure code
- **PROC_IND** – indicates type of procedure code present in the PROC_CD field

Code	Description
	CA-MMIS Fiscal Intermediary (FI) Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used.
0	DELTA Dental Table of Dental Procedures (prior to 7/1/93 when HCPCS [Health Care Financing Administration Common Procedure coding system] replaced them)
1	UB-92s ([Uniform Billing - 1992] Uniform Billing codes began on January 1, 1992.)
2	SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes) Note: EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator.
3	UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. SEE F35B-MEDICAL-SUPPLY- INDICATOR and F35B-PROCE
4	CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Associations CPT-4 refers to procedures delivered by physicians.)
5	Unknown
6	California Health Facilities Commission (CHFC)
7	Los Angeles Waiver/L. A. Waiver
8	Short-Doyle/Medi-Cal (only on Plan Code 8)
9	HCPCS Levels II and III (effective on October 1, 1992)

- **PROV_SPEC_CD** – provider specialty code

Code	Description
	Unknown
0	Unknown
1	Unknown

2	Unknown
3	Unknown
4	Unknown
5	Unknown
6	Unknown
7	Unknown
8	Unknown
#N	Unknown
*G	Unknown
*N	Unknown
00	General Practitioner (Dentists Only)
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease (M.D. only)
07	Dermatology
08	Family Practice
09	Gynecology (D.O. only)
0X	UNKNOWN
1	Unknown
10	Gastroenterology (M.D. only), Oral Surgeon (Dentists Only)
11	Aviation (M.D. only)
12	Manipulative Therapy (D.O. only)
13	Neurology (M.D. only)
14	Neurological Surgery
15	Obstetrics (D.O. only), Endodontist (Dentists Only)
16	Obstetrics-Gynecology (M.D. Only) Neonatal
17	Ophthalmology, Otolaryngology, Rhinology (D.O. only)
18	Ophthalmology
19	Dentists (DMD)
1A	Unknown
1B	Unknown
1C	Unknown
1G	Unknown

1Y	Unknown
2	Nurse Practitioner (non-physician medical practitioner)
20	Orthopedic Surgery, Orthodontist (Dentists Only)
21	Pathologic Anatomy: Clinical Pathology (D.O. only)
22	Pathology (M.D. only)
23	Peripheral Vascular Disease or Surgery (D.O. only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation, Certified Orthodontist (Dentists Only)
26	Psychiatry (child)
27	Psychiatry Neurology (D.O. only)
28	Proctology (colon and rectal)
29	Pulmonary Diseases (M.D. only)
2X	Unknown
3	Physician Assistant (non-physician medical practitioner)
30	Radiology, Pedodontist (Dentists Only)
31	Roentgenology, Radiology (M.D. only)
32	Radiation Therapy (D.O. only)
33	Thoracic Surgery
34	Urology and Urological Surgery
35	Pediatric Cardiology (M.D. only)
36	Psychiatry
37	Unknown
38	Geriatrics
39	Preventive (M.D. only)
4	Nurse Midwife (non-physician medical practitioner)
40	Pediatrics, Periodontist (Dentists Only)
41	Internal Medicine
42	Nuclear Medicine
43	Pediatric Allergy
44	Public Health
45	Nephrology (Renal-Kidney)
46	Hand Surgery
47	Miscellaneous
48	Unknown
49	Unknown

5	Unknown
50	Prosthodontist (Dentists Only)
51	Unknown
52	Unknown
53	Unknown
54	Unknown
55	Unknown
56	Unknown
57	Unknown
58	Unknown
59	Unknown
6	Unknown
60	Oral Pathologist (Dentists Only)
61	Unknown
62	Unknown
63	Unknown
64	Unknown
65	Unknown
66	Emergency Medicine (Urgent Care)
67	Endocrinology
68	Hematology
69	Unknown
6Y	Unknown
7	Unknown
70	Clinic (mixed specialty), Public Health (Dentists Only)
71	Unknown
72	Unknown
73	Unknown
74	Unknown
75	Unknown
76	Unknown
77	Infectious Disease
78	Neoplastic Diseases/Oncology
79	Neurology-Child
7A	Unknown
8	Unknown

80	Full-Time Facility (Dentists Only)
81	Unknown
82	Unknown
83	Rheumatology
84	Surgery-Head and Neck
85	Surgery-Pediatric
86	Unknown
87	Unknown
88	Unknown
89	Surgery-Traumatic
9	Unknown
90	Pathology-Forensic
91	Pharmacology-Clinical
92	Unknown
93	Marriage, family, and child counselor
94	Licensed clinical social worker
95	Registered nurse
96	Unknown
97	Unknown
98	Unknown
99	Unknown (on CA-MMIS Fiscal Intermediary (FI) claims)

- **PROV_TAXON** – billing provider taxonomy, identifies provider type, classification, and specialization for billing provider

- **PROV_274** – DHCS derived field that indicates whether billing NPI, rendering/operating NPI, or referring/prescribing NPI is a network provider identified in the Plan's Network Provider File

- **RECORD_ID** – record identification number, provides a unique number for each claim header record
    - The first four digits of RECORD_ID indicate the year and month the Plan submitted the encounter record to DHCS. For example, if a Plan submitted the encounter record on March 5, 2023, the first four digits would be listed as 2303.

- **REF_PRESC_NPI** – referring/prescribing NPI

- **REMOVE_NOTE** – reason that service count was zeroed out (i.e., Full Dual, Part A or B, Other Coverage, etc.)
- **REMOVE_SVC_CNT** – indicates how much utilization has been zeroed out

- **REND_OPERATING_NPI** – rendering/operating NPI

- **REVENUE_CD** – revenue code

- **SEC_DIAG_CD** – secondary diagnosis code (ICD-9)

- **SEC_DIAG_CD_ICD10** – secondary diagnosis code (ICD-10)

- **SVC_CAT** – Category of Service (COS) groups

SVC_CAT	Description
S01_IP	Inpatient Hospital
S02_ER	Emergency Room
S03_OP	Outpatient Facility
S04_LTC	Long-Term Care
S05_SP	Specialty Physician
S06_PCP	Primary Care Physician
S07_MHOP	Mental Health - Outpatient
S08_NPP	Non-Physician Professional
S09_FQHC	FQHC
S10_OTH	All Other

- **SVC_CNT** – utilization count

- **SVC_FROM_DT** – header level service from date

- **SVC_TO_DT** – header level service to date

- **SVC_UNITS_NBR** – number of service units

- **VENDOR_CD** – vendor code

Code	Description
	Unknown
00	INVALID
01	Adult Day Health Care Centers
02	Medicare Crossover Provider Only
03	CCS / GHPP
04	Genetic Disease Testing
05	Certified Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric NP
08	Certified Family NP
09	Respiratory Care Practitioner
10	Licensed Midwife Program
11	Fabricating Optical Labs
12	Optometric Group
13	Nurse Anesthetist
14	Expanded Access to Primary Care
16	INVALID
19	Portable X-ray Lab
20	Physicians (MD or DO)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Clinical Lab
25	INVALID
26	Pharmacies
27	Dentist
28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist

35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-prof. provider services)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Facility-Developmentally Disabled
49	Birthing Center
50	County Hosp - Acute Inpatient
51	County Hosp - Extended Care
52	County Hosp - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers
57	State Hosp - Mentally Disabled
58	County Hosp - Hemodialysis Center
59	County Hosp - Rehab Facility
60	Community Hosp - Acute Inpatient
61	Community Hosp - Extended Care
62	Community Hosp - Outpatient
63	Mental Health Inpatient Consolidation
64	Short Doyle Community MH - Hosp Services
68	Community Hosp - Renal Dialysis Center
69	Community Hosp - Rehab Facility
70	Acute Psychiatric Hosp
71	Home/Community Based Service Waivers
72	Surgicenter
73	AIDS Waiver Services
74	Short Doyle Community MH Clinic Services
75	Organized Outpatient Clinic
76	DDS Waiver Services
77	Rural Health Clinics/FQHCs/Indian Health Clinics

78	Community Hemodialysis Center
79	Independent Rehabilitation Facility
80	Nursing Facility (SNF)
81	MSSP Waiver Services
82	EPSDT Supplemental Services
83	Pediatric Subacute Rehab/Weaning
84	Assist. Living Waiver Pilot Project (ALWPP)
87	INVALID
88	Self-Directed Services(SDS) Waiver Services
89	Personal Care Services Program (IHSS)
90	Others and Out-of-State
91	Outpatient Heroin Detox
92	Medi-Cal Targeted Case Management
93	DDS Targeted Case Management
94	CHDP Provider
95	Short Doyle Community MH - Rehab Treatment
99	INVALID
A1	INVALID
B1	INVALID
CQ	UNKNOWN
DN	UNKNOWN
NF	UNKNOWN
OD	INVALID
OE	INVALID
OG	INVALID
OH	INVALID
OL	INVALID
OM	INVALID
OO	INVALID
OS	INVALID
OT	INVALID
PA	UNKNOWN
PC	UNKNOWN
PS	UNKNOWN
XX	INVALID

Appendix C: Category of Service Groupings – Mapping Logic

Notes for COS Mapping Logic:

1. DHCS groups encounter service data into different COS. Below is a description of the hierarchy used to identify each of the COS.
2. Logic Format Notes:
    a. All bullet points under each criteria must be met to satisfy that criteria.
    b. For COS where there are multiple criteria, there is a line that reads: "Criteria Combinations". This line explains which criteria need to be met in order to satisfy the requirement for assignment to the COS. For example, if the line reads "Criteria Combinations - (1,2) or (1,3) or (1,4)", then if criteria 1 AND 2, or 1 AND 3, or 1 AND 4 are met, then the claim should be assigned to the COS.
3. The categories of service are listed in hierarchical order and should be followed when services meet criteria for more than one COS. For example, if a service meets criteria for both Inpatient and Emergency Room, the service would be classified as Inpatient because Inpatient is higher on the hierarchy than Emergency Room.

After applying all COS logic, look for S10_OT services with a rendering provider taxonomy not equal to that of the billing provider, and reclassify these from S10_OT to S05_SP, S06_PCP, S07_MHOP, or S08_NPP by applying the same COS logic, but using rendering provider information.

Inpatient Hospital

Unit Type	Unit Type Special Instructions
Days	One inpatient stay per calendar day per member for "earned days" occurring during the service period. (Day Count = INPAT_DISCHARGE_DT – SVC_FROM_DT; when SVC_FROM_DT = INPAT_DISCHARGE_DT, then Day Count = 1)

Description: Facility-related expenses for hospital inpatient services, including room, board, and ancillary charges.

- Criteria #1
    - **FI_CLAIM_TYPE_CD** = "03" (Inpatient Hospital)

- Criteria #2
    - **INPAT_DISCHARGE_DT** or **SVC_TO_DT** > **SVC_FROM_DT**

- Criteria #3

Provider Type Codes	
60 - County Hospital Inpatient	72 - Mental Health Inpatient
16 - Community Hospital Inpatient	

- Criteria #4
    - **INPAT_DAYS_STAY** ≥ 1

Criteria Combinations – (1,2) or (1,3) or (1,4)

Community-Based Adult Services (CBAS)

Description: All expenses related to services provided by a CBAS center. CBAS replaced the former Adult Day Health Care program effective April 1, 2012. CBAS services are bucketed as S10_OT.

- Criteria #1

Vendor Codes
01 - Adult Day Health Care Centers

- Criteria #2

Procedure Codes	
H2000 - Comp multidisciplinary evaluation	S5102 - Adult day care per diem
T1023 - Program intake assessment	S5100 - day care services, adult per 15 minutes
S5101 - day care services, adult per half day	

Criteria Combinations – (1) or (2)

Emergency Room

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and facility (NPI)

Description: All facility-related expenses of an Emergency Room visit that did not result in an inpatient admission.

- Criteria #1
  - **FI_CLAIM_TYPE_CD** = 04 (Outpatient)

- Criteria #2
  - **POS_CD** = 0 (Emergency Room)

- Criteria #3
  - PROC_CD of Z7502, 99281, 99282, 99283, 99284, or 99285

- Criteria #4
  - Revenue Code of 0450, 0451, 0452, 0453, 0454, 0455, 0456, 0457, 0458, or 0459

Criteria Combinations – (1,2) or (1,3) or (1,4)

Outpatient Facility

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (REND_OPERATING_NPI)

Description: All facility-related expenses incurred for outpatient services.

- Criteria #1

Provider Type Codes	
61 - County Hospital Outpatient	15 - Community Hospital Outpatient Departments
49 - Birthing Centers-Prim ary Care Clinics	52 - Alternative Birth Centers- Specialty Clinics
44 - Surgical Clinics	42 - Chronic Dialysis Clinics

- Criteria #2
    - **FI_CLAIM_TYPE_CD** = 04 (Outpatient)

Provider Type Codes	
60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

- Criteria #3
    - **FI_CLAIM_TYPE_CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
    - **POS_CD** = 2 (Outpatient Hospital) or 5 (Office, Lab, Clinic)

- Criteria #4
    - **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)

Provider Taxonomy Codes	
261QX0200X	261QP3300X

- Criteria #5
    - **CLAIM_FORM_IND** = "U"
    - **PROV_TAXON** = 261QM1300X

Criteria Combinations – (1) or (2) or (3) or (4) or (5)

Behavioral Health Treatment (BHT)

Description: All expenses related to BHT services such as Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that prevent or minimize the adverse effects of Autism Spectrum Disorder (ASD). BHT services are bucketed as S10_OT.

- Criteria #1
    - Age < 21

- Criteria #2

Procedure Codes
H0031 - MH health assessment by non-md
H0032 – MH svc plan dev by non-md
H0046 – Mental health service, nos
H2012 – Behavioral health day treat, per hr
H2014 – Skills train and dev, 15 min
H2019 – Therapeutic behavioral svc, per 15 min
S5111 – Home care training, family; per session

- Criteria #3
    - Codes that reflect BHT services, but do not trigger a BHT supplemental payment

Procedure Codes	
0364T - Behavior treatment	0370T - Fam behav treatment guidance
0365T - Behavior treatment addl	0371T - Mult fam behav treat guide
0366T - Group behavior treatment	0372T - Social skills training group
0367T - Group behav treatment addl	0373T - Exposure behavior treatment
0368T - Behavior treatment modified	0374T - Fam behav treatment guidance
0369T - Behav treatment modify addl	

- Criteria #4
    - Comprehensive Diagnostic Evaluation (CDE) services performed with the intent to determine medical necessity

Procedure Codes	
90791 - Psych diagnostic evaluation	96119 - Neuropsych test by technician
90792 - Psych diag eval w/med services	96120 - Neuropsych test admin w/comp
96101 - Psycho testing by psych/phys	90785 - Interactive complexity
96102 - Psycho testing by technician	0359T - Behavioral id assessm ent
96103 - Psycho testing by computer and psych	0360T - Observ behav assessm ent
96105 - Assessment of aphasia	0361T - Observ behav assess addl
96111 - Developmental Testing, Extended	0362T - Expose behav assessm ent
96116 - Neurobehavioral status exam	0363T - Expose behav assess addl
96118 - Neuropsych test by psych/phys	

Criteria Combinations – (1,2) or (1,3) or (1,4)

Mental Health – Outpatient

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (NPI)

Description: All expenses for professional services related to the carve-in of mental health services for individuals with mild/moderate mental health needs/conditions. Services accounted for here are those provided by a Psychiatrist and/or other mental health non- physician professionals (e.g. Psychologist, LCSW, etc.).

- Criteria #1

Provider Specialty Codes	
26 - Psychiatry (child)	36 - Psychiatry
27 - Psychiatry Neurology (D.O. only)	

- Criteria #2

Provider Type Codes	
31 - Psychologists	34 - Licensed Clinical Social Worker (LCSW)

- Criteria #3

Procedure Codes	
90833 - Psytx 30 minutes	90836 - Psytx 45 minutes
90838 - Psytx 60 minutes	Z0300 Individual medical psychotherapy by a physician
90785 - Interactive complexity	90791 - Psych diagnostic evaluation
90792 - Psych diagnostic evaluation w/medical services	90832 - Psytx pt&/family 30 minutes
90834 - Psytx pt&/family 45 minutes	90837 - Psytx pt&/family 60 minutes
90839 - Psytx crisis initial 60 min	90840 - Psytx crisis ea addl 30 min
90845 - Psychoanaly sis	90846 - Family Psychotherapy
90847 - Family psychotherapy 50 minutes	90849 - Multi-Family/Group psychotherapy
90853 - Group psychotherapy	96101 - Psycho testing by psych/phys
96105 - Assessment of aphasia	96110 - Developmental screen w/score
96111 - Developmental test extend	96116 - Neurobehavioral status exam
96118 - Neuropsych tst by psych/phys	96120 - Neuropsych tst admin w/comp
99366 - Team conf w/pat by hc prof	99368 - Team conf w/o pat by hc pro

- Criteria #4
    - **FI_PROV_TYPE_CD** = 50 or 51

Provider Taxonomy Codes	
261QM0855X	261QM0850X
261QM0801X	261QM2800X

- Criteria #5
    - **FI_PROV_TYPE_CD** = 57

Provider Taxonomy Codes	
NOT = 225700000X	NOT = 2255A2300X

Criteria Combinations – (1) or (2) or (3) or (4) or (5)

Long Term Care

Unit Type	Unit Type Special Instructions
Days	Count only one long term care facility stay per calendar day per member (Day Count = INPAT_DISCHARGE_DT – SVC_FROM_DT + 1)

Description: All facility-related expenses of a long-term care facility stay (e.g. skilled nursing home, hospital with a skilled nursing unit, or intermediate care facility)

- Criteria #1

Provider Type Codes	
17 - Long Term Care	65 - Pediatric Subacute Care - LTC

- Criteria #2

Vendor Codes	
47 - Intermediate Care Facility - Developmentally Disabled	80 - Nursing Facility (SNF)

- Criteria #3
    - **FI_CLAIM_TYPE_CD** = 02 (Long Term Care)

- Criteria #4

Provider Type Codes	
60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

- Criteria #5

Vendor Codes	
50 - County Hospital - Acute Inpatient	51 - County Hospital - Extended Care
60 - Community Hospital - Acute Inpatient	61 - Community Hospital - Extended Care
63 - Mental Health Inpatient Consolidation	

- Criteria #6
  - **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)
  - **INPAT_DAYS_STAY** > 0

- Criteria #7
  - **VENDOR_CD** = 40 (Other provider – non-prof. provider services)
  - **INPAT_DAYS_STAY** > 0

- Criteria #8
  - **FI_CLAIM_TYPE_CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
  - **POS_CD** = 3 (Nursing Facility, Level A/B) or 6 (ICF-DD)

Criteria Combinations – (1) or (2) or (3,4) or (3,5) or (3,6) or (3,7) or (8)

Federally Qualified Health Center (FQHC)

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: All expenses for services provided in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Clinic, or Los Angeles County Cost Based Reimbursement Clinic (CBRC).

- Criteria #1

Provider Type Codes	
35 - P.L. 95-210 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	75 - Tribal Health Clinic

- Criteria #2

Place of Service Codes	
50 - Federally Qualified Health Center	72 - Rural Health Clinic

- Criteria #3
    - **FI_PROV_TYPE_CD** = 45 or 50

Provider Taxonomy Codes	
261Q00000X	261QP0904X

Criteria Combinations – (1) or (2) or (3)

Specialty Physician

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: All fee-for-service and contracted services provided by certain physician types (based on the provider specialty code) not included elsewhere.

- Criteria #1

Provider Type Codes	
22 - Physicians Group	26 - Physicians

OR

Vendor Codes	
20 - Physicians (MD or DO)	22 - Physicians Group

PROV_SPEC_CD	
05 - Anesthesiology	23 - Peripheral Vascular Disease or Surgery (D.O. only)
07 - Dermatology	03 - Allergy
06 - Cardiovascular Disease/Cardiology (M.D. only)	28 - Proctology (colon and rectal)
67 - Endocrinology & Metabolism	66 - Emergency Medicine
68 - Hematology	10 - Gastroenterology (M.D. Only)
02 - General Surgery	77 - Infectious Disease
29 - Pulmonary Disease (M.D. only)	45 - Nephrology
14 - Neurologic al Surgery	83 - Rheumatology
13 - Neurology (M.D. only)	42 - Nuclear Medicine
79 - Neurology-Child	20 - Orthopedic Surgery
18 - Ophthalmology	21 - Pathology Anatomy: Clinical Pathology (D.O. Only)
17 - Ophthalmology, Otolaryngology, Rhinology (D.O. only)	22 - Pathology (M.D. Only)
43 - Pediatric Allergy	90 - Pathology-Forensic
35 - Pediatric Cardiology (M.D. only)	25 - Physical Medicine & Rehabilitation
24 - Plastic Surgery	33 - Thoracic Surgery
32 - Radiation Therapy (D.O. only)	91 - Pharmacology Clinical
84 - Surgery-Head and Neck	31 - Roentgenology, Radiology (D.O. only)
85 - Surgery-Pediatric	04 - Otology, Laryngology , Rhinology (ENT)
89 - Surgery-Traum atic	78 - Neoplastic Diseases
34 - Urology and Urological Surgery	16 - Obstetrics-Gy nec ology (MD Only) Neonatal

- Criteria #2
    - **FI_CLAIM_TYPE_CD** = 05 (Medical)

Provider Type Codes	
60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

PROV_SPEC_CD	
05 - Anesthesiology	23 - Peripheral Vascular Disease or Surgery (D.O. only)
07 - Dermatology	03 - Allergy
06 - Cardiovascular Disease/Cardiology (M.D. only)	28 - Proctology (colon and rectal)
67 - Endocrinology & Metabolism	66 - Emergency Medicine
68 - Hematology	10 - Gastroenterology (M.D. Only)
02 - General Surgery	77 - Infectious Disease
29 - Pulmonary Disease (M.D. only)	45 - Nephrology
14 - Neurologic al Surgery	83 - Rheumatology
13 - Neurology (M.D. only)	42 - Nuclear Medicine
79 - Neurology-Child	20 - Orthopedic Surgery
18 - Ophthalmology	21 - Pathology Anatomy: Clinical Pathology (D.O. Only)
17 - Ophthalmology, Otolaryngology, Rhinology (D.O. only)	22 - Pathology (M.D. Only)
43 - Pediatric Allergy	90 - Pathology-Forensic
35 - Pediatric Cardiology (M.D. only)	25 - Physical Medicine & Rehabilitation
24 - Plastic Surgery	33 - Thoracic Surgery
32 - Radiation Therapy (D.O. only)	91 - Pharmacology Clinical
84 - Surgery-Head and Neck	31 - Roentgenology, Radiology (D.O. only)
85 - Surgery-Pediatric	04 - Otology, Laryngology , Rhinology (ENT)
89 - Surgery-Traum atic	78 - Neoplastic Diseases
34 - Urology and Urological Surgery	16 - Obstetrics-Gy nec ology (MD Only) Neonatal

- Criteria #3
    - **FI_PROV_TYPE_CD** = 43 or 50

Provider Taxonomy Codes	
261QM1300X	261QX0200X
261QE0800X	261QM2500X

Criteria Combinations – (1) or (2) or (3)

Primary Care Physician

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: Services provided by all physician types (who were not classified as a specialty physician and did not provide the service in a FQHC). Includes contracted and fee-for-service expenses for practitioners where members receive routine preventive and urgent care treatment from an assigned clinic or primary care provider.

- Criteria #1

Provider Type Codes	
22 - Physicians Group	26 - Physicians
41 - Community Clinics	

- Criteria #2
    - **FI_PROV_TYPE_CD** = 40, 48, or 50

Provider Taxonomy Codes	
261QP0905X	261QM1000X
261QH0100X	261QM1100X
261QC1800X	261QM1101X
261QP2300X	261QV0200X

- Criteria #3
    - **FI_PROV_TYPE_CD** = 87 or 98

Provider Taxonomy Codes
251K00000X

Criteria Combinations – (1) or (2) or (3)

Other Medical Professional/Non-Physician Professional

Unit Type	Unit Type Special Instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and provider (NPI)

Description: All expenses related to services provided (outside of an FQHC) by non-physician professionals who are not classified as Physician Primary Care or Physician Specialty (e.g., Certified Nurse Practitioners, Nurse Midwives, therapists, etc.)

- Criteria #1

Provider Type Codes	
07 - Certified Pediatric Nurse & Certified Nurse	29 - Prosthetists
10 - Group Certified Pediatric NP & Certified Family NP	56 - Respiratory Care Practitioner
62 - Group Respiratory Care Practitioner	23 - Optometric Group
18 - Nurse Anesthetists	12 - Dispensing Opticians
06 - Chiropractor	27 - Podiatrists
32 - Certified Acupuncture	25 - Physical Therapists
19 - Occupational Therapists	37 - Speech Therapist
03 - Audiologist	21 - Orthotists
05 - Certified nurse midwife	20 - Optometrists

- Criteria #2

PROV_SPEC_CD	
2 - Nurse Practitioner	3 - Physician Assistant
4 - Nurse Midwife	

- Criteria #3
    - **FI_PROV_TYPE_CD** = 44 or 50

Provider Taxonomy Codes	
261QF0050X	261QX0100X
261QI0500X	261QP2000X
261QP2000X	261QP1100X
261QA0005X	261QA0900X
261QH0700X	261QA3000X
261QL0400X	261QD1600X
261QA0006X	

- Criteria #4
    - **FI_PROV_TYPE_CD** = 18, 87, or 98

Provider Taxonomy Codes	
363A00000X	174400000X
251C00000X	367500000X

- Criteria #5
    - **FI_PROV_TYPE_CD** = 3 or 13

Provider Taxonomy Codes	
237600000X	237700000X

Criteria Combinations – (1) or (2) or (3) or (4) or (5)

Other

Description: All other MCO-covered medical services not grouped in another category of service, such as Hospice, Multipurpose Senior Services Program, In-Home Supportive Services, Home and Community Based Services Other, Lab and Radiology, Pharmacy, Transportation, and All Other.

Appendix D: Crosswalk of Health Plan Names to Plan Codes

Health Plan	Plan Code	County	Model
Aetna	015	Sacramento	GMC
	016	San Diego	GMC
AHF	915	Los Angeles	AHF
Alameda Alliance for Health	300	Alameda	Two-Plan
Anthem Blue Cross	100	Alpine	Regional
	101	Amador	Regional
	102	Butte	Regional
	103	Calaveras	Regional
	104	Colusa	Regional
	105	El Dorado	Regional
	106	Glenn	Regional
	107	Inyo	Regional
	108	Mariposa	Regional
	109	Mono	Regional
	110	Nevada	Regional
	111	Placer	Regional
	112	Plumas	Regional
	113	Sierra	Regional
	114	Sutter	Regional
	115	Tehama	Regional
	116	Tuolumne	Regional
	117	Yuba	Regional
	144	San Benito	Regional
	190	Sacramento	GMC
	311	Tulare	Two-Plan
	340	Alameda	Two-Plan
	343	San Francisco	Two-Plan
	344	Contra Costa	Two-Plan
	345	Santa Clara	Two-Plan
	362	Fresno	Two-Plan
	363	Kings	Two-Plan

	364	Madera	Two-Plan
Blue Shield	167	San Diego	GMC
CA Health and Wellness	118	Alpine	Regional
	119	Amador	Regional
	120	Butte	Regional
	121	Calaveras	Regional
	122	Colusa	Regional
	123	El Dorado	Regional
	124	Glenn	Regional
	128	Inyo	Regional
	129	Mariposa	Regional
	133	Mono	Regional
	134	Nevada	Regional
	135	Placer	Regional
	136	Plumas	Regional
	137	Sierra	Regional
	138	Sutter	Regional
	139	Tehama	Regional
	141	Tuolumne	Regional
	142	Yuba	Regional
	143	Imperial	Regional
CalOptima	506	Orange	COHS
CalViva	315	Fresno	Two-Plan
	316	Kings	Two-Plan
	317	Madera	Two-Plan
CCAH	505	Santa Cruz	COHS
	508	Monterey	COHS
	514	Merced	COHS
CenCal	501	San Luis Obispo	COHS
	502	Santa Barbara	COHS
Community Health Group	029	San Diego	GMC
Contra Costa Health Plan	301	Contra Costa	Two-Plan
Gold Coast Health Plan	515	Ventura	COHS
Health Net of California	068	San Diego	GMC
	150	Sacramento	GMC
	352	Los Angeles	Two-Plan

	353	Tulare	Two-Plan
	354	San Joaquin	Two-Plan
	360	Kern	Two-Plan
	361	Stanislaus	Two-Plan
Health Plan of San Joaquin	308	San Joaquin	Two-Plan
	312	Stanislaus	Two-Plan
Health Plan of San Mateo	503	San Mateo	COHS
Inland Empire	305	Riverside	Two-Plan
	306	San Bernardino	Two-Plan
Kaiser	079	San Diego	GMC
	170	Sacramento	GMC
	177	Amador	Regional
	178	El Dorado	Regional
	179	Placer	Regional
Kern Health Systems	303	Kern	Two-Plan
LA Care HP	304	Los Angeles	Two-Plan
Molina Healthcare	130	Sacramento	GMC
	131	San Diego	GMC
	145	Imperial	Regional
	355	Riverside	Two-Plan
	356	San Bernardino	Two-Plan
Partnership Health Plan	504	Solano	COHS
	507	Napa	COHS
	509	Yolo	COHS
	510	Marin	COHS
	511	Lake	COHS
	512	Mendocino	COHS
	513	Sonoma	COHS
	517	Humboldt	COHS
	518	Lassen	COHS
	519	Modoc	COHS
	520	Shasta	COHS
	521	Siskiyou	COHS
	522	Trinity	COHS
	523	Del Norte	COHS
San Francisco Health Plan	307	San Francisco	Two-Plan
Santa Clara Family HP	309	Santa Clara	Two-Plan

Appendix E: Change Log

Changes from Previous Versions			
ID	**Change Description**	**Toolkit Section**	**Version Date**
1	Created PHDP encounter data toolkit	All sections	03/2024