



MEDI-CAL UPDATE

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www.medi-cal.ca.gov

Program and Eligibility

June 2003

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Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update may not always contain a "Billing and Policy" section.



HIPAA Transactions and Code Sets: Medi-Cal Implementation Plan

Medi-Cal is continuing its efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets Final Rule. Implementation is taking place in a series of

phases, some of which will extend beyond the October 16, 2003 compliance date. Therefore, it is critical for providers to review monthly *Medi-Cal Updates* over the coming months for detailed HIPAA billing instructions and training information.

Electronic Data Interchange (EDI) and Paper Impact

Medi-Cal anticipates significant changes for electronic and paper billing submission requirements in order to comply with HIPAA standards. These changes include the code set values identified below, in addition to other billing requirements. Provider training sessions focused on HIPAA and these billing practice changes are scheduled for summer 2003. These changes will continue to be communicated in *Medi-Cal Updates* and on the Medi-Cal Web site (www.medi-cal.ca.gov). Please check the Medi-Cal Web site and provider bulletins regularly for the latest HIPAA information and upcoming training locations.

Medi-Cal's phased implementation plan requires that providers continue to follow existing billing instructions until otherwise notified in future *Medi-Cal Updates*. Medi-Cal has scheduled the first implementation phase effective for dates of service on and after September 22, 2003. The following information provides more details about this phase of HIPAA implementation.

Please see HIPAA, page 3



The energy challenge facing California is real. The Department of Health Services encourages practical and feasible energy saving measures while considering the health and safety of clients, workers and family members.

EDS/MEDI-CAL HOTLINES

Border Providers	(916) 636-1000, ext. 2100
Computer Media Claims (CMC).....	(916) 636-1100
DHS Medi-Cal Fraud Hotline.....	1-800-822-6222
Health Access Programs (HAP) – Cancer Detection Programs: Every Woman Counts, OB, CPSP and Family PACT Providers	1-800-257-6900
POS/Internet Help Desk	1-800-427-1295
Provider Support Center (PSC).....	1-800-541-5555
Provider Telecommunications Network (PTN).....	1-800-786-4346
Specialty Programs.....	1-800-541-7747

For a complete listing of specialty programs and hours of operation, please refer to the Medi-Cal Directory in the provider manual.

**MEDI-CAL FRAUD
IS AGAINST THE
LAW**

**MEDI-CAL FRAUD COSTS TAXPAYERS MILLIONS
EACH YEAR AND CAN ENDANGER
THE HEALTH OF CALIFORNIANS.**

**HELP PROTECT MEDI-CAL AND YOURSELF
BY REPORTING YOUR OBSERVATIONS TODAY.**

**DHS MEDI-CAL FRAUD HOTLINE
1-800-822-6222**

THE CALL IS FREE AND YOU CAN REMAIN ANONYMOUS.

Knowingly participating in fraudulent activities can result in prosecution and jail time. Help prevent Medi-Cal fraud.

HIPAA (continued)

Health Care Claims (ASC X12N 837)

Medi-Cal will accept the ASC X12N 837 standard transaction (including Addenda) formats for Professional (004010X098A1) and Institutional (004010X096A1) claims beginning September 22, 2003. The corresponding ASC X12N 837 Companion Guides are being revised to provide clarity and address user inquiries. These guides are available on the Medi-Cal Web site by clicking “HIPAA Update” and then “Draft HIPAA ASC X12N and NCPDP Compound Specifications.” Medi-Cal will extend a phase-out period beyond October 2003 for submission of non-standard and proprietary electronic claim formats. During this phase-out, some field values of the non-standard and proprietary electronic claim formats will be modified. Revised non-standard and proprietary Computer Media Claims (CMC) technical specifications identifying these changes will be made available in a future *Medi-Cal Update* and on the Medi-Cal Web site.

Medicare/Medi-Cal Crossovers

Processing of Medicare/Medi-Cal crossover claims (electronically transmitted from Medicare intermediaries and carriers) will continue as it does currently, with the exception of the transaction standard upgrade. Medi-Cal is engaged in testing activities with Medicare intermediaries and carriers to receive and process ASC X12N 837 Institutional and Professional crossover claims. Medicare/Medi-Cal crossover claims processing functionality is not changing, including Part A and B pricing. Medicare Part A adjustments/replacements and Part B services billing to the Part A intermediary are not currently processed electronically and must be provider-generated. The requirement to bill provider-generated crossover claims on paper remains unchanged, although some code set values and form locations (FL) will change (as listed in the correlation tables referenced below). All other Medicare/Medi-Cal crossover claims billing instructions will remain in effect.

Administrative Code Sets

HIPAA mandates the standardization of internal (administrative) code sets, such as condition codes, Place of Service codes, delay reason codes, patient status codes, etc. The conversion of interim (formerly referred to as local) codes to national (administrative) codes will be implemented using the same update process as the current annual HCPCS update, in which code application is effective based on the date of service. The code values are effective for dates of service on and after September 22, 2003 for all billing media and all Medi-Cal (fee-for-service), waiver and public health program areas. There will not be a transition (grace) period.

Medi-Cal’s administrative code correlation tables are included with this bulletin and will be posted on the Medi-Cal Web site. The tables apply to both paper and electronic claim submission for the following claim types:

- Inpatient
- Outpatient
- Long Term Care
- Medical
- Vision

Please see HIPAA, page 4

HIPAA (continued)

The tables have been developed and separated by claim type and billing media (paper, current proprietary and non-standard formats and HIPAA standards). The correlation tables also contain key billing requirement changes, form location changes, specification changes and tips for use. Providers will need to read through these documents carefully to determine the appropriate claim type and correlation tables for their billing practices. These values are provided to begin to prepare for business operation modifications, including software, practice management systems and vendor or clearinghouse use. These values are not to be used for billing purposes for dates of service prior to September 22, 2003. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*.

Service/Procedure Code Sets

HIPAA mandates the use of standard service/procedure code sets for transactions. These standard code sets consist of revenue codes, national drug codes, ICD-9-CM codes, CPT-4 codes and HCPCS codes. The conversion of interim (local) codes to national service/procedure codes will be implemented in phases and effective based on date of service. In this first phase, Medi-Cal is converting Orthotics and Prosthetics, Chiropractic, and Immunization and Vaccine code sets. These specific code values are effective for dates of service on and after September 22, 2003 for all billing media and all Medi-Cal (fee-for-service) and public health program areas. There will not be a transition (grace) period. These service code pricing values also apply to Medicare/Medi-Cal crossover claims (from intermediaries, carriers or providers). All other interim code values remain in effect and should be used for billing purposes until providers are instructed otherwise. These changes will be announced in future *Medi-Cal Updates*.

Medi-Cal's code correlation table for Inpatient revenue codes is included with this bulletin and will be posted on the Medi-Cal Web site. These values are being provided to allow for business operation modifications, including software, practice management systems and vendor or clearinghouse use. These values are not to be used for billing purposes for dates of service prior to September 22, 2003. Provider manual replacement pages will be included in a future *Medi-Cal Update*.

Note: The correlation table for Inpatient ICD-9-CM Volume 3 surgical codes (formerly CPT-4 codes) is not finalized yet. It will be published at a later date. Correlation tables will not be developed for Chiropractic, Orthotics and Prosthetics, and Immunizations and Vaccines code sets and associated modifiers because one-to-one correlations of interim (local) to national codes are not applicable for these groups. Refer to the appropriate Part 2 bulletin in this month's *Medi-Cal Update* for information regarding changes to these code sets.

Pharmacy Compound Drug Claim Submission

Medi-Cal will accept pharmacy compound drug claims in the NCPDP Version 5.1 (Telecommunication) standard beginning September 22, 2003. Draft Technical Specifications were posted to the Medi-Cal Web site in April 2003. To correspond with the data element changes mandated by the NCPDP electronic standard for compound drugs, a new paper Medi-Cal *Pharmacy Compound Drug Claim Form* (30-4) will be implemented, and modifications will be made to the Real-Time Internet Pharmacy (RTIP) claim submission system to allow for compound drug claim submission. Compound drug claims will not be accepted in the NCPDP 1.1 batch format (CMC). Compound drug claims submitted on the current paper claim form (30-1) will be allowed during a transition (grace) period only.

This is a significant change for providers who dispense compound drugs to Medi-Cal recipients. It includes claims for sterile solutions (IVs, etc.) as well as ointments, capsules and other non-sterile compound preparations.

Please see **HIPAA**, page 5

HIPAA (continued)

Because of the specialized nature of this provider community, Medi-Cal is pursuing additional avenues to ensure provider outreach and training. Pharmacy compound drug providers and their vendors are urged to call Medi-Cal at 1-800-541-5555, prompt option “4,” and provide the information requested at the prompts. An education and outreach mailing list will be developed from this information and further contacts and plans communicated.

Additional information regarding compound drug electronic claim submission, the new claim form, associated billing instructions and provider training will be communicated in future Medi-Cal Updates and on the Medi-Cal Web site. Please check the Medi-Cal Web site and provider bulletins regularly for the latest information regarding these changes.

Real-Time Pharmacy Claim Submission

Medi-Cal is currently accepting pharmacy claims in the NCPDP 5.1/1.1 and 3.2 versions. Providers are urged to contact their software vendors and begin to transition to the NCPDP 5.1/1.1 standard. The transition period expires September 30, 2003. Medi-Cal will not accept real-time pharmacy claim transmissions in the NCPDP 3.2 standard beginning October 1, 2003.

Remittance Advice (Health Care Claim Payment/Advice) for all Claim Types (ASC X12N 835)

Medi-Cal will generate the ASC X12N 835 004010X091A1 standard transaction (including Addenda) format for claims remittance advice beginning October 1, 2003 for claims adjudicated on or after September 22, 2003. Providers who elect to receive an electronic remittance advice in the ASC X12N 835 standard format will be able to download the remittance advice from the Internet Bulletin Board System (IBBS) beginning October 1, 2003. In addition to the adjustment reason codes required in the standard transaction format, Medi-Cal also will provide situational health care remarks codes. The health care remarks codes provide an additional level of detail not contained in the adjustment reason codes. Medi-Cal has begun correlating health care remarks codes with the Remittance Advice Details (RAD) codes currently used on the paper remittance advice. It is not anticipated that all RAD code correlations to remarks codes will be finalized by October 1, 2003.

The ASC X12N 835 transaction enrollment process begins July 21, 2003. An ASC X12N 835 transaction receiver or receivers will be required to be an authorized Computer Media Claims (CMC) submitter or have a valid *Medi-Cal Point of Service (POS) Network/Internet Agreement* on file. Authorizing providers will be required to complete and sign the new *Electronic Health Care Claim Payment/Advice Receiver Agreement* form (included with this bulletin) before they can receive ASC X12N 835 transactions from Medi-Cal or designate a receiver or receivers for 835 transactions. This form is being added to the end of the *Remittance Advice Details (RAD): Electronic* section of the Medi-Cal Provider Manual and on the forms page of the Provider Relations Organization Web site (pro.medi-cal.ca.gov/forms.asp). Providers will be notified when their enrollment has been completed or if there is a problem with their application.

Please see HIPAA, page 6

HIPAA (continued)

On the receiver agreement, the authorizing provider may designate up to two receivers (CMC submitter or Internet-enabled) for ASC X12N 835 transactions (the authorizing provider may designate itself as a receiver). If a provider with multiple sites chooses the same receiver, one downloadable zip file will be sent with all of the sites' warrant information (ASC X12N 835 transactions) included. An ASC X12N 835 transaction will equate to one check. This is consistent with Medi-Cal's current disbursement policy. Medi-Cal does not price Inpatient or Medicare/Medi-Cal crossover claims at the detail line. Therefore, Medi-Cal will not be sending the service (SVC) segment for these claims.

Medi-Cal's adjustment reason code correlation table will be published and posted to the Medi-Cal Web site at a later date. These values will be provided to allow for business operation modifications, including software, practice management systems and vendor or clearinghouse use.

Testing

Medi-Cal currently is not prepared to accept or acknowledge test transactions for HIPAA-compliant standards from its trading partners. Future *Medi-Cal Updates* will outline specific testing requirements and time schedules. Electronic billing activation and media testing for the ASC X12N 837 Professional (004010X098A1) and Institutional (004010X096A1) standard transactions will be required for all CMC submitters. This will require completion of a new *Medi-Cal Telecommunications Provider and Biller Application/Agreement* form, which constitutes a Trading Partner Agreement. Electronic billing activation and media testing for all CMC providers is scheduled to begin this summer. Providers preparing to submit NCPDP 5.1 compound drug claims will not be required to complete a test transaction if they already are approved for the NCPDP 5.1 standard. Medi-Cal will not require testing of the ASC X12N 835 transaction with authorized receivers.

Medi-Cal will perform beta testing for transaction submission, system processing and end-to-end remittance advice generation with a select group of providers, submitters, vendors and clearinghouses. Beta testing for the ASC X12N 835 and ASC X12N 837 transactions is scheduled for late summer. More testing information will be provided in future *Medi-Cal Updates* and on the Medi-Cal Web site.

Technical Specifications/Companion Guides

Newly revised Medi-Cal draft ASC X12N Companion Guides and NCPDP 5.1 compound drug Technical Specifications are available on the Medi-Cal Web site by clicking "HIPAA Update" and then "Draft HIPAA ASC X12N and NCPDP Compound Specifications." Medi-Cal does not expect substantive changes to these draft documents and encourages providers, submitters, vendors and clearinghouses to review them and prepare for internal testing based on these guides. These drafts will be finalized following the testing phase scheduled for late summer. The Companion Guides and Technical Specifications will be published in their final forms by October 2003.

Frequently Asked Questions

Medi-Cal has developed a HIPAA Frequently Asked Questions section of the Medi-Cal Web site, which can be accessed by clicking "HIPAA Update" and then "HIPAA Frequently Asked Questions." Providers are encouraged to check the Web site regularly for updates. For more information about HIPAA and Medi-Cal's implementation plan, call the Provider Support Center (PSC) at 1-800-541-5555 and select prompt option "4."

2003 – 2004 State Budget: Reimbursement Contingency

If the State of California does not enact the fiscal year 2003 – 2004 budget by June 30, 2003, the Department of Health Services (DHS) will direct the fiscal intermediary, EDS, to implement provisions to continue processing and adjudicating claims as outlined below.

The State of California established, through Assembly Bill 561 (AB 561), an interim \$2 billion fund to provide continuing payments for services rendered from July 1 to August 31 each year, or until the fund is exhausted. Under authority of this bill, EDS will process and adjudicate claims for the following programs, regardless of date of service.

- Medi-Cal
- Family PACT (Planning, Access, Care and Treatment)
- Child Health and Disability Prevention (CHDP) Medi-Cal
- California Children's Services (CCS)/Medi-Cal
- County Medical Services Program (CMSP)
- Children's Treatment Programs (CTP)

Note: EDS will withhold all CCS-only reimbursements regardless of dates of service. The last warrant date for CCS-only claims is June 26, 2003.

Effective for dates of service on or after July 1, 2003, EDS will process claims but withhold reimbursement for services for the following programs:

- Expanded Access to Primary Care Programs (EAPC)
- Cancer Detection Programs: Every Woman Counts
- Child Health and Disability Prevention (CHDP) [General Fund and Tobacco Funds, non Medi-Cal]
- Healthy Families
- Genetically Handicapped Persons Program (GHPP)

Withholds will continue until the state budget is approved and EDS receives notification from DHS to resume reimbursement of claims for the above-mentioned programs. All providers are asked to continue to render services and submit claims for processing.

Checkwrite Schedule 2003 – 2004: Programs Update

Effective immediately, the checkwrite schedule has been updated for fiscal year 2003 – 2004. This schedule reflects warrant release dates and Electronic Fund Transfer dates of deposit for the following programs:

- Medi-Cal
- County Medical Services Program (CMSP)
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Abortion
- Family PACT (Planning, Access, Care and Treatment)
- Healthy Families (HF)
- Child Health and Disability Prevention (CHDP)
- Cancer Detection Programs: Every Woman Counts
- Expanded Access to Primary Care (EAPC)

This information is reflected on manual replacement page [check 1](#) (Part 1).

CHDP Gateway: New Pre-Enrollment Process

Starting July 1, 2003, Child Health and Disability Prevention (CHDP) program providers will be able to pre-enroll children in the Medi-Cal program using the new CHDP Gateway Pre-Enrollment Application form (DHS 4073) on either the Medi-Cal Web site or a Point of Service (POS) device. Children younger than 19 years of age who are pre-enrolled in Medi-Cal at the time of a CHDP health assessment will receive full-scope, no-cost Medi-Cal benefits and dental coverage for up to two months. Eligibility will be based on age, family size and income, and California residency.

The CHDP Gateway will include the following features:

- Pre-enrollment in Medi-Cal will be easy and fast.
- Submitting information from the CHDP Gateway Pre-Enrollment Application form will produce an immediate response with real-time eligibility processing.
- Eligible children will receive CHDP health assessments and any necessary follow-up care for problems identified during a health assessment.
- Families can request an application for continuing health care coverage beyond the pre-enrollment period through Medi-Cal or Healthy Families.

CHDP providers will have a six-month period in which to completely adopt the automated enrollment process in their offices. After January 1, 2004, low-income children not already full-scope Medi-Cal recipients must pre-enroll through the CHDP Gateway to access CHDP services.

Note: Providers who continue to deliver state-funded CHDP services under the existing processes will not be able to use the Gateway process to pre-enroll children in Medi-Cal.

How the CHDP Gateway Works

During a child's CHDP health assessment visit, a provider will electronically submit information from the CHDP Gateway Pre-enrollment Application form through the Medi-Cal Web site or POS device. The provider will receive an immediate response indicating the child's eligibility status. An eligible child can receive coverage during the month of application and the subsequent month.

If a child is eligible for Medi-Cal benefits, a Benefits Identification Card (BIC) number will be included in the eligibility response. The provider will print an Immediate Need Eligibility Document for the child, who does not currently have a BIC card, from the Web site or POS device. The parent, legal guardian or emancipated minor can give this temporary BIC to any Medi-Cal provider and since Medi-Cal coverage is immediate, the child can receive services that same day. Typically, a permanent BIC will be issued to the child within 10 days.

Please see CHDP, page 9

CHDP (continued)

CALIFORNIA
 DEPARTMENT OF HEALTH SERVICES
 MEDI-CAL POS NETWORK
 <Header Line #6>

B4/B1/2003 12:04:22

TERMINAL: V123456789
 SOFTWARE: ZZACH01
 PROVIDER NUMBER: CHA123456

**CHDP GATEWAY
 PRE-ENROLLMENT
 RESPONSE**

PATIENT NAME:
 ANDREW MIKE JOSS

DATE OF BIRTH:
 1988-01-01

GENDER:
 M

BIC ID#: 1234567898

ISSUE DATE:
 2002-12-19

GOOD THRU DATE:
 2003-01-31

YOU ARE TEMPORARILY ELIGIBLE FOR
 CHDP SERVICES THROUGH 01/31/2003.
 USE THIS DOCUMENT TO ACCESS CHDP
 AND EMERGENCY MEDI-CAL SERVICES
 UNTIL YOUR BIC CARD ARRIVES.

X _____
 CLIENT SIGNATURE

Sample Immediate Need Eligibility Document via POS device

CHDP Gateway Pre-enrollment Application Response

CHDP GATEWAY PRE-ENROLLMENT RESPONSE

Provider Number : zzzzzzzzz Application Date/Time: 12/19/2002 9:26:50 AM

Patient's Name: Joss Andrew Mike

Date of Birth: 01/01/1988

Gender: Male

BIC ID#: 99301490P0

BIC Issue Date: 12/19/2002

Good Thru Date: 01/31/2003

You are temporarily eligible for Medi-Cal through 01/31/2003. Use this document to access Medi-Cal services until your Benefits Identification Card arrives. To continue your coverage, you must return a completed joint Healthy Families/Medi-Cal application before 01/31/2003. If you do not receive the application in the mail within 10 days, call 1-800-880-5305.

Client Signature: _____

Next Application Print

Sample Immediate Need Eligibility Document via Medi-Cal Web site

Note: To ensure the appropriate services are rendered and reimbursable, the provider should verify the child’s eligibility status during each encounter using the BIC number on the child’s BIC or Immediate Need Eligibility Document.

Provider Assistance

For questions regarding POS or Internet requirements, contact the POS/Internet Help Desk at 1-800-427-1295, seven days a week, from 6 a.m. to midnight.

Please refer to the Medi-Cal Web site (www.medi-cal.ca.gov) for more information about this program. Providers who are interested in becoming CHDP providers can contact their local CHDP program (please see www.dhs.ca.gov/chdp for a list of local CHDP programs).

CHDP Gateway and Medi-Cal/Healthy Families Programs: New Aid Codes

Effective for dates of service on or after July 1, 2003, new aid codes 8W and 8X are full-scope Medi-Cal benefits with no Share of Cost (SOC) and are valid for Child Health and Disability Prevention (CHDP) program services. New aid code 8Y is for CHDP services only. All three new aid codes are for children younger than 19 years of age.

<u>Code</u>	<u>Program/Description</u>
8W	CHDP Gateway Medi-Cal. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for no-cost Medi-Cal eligibility. Provides temporary full-scope Medi-Cal benefits with no Share of Cost (SOC). The FFP for these benefits is available through Title XIX of the Social Security Act.
8X	CHDP Gateway Healthy Families. Provides for the pre-enrollment of children into the Medi-Cal program who are screened as probable for Healthy Families eligibility. Provides temporary full-scope Medi-Cal benefits with no SOC. The FFP for these benefits is available through Title XXI of the Social Security Act.
8Y	CHDP. Provides eligibility in the CHDP program for children who are known to Medi-Cal Eligibility Data System (MEDS) as not having citizenship or satisfactory immigration status. There is no FFP for these benefits.

The CHDP program will be used as a gateway to the Medi-Cal and Healthy Families programs to enable children to receive full-scope health care coverage. Children younger than 19 years of age who have met or certified their SOC at the time of the CHDP visit can pre-enroll in the CHDP Gateway and receive no-cost Medi-Cal coverage for the following month.

New Eligibility System Message

The Eligibility Verification System will add the following new message to inform CHDP providers that all children younger than 19 years of age who have met their SOC for the month in which they receive CHDP services may be eligible for the CHDP Gateway program: “Attention CHDP providers, continue with the CHDP Gateway application.”

This information is reflected on manual page aid codes 15 (Part 1).

Denti-Cal: Brochure and Poster Available

All children enrolled in Medi-Cal, including those pre-enrolled through the Child Health and Disability Prevention (CHDP) Gateway, are eligible for Medi-Cal dental benefits. Providers can order a brochure to be given to prospective dental patients. The brochure includes preparatory information for a child’s dental visit, such as which documents the parent, legal guardian or emancipated minor should bring to the dental office. The brochure is available in both English and Spanish. An accompanying poster containing the same information is available in English. Providers may write to the following address to request multiple copies of the brochure and poster, free of charge:

Denti-Cal
California Medi-Cal Dental Program
Printing and Publications Unit
P.O. Box 15609
Sacramento, CA 95852-0609

Fee-for-Service/Managed Care Network Pilot Program Termination

Effective for dates of service on or after July 1, 2003, the Fee-for-Service/Managed Care Network (FFS/MCN) pilot program, consisting of Placer County Managed Care Network (HCP 640) and Sonoma County Partners for Health Managed Care Network (HCP 642), is terminated as a result of 2003 – 2004 California State Budget constraints. Former FFS/MCN plan participants are automatically eligible for straight Medi-Cal fee-for-service and/or Special Program billing, for example, County Medical Services Program (CMSP).

Although this pilot program is terminated, Medi-Cal Provider Manual sections *MCP: Fee-For-Service/Managed Care (FFS/MC)* (Part 1) and *MCP: Fee-For-Service/Managed Care Network (FFS/MCN) Billing Guidelines* (Part 2) are being retained for post-plan reference through June 2005 to assist providers who must process outstanding FFS/MCN claims.

RAF/TAR Submittal

Currently, all non-plan providers are required to submit a *Referral Authorization Form* (RAF) prior to rendering specific FFS/MCN plan-covered outpatient and medical services. With the termination of the FFS/MCN pilot program, RAFs will be approved only for services that occur on or before June 30, 2003.

Effective for dates of service on or after July 1, 2003, providers are required to submit a *Treatment Authorization Request* (TAR), in lieu of a RAF, for what were previously plan-covered outpatient and medical services that require Medi-Cal prior authorization. (Most plan-covered services do not require a TAR.) This includes services with an approved RAF because RAF and TAR requirements are not interchangeable. Medi-Cal field offices will begin accepting TAR requests beginning May 12, 2003, for dates of service on or after July 1, 2003.

To avoid claim denials, refer to the *TAR Overview* section in the appropriate Part 2 Medi-Cal Provider Manual or on the Medi-Cal Web site at www.medi-cal.ca.gov (click the “Publications” link).

Provider Support

For FFS/MCN billing support, providers may call the FFS/MCN Unit at 1-800-586-3026 from 8 a.m. to 12 p.m. and from 1 p.m. to 5 p.m., Monday through Friday, except holidays. However, this number will eventually be phased out. When unable to reach FFS/MCN Unit staff, call the Provider Support Center (PSC) at 1-800-541-5555 where assistance with TAR, straight Medi-Cal and Special Program billing is also available.

The following manual replacement pages are edited to reflect this change: county med 3 and 11 (Part 1), mcp an over 1 (Part 1), mcp code dir 4 and 10 (Part 1), mcp ffs 1 (Part 1) and prov rel 3 (Part 1).

County Medical Services Program: Benefit Update

Effective for dates of service on or after April 1, 2003, County Medical Services Program (CMSP) prescription drug benefits are provided under a contract with MedImpact Healthcare Systems, Inc. (MedImpact), a pharmacy benefit management company. This change affects CMSP recipients with primary aid codes 50, 84, 85, 88 and 89. With the exception of certain AIDS and psychiatric drugs, this contract does not affect the delivery of prescription drug benefits to CMSP recipients with primary aid codes 84 and 85 who are participating in Solano County’s Partnership HealthPlan of California (PHC). Certain AIDS and psychiatric drugs are not covered by the Solano County PHC and will be provided under the contract with MedImpact. In addition, medical and incontinence supplies provided to CMSP recipients will continue to be billed to EDS without changes in current coverage or authorization. For more information regarding this benefit update, call the MedImpact Pharmacy Help Desk at 1-800-788-2949.

RAD Code: Updates

The following Remittance Advice Details (RAD) messages have been updated to help reconcile your accounts.

<u>Code</u>	<u>Message</u>
9076	The anesthesia code must be documented as general, regional, or both general and regional in the <i>Remarks</i> area on the UB-92 claim form or in the <i>Reserved for Local Use</i> field (Box 19) of the HCFA 1500 claim form. Billing Tip: Refer to the <i>Anesthesia</i> section in the appropriate Part 2 Medi-Cal provider manual for more information.
9077	Indicate the start and stop times for the procedure billed in the <i>Remarks</i> area/ <i>Reserved for Local Use</i> field (Box 19) of the claim form.
9598	A statement that says “the equipment is patient-owned” is missing from the <i>Reserved For Local Use</i> field (Box 19) of the claim.

Please refer to revised manual pages remit cd9000 8 and 29 (Part 1) included with this bulletin.

www.medi-cal.ca.gov

**AEVS Other Health Coverage Carrier Codes:
June Updates**

The *AEVS: Other Health Coverage Carrier Codes* list has been updated. Providers should refer to the complete *AEVS: Other Health Coverage Carrier Codes* list on the Medi-Cal Web site at www.medi-cal.ca.gov. These codes are updated monthly and are accessible by clicking the “Publications” link, the appropriate “Provider Manual” link and the “Online-Only Section” link. Additions and changes are shown in bold and underlined type.

Providers may order a hard copy update of the section by calling the Provider Support Center (PSC) at 1-800-541-5555. Updates are listed below.

<u>Code</u>	<u>Carrier</u>	<u>Code</u>	<u>Carrier</u>
A421	TOTAL BENEFIT SOLUTIONS	L216	LANE FURNITURE INDUSTRIES
B274	BENEFIT MANAGEMENT ADMIN	M458	MERCY CARE PLAN
C286	CBCA INCORPORATED	Q031	SOUTHERN HEALTH SERVICES INC
C287	CARPENTERS HWTF OF INDIANA	R068	RIVERSIDE PHYSICIAN NETWORK
D224	DEFINITY HEALTH	U113	UNION LABOR LIFE INSURANCE
I196	INNOVATIVE ADMINISTRATIVE SRV		

www.medi-cal.ca.gov

**Medi-Cal Suspended and Ineligible Provider List:
June Updates**

The *Medi-Cal Suspended and Ineligible Provider List* (S&I List) is updated monthly and is available on the Internet at www.medi-cal.ca.gov. Additions and changes are shown in bold type and reinstated providers are removed from the S&I List. Always refer to the S&I List when verifying provider ineligibility.

Please see the S&I List by clicking the “Publications” link, the appropriate “Provider Manual” link and then the “Online-Only Section” link on the Medi-Cal Web site. Providers may view or download the S&I List in Microsoft Word format. Providers may also order a hard copy update of the section by calling the Provider Support Center (PSC) at 1-800-541-5555.

<u>Physicians (susp A)</u>					
Brown, Shirley Elizabeth aka: Brown-Ornish, Shirley Elizabeth 7 Miller Avenue Sausalito, California	C41571	Suspended indefinitely effective 3/28/02.	Hilde, Reuben Lynn, Jr. aka: Hilde, Lynn Jr. 7957 South Painter Avenue Whittier, California	G22770	Suspended indefinitely effective 12/4/02.
Doran, Andrew J. Connick 4445 Dundee Drive Los Angeles, California	G2718	Suspended indefinitely effective 2/12/03.	Lakner, George Stephen 11201 Benton Street, Suite 116A Loma Linda, California	CT23364 DC16011 IL77045 PK26288 MD25404 MA50841 NV8744 NH9679 NJ41726 NY144504 VA40690 PA42384	Suspended indefinitely effective 12/19/01.
Garabet, Antoine Leon aka: Garabet, Tony 840 North Pennsylvania Avenue Glendora, California	G50394	Suspended indefinitely effective 3/28/03.			

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S&I (continued)

Lombardi, Luis Alejandro 633 North Marine Avenue Wilmington, California	A52499	Suspended indefinitely effective 5/7/03.
Lusman, Jules Mark 925 Westgate Avenue, Suite 401 Los Angeles, California	A47985	Suspended indefinitely effective 12/6/02.
Manthey, Russell 1772-J Avenue De Los Arboles, #148 Thousand Oaks, California	C41884	Suspended indefinitely effective 2/3/03.
Nelson, Ricky Joe 12101 North Macarthur, #129 Oklahoma City, Oklahoma	G70300	Suspended indefinitely effective 3/1/01.
Oakes, Cecil Everett Jr. 1701 Marshall Road 282 Vacaville, California	C43319	Suspended indefinitely effective 12/10/02.
Opsahl, Jon Steven 930 South Mount Vernon Avenue, Suite 400 Colton, California	G79640	Suspended indefinitely effective 5/1/02.
Saleh, Saeed 4726 Doewridge Road Orchard Lake, Missouri	A39735	Suspended indefinitely effective 6/26/01.
Scallion, Gerald J. 81-893 Dr. Carreon Boulevard, Suite 5 Indio, California	C43281	Suspended indefinitely effective 11/5/02.
Sison, Renato Fernandez 3714 Tibbetts Street, #104 Riverside, California	A48516	Suspended indefinitely effective 1/8/03.
Yabut-Baluyut, Fredesmina L. 25552 Saddle Rock Place Laguna Hills, California	A42583	Suspended indefinitely effective 9/6/02.
Yoonessi, Mahmood 9 Bobbie Lane Williamsville, New York	C50545	Suspended indefinitely effective 11/27/01.

Physician Assistant (susp A)

Murray, Harry Lynn 2131 Locust Avenue Long Beach, California	PA11607	Suspended indefinitely effective 5/13/03.
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Marriage, Family & Child Counselor (susp C)

Ferguson, Daniel Stephen 36128 Sharon Way Yucaipa, California	MFC23452	Suspended indefinitely effective 1/20/03.
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Psychiatric Technician (susp C)

Palacio, Dorothy Elizabeth P.O. Box 1510 Yucaipa, California	PT29653	Suspended indefinitely effective 1/20/03.
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Psychological Assistant (susp C)

McGee, Michael Kevin 5095 Lambert Lane San Diego, California	PSB25328	Suspended indefinitely effective 1/20/03.
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Psychologist (susp C)

Wickram, Ian E. 2041 Superior Court Tracy, California	PSY15096	Suspended indefinitely effective 1/17/03.
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Dental Clinic (susp G)

Alosta Family Dental 750 West Alosta, Suite F Glendora, California	G91696	Suspended indefinitely effective 10/20/02.
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Acupuncturist (susp I)

Lee, Jeong Pyo 3893 Malagu Street Corona, California	AC-4628	Suspended indefinitely effective 1/20/03.
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Chiropractor (susp J)

Biernacki, Richard Stanley P.O. Box 277 Fairfax, California	DC-24286	Suspended indefinitely effective 3/12/03.
Hodies, Geoffrey Adam 3694 San Pablo Dam Road El Sobrante, California	DC-20224	Suspended indefinitely effective 5/7/03.
Hurtado, Arthur F. 5051 Canyon Crest Drive, #101 Riverside, California	16424	Suspended indefinitely effective 3/12/03.
Millikan, Ronal D. 2365 Alden Avenue Redding, California	DC-11227	Suspended indefinitely effective 12/31/02.
Polidori, Rollie J. 1725 Lampton Lane Norco, California	DC12508	Suspended indefinitely effective 5/28/03.
Uchibori, Bert Harumi P.O. Box 552 Penngrove, California	DC17517	Suspended indefinitely effective 12/31/02.

Chiropractic Clinics (susp J)

Stockton Chiropractic Center 4422 North Pershing Avenue, #D-9 Stockton, California		Suspended indefinitely effective 1/20/03.
Straight Chiropractic 1850 East 17th Street, Suite 102 Santa Ana, California		Suspended indefinitely effective 8/20/01.

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S&I (continued)

Laboratory (susp M)

Pulmonary Testing Services
 Jimenez, Joaquin Jose (Owner)
 aka: Jimenez, Jake
 Federal Register #20670112
 MDC Los Angeles
 P.O. Box 1500
 Los Angeles, California
 Suspended indefinitely effective 1/20/03.

Zapatero, Adalberto
 aka: Zapatero, Adalberto Al
 Albert
 Zapatero, Adalberto Garcia
 Federal Register #20543112
 Taft Correctional Institution
 P.O. Box 7001
 Taft, California
 Suspended indefinitely effective 1/20/03.

Hall, Sybil Michelle 555931 Suspended
 11779 Stoney Peak Drive, #625 indefinitely effective
 San Diego, California 11/24/02.

Lyons, Julie Lynne 561419 Suspended
 17130 Chola Avenue indefinitely effective
 Hesperia, California 11/24/02.

McGee-Jones, Barbara D. 362536 Suspended
 aka: McGee, Barbara Jones 5609 indefinitely effective
 Jones, Barbara Dale McGee 12/8/02.
 865 America Way
 Del Mar, California

Turner, Elda Fern 521693 Suspended
 505 B North Montgomery Street indefinitely effective
 Ojai, California 12/8/02.

Respiratory Care Practitioner (susp S)

Emergency Medical Technician (sup N)

Bustamonte, Dario Jr. P17077 Suspended
 P.O. Box 214 indefinitely effective
 Sanger, California 1/20/03.

Taylor, Kenneth Edward 6998 Suspended
 1621 Radford Place indefinitely effective
 Monrovia, California 10/11/02.

Yates, Roy L. 12727 Suspended
 4053 Perlita Avenue, indefinitely effective
 Apartment C 10/14/02.
 Los Angeles, California

Paramedic (susp N)

Ellington, Joshua Thomas PO4479 Suspended
 aka: Ellington, Joshua indefinitely effective
 Thomas Danie 1/20/03.
 Ellington, Joshua
 155 Laws Avenue 1
 Ukiah, California

Employees (susp T)

Durkee, Susan E. Suspended
 1003 Tanzania Drive indefinitely effective
 Roseville, California 5/28/03.

Gellis, Richard Barry Suspended
 2218 Cambridge Street indefinitely effective
 Los Angeles, California 5/15/03.

Novikov, Leonid Suspended
 2303 Weybridge Lane indefinitely effective
 Los Angeles, California 5/7/03.

Physical Therapist (susp O)

Clonch, Mark Edward PT11274 Suspended
 13405 Melody Road indefinitely effective
 Chino, California 12/9/02.

Health Maintenance Organization (susp P)

Better Bodies, Inc. Suspended
 10660 South La Mirada Boulevard indefinitely effective
 Whittier, California 8/20/01.

Peaslee, Geraldine Elizabeth Suspended
 7367 Central, Apartment 274 indefinitely effective
 Highland, California 10/20/02.

Licensed Vocational Nurse (susp R)

Renfrow, John C. VN185663 Suspended
 P.O. Box 444 indefinitely effective
 Morgan Hill, California 8/17/02.

Stack, Sophia Dao Suspended
 876 South Harbor Boulevard indefinitely effective
 Anaheim, California 1/20/03.

Registered Nurse (susp R)

Castorina, Cyndi Ann 423471 Suspended
 9956 Bonavista Lane indefinitely effective
 Whittier, California 12/8/02.

DeGroot, William Edward 443472 Suspended
 P.O. Box 582201 indefinitely effective
 Modesto, California 11/24/02.

Gallea, Michelle Ann 538074 Suspended
 1440 Calhoun Court, #D indefinitely effective
 Hemet, California 1/20/03.

Code Correlations: Condition Codes

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing Media and table being represented separately. Information for this code set is provided for the following billing media:

- ❖ Inpatient and Outpatient Paper Claims (UB-92)
- ❖ Version 4 Flat File
- ❖ CMC Proprietary
- ❖ ANSI ASC X12N 837 version 3041
- ❖ ANSI ASC X12N 837I version 4010A1

Code Set: Condition Codes – Inpatient and Outpatient Billing Media: Paper Claims (UB-92)

Modifications for billing: Field Locator (FL) 24-30 – Condition Codes

- The delay reason code (billing limit exception indicator) values used in Medi-Cal billing will no longer be inserted in the condition codes Field Locator (FL) 24-30 for paper but instead will be inserted into FL 31. Please reference the delay reason code correlation section for the appropriate correlations.

General billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The Medicare Status and Medi/Medi Charpentier condition codes (Y0 thru Z3) will not be changed since these claims cannot be billed electronically at this time due to paper attachment requirements.
- The following correlation is in Medi-Cal current code value order.

CONDITION CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
A1	CHDP Screening	A1	EPSDT/CHAP
A3	Family Planning/Sterilization	A1	Sterilization - Paper submission due to required attachments
A4	Family Planning/Other	A4	Family Planning
80	Other Coverage	80	Other Coverage
81	Emergency Indicator	81	Emergency Indicator - Inpatient claims currently are currently being submitted on paper if the emergency indicator is needed, due to the requirements for emergency certification.
82	Outside Lab	82	Outside Lab

Bolded items denote changes to previously used values.

**Code Set: Condition Codes – Inpatient and Outpatient
Billing Media: Version 4 Flat File**

Modifications for billing: Type 41, Field #4-13 – Condition Codes

- The delay reason code (billing limit exception indicator) values used in Medi-Cal billing will continue to be inserted in the condition codes field for the Version 4 Flat File format (Record Type 41, Field #4-13). Please reference the delay reason code section for more information.

General billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The Medicare Status and Medi/Medi Charpentier Condition codes (Y0 thru Z3) will not be changed since these claims cannot be billed electronically at this time due to paper attachment requirements.
- The following correlation is in Medi-Cal current code value order.

CONDITION CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
A1	CHDP Screening	A1	EPSDT/CHAP
A3	Family Planning/Sterilization	AI	Sterilization - Paper submission due to required attachments
A4	Family Planning/Other	A4	Family Planning
80	Other Coverage	80	Other Coverage
81	Emergency Indicator	81	Emergency Indicator - Inpatient claims currently are currently being submitted on paper if the emergency indicator is needed, due to the requirements for emergency certification.
82	Outside Lab	82	Outside Lab

Bolded items denote changes to previously used values.

Code Set: Condition Codes – Inpatient and Outpatient

Billing Media: CMC Proprietary (CMC 03 and CMC 04)

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The CMC proprietary formats will not be modified; therefore, continue to use the CMC-designated fields for the CHDP Screening, Family Planning/Sterilization, Family Planning/Other, Outside Lab, Other Coverage, Emergency Certification, and Medicare Status indicators.

Code Set: Condition Codes – Inpatient and Outpatient

Billing Media: ANSI ASC X12 837 version 3041

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The ANSI ASC X12N format will not be modified; therefore, continue to use the ANSI ASC X12N 837 designated fields for the CHDP Screening, Family Planning, Outside Lab, Other Coverage, Emergency Certification, and Medicare Status indicators.

Code Set: Condition Codes – Inpatient and Outpatient

Billing Media: ANSI ASC X12N 837 version 4010A1

Modifications for billing: Loop 2300, HI – Condition Information

- The delay reason code (billing limit exception indicator) values used in Medi-Cal billing will no longer be inserted in the condition codes field on the new version 4010A1 837I but instead will be inserted into the designated ASC X12N 837I delay reason field (Loop 2300, CLM20). Please reference the delay reason code correlation section for the appropriate correlations.

General billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September, 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The Medicare Status and Medi/Medi Charpentier condition codes (Y0 thru Z3) will not be changed since these claims cannot be billed electronically at this time due to paper attachment requirements.
- The following correlation is in Medi-Cal current code value order.

CONDITION CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
A1	CHDP Screening	A1	EPSDT/CHAP
A3*	Family Planning/Sterilization	AI	Sterilization - Paper submission due to required attachments
A4	Family Planning/Other	A4	Family Planning
80	Other Coverage	Loop 2320, AMT02	Other Coverage – This information will now be carried in the Payer Prior Payment field on the 837 v.4010A1
81*	Emergency Indicator	81	Emergency Indicator - Inpatient claims currently are currently being submitted on paper if the emergency indicator is needed, due to the requirements for emergency certification.
82	Outside Lab	Loop 2310E, NM109	Outside Lab – This information will now be carried in the Other Facility Name segment.

Bolded items denote changes to previously used values.

* Asterisked items cannot be billed electronically at this time due to paper attachment requirements.

Code Correlations: Delay Reason Codes (Formerly Billing Limit Exception Indicators)

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. Information for this code set is provided for the following billing media:

- ❖ Long Term Care (25-1), Medical (HCFA 1500 and Vision (45-1) Paper Claims)
- ❖ Inpatient and Outpatient (UB-92) Paper Claims
- ❖ Version 4 Flat File, CMC Proprietary and ANSI ASC X12N 837 version 3041
- ❖ ANSI ASC X12N 837 version 4010A1 (Long Term Care, Medical and Vision)
- ❖ ANSI ASC X12N 837I version 4010A1 (Inpatient and Outpatient)

Code Set: Delay Reason Codes

Billing Media: Long Term Care (25-1), Medical (HCFA 1500) and Vision (45-1) Paper Claims

Modifications for billing:

- Long Term Care (25-1): Field #11 – Billing Limit
- Medical (HCFA 1500): Field #24J – Billing Limit Exception
- Vision (45-1): Field #9 – Billing Limit

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- For Long Term Care claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #11 on the 25-1. This field occurs once for each of six possible recipients on the claim form. In cases where the national value is two digits, the value must be inserted in and adjacent to the single-digit field (#11). A billing example illustrating this requirement will be developed and published in a *Medi-Cal Update* prior to the implementation date.
- For Medical paper claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #24J on the HCFA 1500 claim form.
- For Vision paper claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #9 on the 45-1 Vision paper claim form. In cases where the national value is two digits, the value must be inserted in and adjacent to the single-digit field (#9). A billing example illustrating this requirement will be developed and published in a *Medi-Cal Update* prior to the implementation date.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal Current Code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
1	POE unknown	1	POE unknown or unavailable
2	Medicare/Other Coverage	7	Third Party Processing Delay
3	TAR approval delay	3	Authorization Delays
4	Delay by DHS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
6	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
7	Theft, Sabotage	11	Other Attachment <i>Indicator must be checked as this option requires attachments.</i>
8	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
A	After 6 month/No reason	11	Other

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes

Billing Media: Inpatient and Outpatient (UB-92) Paper Claims

Modifications for billing: Field Locator (FL) 31

- The delay reason code (billing limit exception indicator) values used in Medi-Cal billing will no longer be inserted in the condition codes FL 24-30 for paper but instead will be inserted into FL 31.

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
X1	POE unknown	1	POE unknown or unavailable
X2	Medicare/Other Coverage	7	Third Party Processing Delay
X3	TAR approval delay	3	Authorization Delays
X4	Delay by DHS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
X5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
X6	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
X7	Theft, Sabotage	11	Other <i>Attachment Indicator must be checked as this option requires attachments.</i>
X8	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
X9	Late Charges (Inpatient Only)	11	Other <i>The third character of Type of Bill (Claim Frequency) must be "5".</i>
X0	After 6 month/No reason	11	Other

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes

Billing Media: Inpatient and Outpatient Version 4 Flat File, CMC Proprietary (CMC 02, 03, 04, 05, 07) and ANSI ASC X12 837 Version 3041 (Inpatient, Outpatient and Medical)

Modifications for billing:

- Version 4 Flat File: Record Type 41, Field 4-13 – Condition Code
- CMC Proprietary: Billing Limit Exception (Remark)
- ANSI ASC X12 837 v.3041: Loop 2300, K3 – Billing Limit

Billing information:

- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the condition code field for the Version 4 Flat File Format (Record Type 41, Field # 4-13).
- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the remarks Record 6 of the CMC Proprietary Formats.
- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the “K3” field of the ANSI ASC X12 837 version 3041 format.
- The Medi-Cal interim (local) values used for billing limit exception indicators for the Inpatient and Outpatient Version 4 Flat File, CMC Proprietary (all claim types) and ANSI ASC X12 version 3041 format will continue to be used for all dates of service.

Code Set: Delay Reason Codes

Billing Media: ANSI ASC X12N 837 Version 4010A1 (Long Term Care, Medical and Vision)

Modifications for Billing: Loop 2300, CLM20 – Delay Reason Code

Billing information:

- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September, 22, 2003.
- When completing a claim for beginning date of service before 9/22/03, the Medi-Cal interim (local) codes must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
1 [^]	POE unknown	1	POE unknown or unavailable
2*	Medicare/Other Coverage	7	Third Party Processing Delay
3	TAR approval delay	3	Authorization Delays
4	Delay by DHS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
6*	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
7*	Theft, Sabotage	11	Other <i>Attachment Indicator must be checked as this option requires attachments.</i>
8*	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
A	After 6 month/No reason	11	Other

* Asterisked Billing Limit Exception/Delay Reasons cannot be billed electronically at this time due to paper attachment requirements.

[^] Claims for Share of Cost Reimbursement must be billed on paper.

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes

Billing Media: ANSI ASC X12N 837I Version 4010A1 (Inpatient and Outpatient)

Modifications for billing: Loop 2300, CLM20 – Delay Reason Code

Billing information:

- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the Medi-Cal interim (local) codes must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
X1 [^]	POE unknown	1	POE unknown or unavailable
X2*	Medicare/Other Coverage	7	Third Party Processing Delay
X3	TAR approval delay	3	Authorization Delays
X4	Delay by DHS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
X5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
X6*	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
X7*	Theft, Sabotage	11	Other Attachment Indicator must be checked as this option requires attachments.
X8*	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
X9	Late Charges (Inpatient Only)	11	Other The third character of Type of Bill (Claim Frequency must be "5".
X0	After 6 month/No reason	11	Other

* Asterisked Billing Limit Exception/Delay Reasons cannot be billed electronically at this time due to paper attachment requirements.

[^] Claims for Share of Cost Reimbursement must be billed on paper.

Bolded items denote changes to previously used values.

Code Correlations: Inpatient Revenue Codes (Formerly Accommodation Codes)

Medi-Cal has developed a service code set correlation table for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. The table for this code set applies to the following billing media:

- ❖ Inpatient and Outpatient Paper Claims (UB-92)
- ❖ Version 4 Flat File
- ❖ CMC Proprietary (CMC 03)

- ❖ ANSI ASC X12N 837 version 3041
- ❖ ANSI ASC X12N 837I version 4010A1

Modifications for billing:

- Paper: Field Locator (FL) 42 – Revenue Code
- Version 4 Flat File: Record Type 50, Field 4 – Accommodation Revenue Code
- CMC Proprietary: CHFC Code
- ANSI ASC X12 837 version 3041: Loop 2400, SV201 – Revenue Code
- ANSI ASC X12N 837I version 4010A1: Loop 2400, SV201 – Revenue Code

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time. Some codes referenced in the correlation may be billed on paper only. Please reference the appropriate Medi-Cal Provider Manual for specific billing instructions.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September, 22, 2003, the current Medi-Cal code must be used.
- Additional information on billing inpatient Revenue codes and new benefit changes will be provided in future *Medi-Cal Updates*.
- The following correlation is in Medi-Cal current code value order.

ACCOMMODATION CODES/REVENUE CODES – INPATIENT			
CURRENT CODE	DESCRIPTION	NATIONAL CODE	DESCRIPTION
080	Other Acute Care Units	119	Room and Board, Private (Medical or General), Other
080	Other Acute Care Units	129	Room and Board, Semi-Private Two Beds (Medical or General), Other
080	Other Acute Care Units	139	Room and Board, Semi-Private Three or Four Beds, Other
080	Other Acute Care Units	159	Room and Board, Ward (Medical or General), Other
082	Psychiatric Emergency Room	459	Emergency Room, Other Emergency Room
083	Lung Transplant (Single Or Double), Intensive Care	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
084	Heart-Lung Transplant, Intensive Care	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
085	Nursery Acute Without Associated Delivery	172	Nursery, Newborn, Level II
086	Intensive Care, Heart Transplant	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
087	Intensive Care, Liver Transplant	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
088	Intensive Care, Bone Marrow Transplant	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
089	Intensive Care, Kidney Transplant	201	Intensive Care, Surgical, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future <i>Medi-Cal Updates</i>).
090	Lithotripsy	790	Lithotripsy, General Classification
091	Lithotripsy (Per Discharge Rate)	790	Lithotripsy, General Classification
092	Obstetrics Acute (Per Discharge Rate)	112	Room and Board, Private Medical or General), OB
092	Obstetrics Acute (Per Discharge Rate)	122	Room and Board, Semi-Private, 2 beds (Medical or General), OB

ACCOMMODATION CODES/REVENUE CODES – INPATIENT			
CURRENT CODE	DESCRIPTION	NATIONAL CODE	DESCRIPTION
092	Obstetrics Acute (Per Discharge Rate)	132	Room and Board, Semi-Private, 3 or 4 Beds, OB
092	Obstetrics Acute (Per Discharge Rate)	152	Room and Board, Ward (Medical or General), OB
093	Other Physical Medicine	949	Other Therapeutic Services
094	Nursery Newborn, Ineligible Mother	170	Nursery, General Classification
095	Nursery Acute With Associated Delivery	172	Nursery, Newborn, Level II, must be billed with the appropriate ICD-9-CM Volume 3 Procedure Code (which will be published in future Medi-Cal Updates).
097	Psychiatric Acute (Adolescent and Child)	114	Room and Board, Private (Medical or General), Psychiatric
097	Psychiatric Acute (Adolescent And Child)	124	Room and Board, Semi-Private Two Bed (Medical or General), Psychiatric
097	Psychiatric Acute (Adolescent and Child)	134	Room and Board, Semi-Private, 3-4 Beds (Medical or General), Psychiatric
097	Psychiatric Acute (Adolescent and Child)	154	Room and Board, Ward (Medical or General), Psychiatric
098	Administrative Days	169	Room and Board, Other
099	Disproportionate Share (Sick Baby with Mother)	099	Non-Revenue Code (Disproportionate Share)
175	Nursery, Neonatal Intensive Care Unit	174	Nursery, Newborn Level IV
1080	Other Acute Care Units, Per Discharge Rate	119	Room and Board, Private (Medical or General), Other
1080	Other Acute Care Units, Per Discharge Rate	129	Room and Board, Semi-Private Two Beds (Medical or General), Other
1080	Other Acute Care Units, Per Discharge Rate	139	Room and Board, Semi-Private Three or Four Beds, Other
1080	Other Acute Care Units, Per Discharge Rate	159	Room and Board, Ward (Medical or General), Other
1085	Nursery Acute Without Associated Delivery	172	Nursery, Newborn, Level II
1094	Nursery Newborn, Ineligible Mother	170	Nursery, General Classification

ACCOMMODATION CODES/REVENUE CODES – INPATIENT			
CURRENT CODE	DESCRIPTION	NATIONAL CODE	DESCRIPTION
1111	All Inclusive Per Discharge Rate, Room And Board, Private, Medical/Surgical/Gyn	111	Room and Board, Private (Medical or General), Medical/Surgical/Gyn
1112	All Inclusive Per Discharge Rate, Room And Board, Private, Ob	112	Room and Board, Private Medical or General), OB
1113	All Inclusive Per Discharge Rate, Room And Board, Private, Medical/Surgical/Gyn	113	Room and Board, Private (Medical or General), Pediatric
1117	All Inclusive Per Discharge Rate, Room And Board, Private, Oncology	117	Room and Board, Private (Medical or General), Oncology
1118	All Inclusive Per Discharge Rate, Room And Board, Private, Rehabilitation	118	Room and Board, Private (Medical or General), Rehabilitation
1121	All Inclusive Per Discharge Rate, Room And Board, Semi-Private Two Bed, Medical/Surgical/Gyn	121	Room and Board, Semi-Private Two Bed (Medical or General), Medical/Surgical/GYN
1122	All Inclusive Per Discharge Rate, Room And Board, Semi-Private Two Bed, Ob	122	Room and Board, Semi-Private, 2 beds (Medical or General), OB
1123	All Inclusive Per Discharge Rate, Room And Board, Semi-Private Two Bed, Pediatric	123	Room and Board, Semi-Private Two Bed (Medical or General), Pediatric
1127	All Inclusive Per Discharge Rate, Room And Board, Semi-Private Two Bed, Oncology	127	Room and Board, Semi-Private Two Bed (Medical or General), Oncology
1128	All Inclusive Per Discharge Rate, Room And Board Semi-Private Two Bed, Rehabilitation	128	Room and Board, Semi-Private Two Bed (Medical or General), Rehabilitation
1131	All Inclusive Per Discharge Rate, Room And Board, Semi-Private, three Or four Bed, Medical/Surgical/Gyn	131	Room and Board, Semi-Private three or four beds, Medical/Surgical/GYN
1132	All Inclusive Per Discharge Rate, Room And Board, Semi-Private 3 Or 4 Bed, Ob	132	Room and Board, Semi-Private, 3 or 4 Beds, OB

ACCOMMODATION CODES/REVENUE CODES – INPATIENT			
CURRENT CODE	DESCRIPTION	NATIONAL CODE	DESCRIPTION
1133	All Inclusive Per Discharge Rate, Room And Board, Semi-Private three Or four Bed, Pediatric	133	Room and Board, Semi-Private three or four Bed, Pediatric
1137	All Inclusive Per Discharge Rate, Room And Board, Semi-Private three Or four Bed, Oncology	137	Room and Board, Semi-Private three or four Bed, Oncology
1138	All Inclusive Per Discharge Rate, Room And Board, Semi-Private three Or four Bed, Rehabilitation	138	Room and Board, Semi-Private three or four Bed, Rehabilitation
1151	All Inclusive Per Discharge Rate, Room And Board, Ward (Medical Or General), Medical/Surgical/Gyn	151	Room and Board, Ward (Medical and General), Medical/Surgical/GYN
1152	All Inclusive Per Discharge Rate, Room And Board, Ward (Medical Or General), Ob	152	Room and Board, Ward (Medical or General), OB
1153	All Inclusive Per Discharge Rate, Room And Board, Ward (Medical Or General), Pediatric	153	Room and Board, Ward (Medical or General), Pediatric
1157	All Inclusive Per Discharge Rate, Room and Board, Ward (Medical Or General), Oncology	157	Room and Board, Ward (Medical or General), Oncology
1158	All Inclusive Per Discharge Rate, Room And Board, Ward (Medical Or General), Rehabilitation	158	Room and Board, Ward (Medical or General), Rehabilitation
1171	All Inclusive Per Discharge Rate, Newborn Nursery	171	Nursery, Newborn Level I
1175	All Inclusive Per Discharge Rate, Nursery, Neonatal Intensive Care	174	Nursery, Level IV
1200	All Inclusive Per Discharge Rate, Intensive Care, General	200	Intensive Care, General Classification

ACCOMMODATION CODES/REVENUE CODES – INPATIENT			
CURRENT CODE	DESCRIPTION	NATIONAL CODE	DESCRIPTION
1201	All Inclusive Per Discharge Rate, Intensive Care, Surgical	201	Intensive Care, Surgical
1202	All Inclusive Per Discharge Rate, Intensive Care, Medical	202	Intensive Care, Medical
1203	All Inclusive Per Discharge Rate, Intensive Care, Pediatric	203	Intensive Care, Pediatric
1204	All Inclusive Per Discharge Rate, Intensive Care, Psychiatric	204	Intensive Care, Psychiatric
1206	All Inclusive Per Discharge Rate, Intensive Care, Post Icu	206	Intensive Care, Intermediate ICU
1207	All Inclusive Per Discharge Rate, Intensive Care, Burn Care In Licensed Burn Center Beds	207	Intensive Care, Burn Care
1208	All Inclusive Per Discharge Rate, Intensive Care, Trauma	208	Intensive Care, Trauma
1209	All Inclusive Per Discharge Rate, Intensive Care, Other	209	Intensive Care, Other
1210	All Inclusive Per Discharge Rate, Coronary Care, General	210	Coronary Care, General Classification
1211	All Inclusive Per Discharge Rate, Coronary Care, Myocardial Infarction	211	Coronary Care, Myocardial Infarction
1212	All Inclusive Per Discharge Rate, Coronary Care, Pulmonary Care	212	Coronary Care, Pulmonary Care
1214	All Inclusive Per Discharge Rate, Coronary Care, Post Ccu	214	Coronary Care, Intermediate CCU
1219	All Inclusive Per Discharge Rate, Coronary Care, Other	219	Coronary Care, Other

Bolded items denote changes to previously used values.

Code Correlations: Patient Status Codes

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. The table for this code set applies to the following billing media:

- ❖ Inpatient Paper Claims (UB-92)
- ❖ Version 4 Flat File
- ❖ CMC Proprietary (CMC 03)
- ❖ ANSI ASC X12N 837 version 3041
- ❖ ANSI ASC X12N 837I version 4010A1

Modifications for billing:

- Paper: Field Locator (FL) 22 – Patient Status
- Version 4 Flat File: Record Type 20, Field 21 – Patient Status
- CMC Proprietary: Patient Status
- ANSI ASC X12 837 version 3041: Loop 2300, CL103 – Patient Status
- ANSI ASC X12 837 version 3041: Loop 2300, CL103 – Patient Status

Billing information:

- Long Term Care interim (local) patient status codes will be converted to national patient status codes after October 2003. Until instructed otherwise, continue to use the interim (local) patient status code values.
- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal current code value order.

PATIENT STATUS CODES			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
01	Discharged to Home or self care (routine discharge)	01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short term general hospital for inpatient care	02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to Skilled Nursing Facility	03	Discharged/transferred to Skilled Nursing Facility (SNF)
		61	Discharged/transferred within this institution to hospital based Medicare approved swing bed
		64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
04	Discharged/transferred to an Intermediate Care Facility	04	Discharged/transferred to an intermediate care facility (ICF)
20	Expired	20	Expired
30*	Still a patient or expected to return for outpatient services	30	Still a patient
31*	Admitted (first interim bill)	31	Still patient to be defined at state level, if necessary

* Enter “31” to identify patients still admitted at the end of the billing period. Code “31” is used on the first interim billed. Use code 30 for subsequent billing

Bolded items denote changes to previously used values.

Code Correlations: Place of Service Codes

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. Information for this code set is provided for the following billing media:

- ❖ Inpatient Paper Claims (UB-92) and ANSI ASC X12N 837I version 4010A1
- ❖ Inpatient Version 4 Flat File, CMC Proprietary (CMC 03) and ANSI ASC X12N 837 version 3041
- ❖ Outpatient Paper Claims (UB-92) and ANSI ASC X12N 837I version 4010A1
- ❖ Outpatient Version 4 Flat File, CMC Proprietary (CMC 04) and ANSI ASC X12 837 version 3041
- ❖ Medical Paper Claims (HCFA 1500) and ANSI ASC X12N 837P version 4010A1
- ❖ Medical CMC Proprietary (CMC 05) and ANSI ASC X12 837 version 3041
- ❖ Vision Paper Claims (45-1) and ANSI ASC X12N 837P version 4010A1
- ❖ Vision CMC Proprietary (CMC 07)

Code Set: Place of Service (Facility Type) – Inpatient

Billing Media: Inpatient Paper Claims (UB-92) and ANSI ASC X12N 837I version 4010A1

Billing modifications:

- Paper (UB-92): Field Locator (FL) 4 Type of Bill
- ANSI ASC X12N 837I version 4010A1: Loop 2300, CLM05-1 – Type of Bill (Facility Type)

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The first two digits of the Type of Bill field denote Facility Type. When completing a claim with a beginning date of service on or after September 22, 2003, the Type of Bill must be used. Please reference the National Uniform Billing Committee (NUBC) UB-92 Billing Manual for a list of valid Facility Types values.
- When completing a claim for beginning date of service before September 22, 2003, the Type of Bill is optional for paper claims. Although Medi-Cal does not require that claims submitted before September 22, 2003 carry the Type of Bill, it is a required on the transaction and therefore must be submitted when using the ANSI ASC X12N 837I version 4010A1.

Code Set: Facility Type (Place of Service) – Inpatient

Billing Media: Version 4 Flat File, CMC Proprietary (CMC 03) and ANSI ASC X12 837 version 3041

Billing information:

- Type of Bill/Facility Type (Place of Service) is not required on the Version 4 Flat File, CMC Proprietary (CMC 03) or ANSI ASC X12 837 version 3041 formats for all dates of service.

Code Set: Place of Service – Outpatient

Billing Media: Outpatient Paper Claims (UB-92) and ANSI ASC X12N 837I version 4010A1

Billing modifications:

- Paper (UB-92): Field Locator (FL) 50 Payer Name and Field Locator (FL) 4 Type of Bill
- ANSI ASC X12N 837I v.4010A1: Loop 2300, CLM05-1 – Type of Bill (Facility Type)

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- All current Medi-Cal Place of Service codes will be correlated to national Place of Service codes.
- The first two digits of the Type of Bill field denote Facility Type. The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September 22, 2003.
- When completing a claim with a beginning date of service before September 22, 2003, the current Medi-Cal code and location FL 50 must be used.
- The following correlation is in Medi-Cal current code value order.

PLACE OF SERVICE – OUTPATIENT			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
1	Office	79	Clinic – Other
2	Home	33	Home Health - Outpatient
3	Inpatient Hospital	11 12	Hospital - Inpatient (Including Medicare Part A) Inpatient (Medicare Part B only)
4	Nursing Facility level B (SNF)	26	Skilled Nursing - Intermediate Care Level II
5	Outpatient Hospital	13	Hospital - Outpatient
6	Independent Laboratory	89	Special Facility - Other
7	Other	14	Hospital - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment).
7	Other	24	Skilled Nursing - Other (for hospital referenced diagnostic services, or home health not under a plan treatment).
7	Other	34	Home Health - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment).
7	Other	44	Religious Non Medical Health Care Institution - Hospital Inpatient - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment).
7	Other	54	Religious Non Medical Health Care Institution - Post Hospital Extended Care Services - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment).
7	Other	64	Intermediate Care - Other (for hospital referenced diagnostic services, or home health not under a plan of treatment)
8	Independent Kidney Treatment Center	72	Clinic - Hospital Based or Independent Renal Dialysis Center
9	Clinic	71	Clinic - Rural Health
9	Clinic	73	Clinic - Free Standing
9	Clinic	74	Clinic - Outpatient Rehabilitation Facility (ORF)
9	Clinic	75	Clinic - Comprehensive Outpatient Rehabilitation Facilities (CORF)
9	Clinic	76	Clinic – Community Mental Health
A	Surgery Clinic	83	Special Facility - Ambulatory Surgery Center
B	Emergency Room	14	Hospital - Other (for Hospital referenced diagnostic services, or home health not under a plan of treatment. Admit Type is "Emergency" – Value "1").

PLACE OF SERVICE – OUTPATIENT			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
C	Nursing Facility Level A (ICF)	25	Skilled Nursing - Intermediate Care Level II
F	Subacute Care Facility	27	Skilled Nursing - Subacute. Provider must use an additional Modifier "HB" to indicate "Adult" .
G	Intermediate Care Facility - Developmentally Disabled (ICF/DD)	65	Intermediate Care - Intermediate Care Level I
H	Intermediate Care Facility - Developmentally Disabled, Habilitative (ICF/DD-H)	65	Intermediate Care - Intermediate Care Level I
I	Specialized Treatment Center/Intermediate Care Facility-Nursing/Mentally Retarded	86	Special Facility - Residential Facility
M	Pediatric Subacute Care	27	Skilled Nursing - Subacute. Provider must use an additional Modifier "HA" to indicate "Child" .

Bolded items denote changes to previously used values.

Code Set: Place of Service – Outpatient

Billing Media: Version 4 Flat File, CMC Proprietary (CMC 04) and ANSI ASC X12 837 version 3041

Billing modifications:

- Version 4 Flat File: Record 30, Field 8 – Payer Name and POS
- CMC Proprietary: Place of Service
- ANSI ASC X12 837 v.3041: Loop 2300, CLM05-1 (Place of Service)

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- There is no field change for the current Medi-Cal Outpatient Place of Service for the above three electronic claim formats. Providers will continue to bill the interim (local) values on these formats before and after the September 22, 2003 implementation date. For a list of valid values, please reference the appropriate Medi-Cal Provider Manual.

Code Set: Place of Service – Medical

Billing Media: Paper Claims (HCFA 1500) and ANSI ASC X12N 837P version 4010A1

Billing modifications:

- Paper (HCFA 1500): Field Place of Service (POS) – Field # 24B - POS
- ANSI ASC X12N 837P v.4010A1: Loop 2300, CLM05-1 and SV105 – Place of Service

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- All current Medi-Cal Place of Service codes will be correlated to national Place of Service codes. All but 91, 92, 93, 96 are already national codes.
- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal current code order.

PLACE OF SERVICE – MEDICAL			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
11	Office	11	Office
12	Home	12	Home
21	Inpatient Hospital	21	Inpatient Hospital
22	Outpatient Hospital	22	Outpatient Hospital
23	Emergency Room (Hospital)	23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic	24	Ambulatory Surgery Clinic
25	Birthing Center	25	Birthing Center
31	Skilled Nursing Facility	31	Skilled Nursing Facility (SNF)
32	Nursing Facility Level A (ICF)	32	Nursing Facility
41	Ambulance - Land	41	Ambulance - Land
42	Ambulance - Air or Water	42	Ambulance - Air or Water
53	Community Mental Health Center	53	Community Mental Health Center
54	Specialized Treatment Center/Intermediate Care Facility-Nursing/Mentally Retarded	54	Intermediate Care Facility - Mentally Retarded
55	Residential Treatment Center/ Substance Abuse	55	Residential Substance Abuse Treatment Facility
62	Comprehensive Outpatient Rehabilitation Facility	62	Comprehensive Outpatient Rehabilitation Facility
65	Independent Kidney Disease Treatment Center	65	End Stage Renal Disease Treatment Facility
71	State of Local Public Health Clinic	71	State of Local Public Health Clinic
72	Rural Health Clinic	72	Rural Health Clinic
81	Independent Laboratory	81	Independent Laboratory
91	Subacute Care Facility	99	Other - Provider must use an additional Modifier "HB" to indicate "Adult"
92	Intermediate Care Facility - Developmentally Disabled (ICF/DD)	54	Intermediate Care Facility Mentally Retarded
93	Intermediate Care Facility - Developmentally Disabled, Habilitative (ICF/DD-H)	54	Intermediate Care Facility - Mentally Retarded
96	Pediatric Subacute Care	99	Other – Provider must use an additional Modifier "HA" to indicate "Child"
99	Other	99	Other

Bolded items denote changes to previously used values.

Code Set: Place of Service – Medical

Billing Media: CMC Proprietary (CMC 05) and ANSI ASC X12 837 version 3041

Billing modifications:

- CMC Proprietary: Place of Service
- ANSI ASC X12 837 v.3041: Loop 2400, SV105 – Place of Service

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- There is no field change for the current Medi-Cal Medical Place of Service for the above two electronic claim formats. Providers will continue to bill the interim (local) values on these formats before and after the September 22, 2003 implementation date. For a list of valid values, please reference the appropriate Medi-Cal Provider Manual.

Code Set: Place of Service – Vision

Billing Media: Vision Paper Claims (45-1) and ANSI ASC X12N 837P version 4010A1

Billing modifications:

- Paper (45-1): Field # 7 – Place of Service
- ANSI ASC X12N 837P version 4010A1: Loop 2300, CLM05-1 and Loop 2400, SV105 – Place of Service

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- All current Medi-Cal Place of Service codes will be correlated to National Place of Service codes.
- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after 9/22/03.
- When completing a claim for beginning date of service before 9/22/03, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal Current Code value order.

PLACE OF SERVICE – VISION			
LOCAL VALUES	DESCRIPTION	NATIONAL VALUES	DESCRIPTION
1	Office	11	Office
2	Home	12	Home
3	Inpatient Hospital	21	Inpatient Hospital
4	Nursing Facility Level B (SNF)	31	Skilled Nursing Facility (SNF)
5	Outpatient Hospital	22	Outpatient Hospital
6	Independent Laboratory	81	Independent Laboratory
7	Other (Describe in Remarks Section)	99	Other (Describe in Remarks Section)
8	Independent Kidney Disease Treatment Center	65	End Stage Renal Disease Treatment Facility
9	Clinic	25	Birthing Center
9	Clinic	53	Community Mental Health Center
9	Clinic	71	State of Local Public Health Clinic
9	Clinic	72	Rural Health Clinic
A	Ambulatory Surgery Clinic	24	Ambulatory Surgery Clinic
B	Emergency Room	23	Emergency Room (Hospital)
C	Nursing Facility Level A (ICF)	32	Nursing Facility
F	Subacute Care Facility	99	Other (Describe in Remarks Section)
G	Intermediate Care Facility - Developmentally Disabled (ICF/DD)	54	Intermediate Care Facility - Mentally Retarded
H	Intermediate Care Facility - Developmentally Disabled, Habilitative (ICF/DD-H)	54	Intermediate Care Facility - Mentally Retarded
I	Intermediate Care Facility - Developmentally Disabled, Nursing (ICF/DD-N)	54	Intermediate Care Facility - Mentally Retarded

Bolded items denote changes to previously used values.

Code Set: Place of Service – Vision

Billing Media: CMC Proprietary (CMC 07)

Billing modification:

- CMC Proprietary: Place of Service

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- There is no field change for the current Medi-Cal Vision Place of Service for the proprietary electronic claim format. Providers will continue to bill the interim (local) values on this format before and after the September 22, 2003 implementation date. For a list of valid values, please reference the appropriate Medi-Cal Provider Manual.

Code Correlations: Value Codes (Patient’s Share of Cost)

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. Information for this code set is provided for the following billing media:

- ❖ Inpatient Paper Claims (UB-92), Version 4 Flat File, CMC Proprietary (CMC 03 and 04), ANSI ASC X12N 837 version 3041
- ❖ Long Term Care Paper Claims (25-1), CMC Proprietary (CMC 02)
- ❖ Inpatient, Outpatient and Long Term Care ANSI ASC X12N 837I version 4010A1

Code Set: Value Codes (Patient Share of Cost)

Billing Media: Inpatient and Outpatient Paper Claims (UB-92), Version 4 Flat File, CMC Proprietary (CMC 03 and 04) and ANSI ASC X12 837 version 3041

Billing modifications:

- Paper (UB-92): Field Locator (FL) Codes 39-41 Value Codes
- Version 4 Flat File: Record Type 41, Field 16-39 Value Codes
- CMC Proprietary: Patient’s Share of Cost
- ANSI ASC X12 837 version 3041: Loop 2300, AMT 02 – Share of Cost Amount

Billing information:

- Medi-Cal currently only uses one Value Code – “23” to represent Patient Share of Cost.
- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- There is no change in billing for Patient Share of Cost for these format types for all dates of service.

Code Set: Value Codes (Patient Share of Cost)

Billing Media: Long Term Care Paper Claims (25-1) and CMC Proprietary (CMC 02)

Billing modifications:

- Paper (25-1): Field #18 – Patient Liability
- CMC Proprietary: Patient Liability

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- There is no change in billing for Patient Share of Cost for these format types for all dates of service.

Code Set: Value Codes (Patient Share of Cost)

Billing Media: Inpatient, Outpatient and Long Term Care ANSI ASC X12N 837I version 4010A1

Billing modifications:

- Loop 2300, AMT 02 – Patient Paid Amount

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The Patient Share of Cost will be carried in the Patient Paid Amount field when completing a claim for all dates of service.

Instructions for Manual Replacement Pages Program and Eligibility

June 2003

Part 1

Remove and replace: aid codes 15/16
check 1
county med 3/4, 11/12
mcp an over 1 thru 3
mcp code dir 1 thru 6, 9/10
mcp ffs 1/2
prov rel 3/4
remit cd9000 7/8, 29

Insert at the end of section *Remittance Advice Details (RAD): Electronic* *Electronic Health Care Claim Payment/Advice Receiver Agreement Form (new)*

Updated sections available at www.medi-cal.ca.gov

Automated Eligibility Verification System Carrier Codes for Other Health Coverage
Medi-Cal Suspended and Ineligible Provider List

Updated Indexes and Glossary available at www.medi-cal.ca.gov