

# **Short-Doyle Medi-Cal Phase II ADP**

## **Standard Companion Guide Transaction Information**

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

**Companion Guide Version Number: 1.3**

**January 13, 2012**

This template is Copyright © 2010 by The Workgroup for Electronic Data Interchange (WEDI) and the Data Interchange Standards Association (DISA), on behalf of the Accredited Standards Committee (ASC) X12. All rights reserved. It may be freely redistributed in its entirety provided that this copyright notice is not removed. It may not be sold for profit or used in commercial documents without the written permission of the copyright holder. This document is provided “as is” without any express or implied warranty. Note that the copyright on the underlying ASC X12 Standards is held by DISA on behalf of ASC X12.

2011 © Companion Guide copyright by State of California, Department of Alcohol and Drug Programs.

## **Preface**

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

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

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

# Table of Contents

<b>1</b>	<b>TI Introduction.....</b>	<b>5</b>
1.1	Background.....	5
1.1.1	Overview of HIPAA Legislation .....	5
1.1.2	Compliance according to HIPAA .....	5
1.1.3	Compliance according to ASC X12 .....	6
1.2	Intended Use .....	6
<b>2</b>	<b>Included ASC X12 Implementation Guides.....</b>	<b>6</b>
<b>3</b>	<b>Instruction Tables .....</b>	<b>7</b>
<b>4</b>	<b>TI Additional Information .....</b>	<b>20</b>
4.1	Business Scenarios .....	20
4.2	Payer Specific Business Rules and Limitations .....	20
4.2.1	837 Transaction Set Claim Limitation.....	20
4.2.2	Claim Overpayment Recovery.....	20
4.2.3	Other health Coverage (OHC) Billing Scenarios .....	20
4.2.4	ICD-9 Codes.....	24
4.2.5	Adjustment Reason Codes.....	25
4.3	Frequently Asked Questions.....	26
4.4	Other Resources.....	27
<b>5</b>	<b>TI Change Summary .....</b>	<b>27</b>
<b>6</b>	<b>Appendix C – Communication / Connectivity Instructions (CCI) Template.....</b>	<b>28</b>
6.1	Communication/Connectivity Instructions .....	29
6.1.1	Preparing EDI for Upload .....	29
6.1.2	Submitting EDI via ITWS.....	30

# Transaction Instruction (TI)

## 1 TI Introduction

### 1.1 Background

#### 1.1.1 Overview of HIPAA Legislation

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

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

#### 1.1.2 Compliance according to HIPAA

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

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

### 1.1.3 Compliance according to ASC X12

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

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

### 1.2 Intended Use

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

## 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

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

### 3 Instruction Tables

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

<b>Legend</b>
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

#### 005010X222 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
	<b>BHT</b>	<b>BEGINNING OF HIERARCHICAL TRANSACTION</b>			
	BHT06	Claim or Encounter Identifier	CH	6	ADP only accepts claims. “CH” is the only acceptable value.
<b>1000A</b>	<b>NM1</b>	<b>SUBMITTER NAME</b>		2	Always identify the county or direct provider on whose behalf the transaction set is being submitted.
1000A	NM109	Submitter Identifier		2	ADP requires submitters to be identified by their Federal Tax ID.
<b>1000B</b>	<b>NM1</b>	<b>RECEIVER NAME</b>			
1000B	NM103	Receiver Name		2	“CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS” should be supplied here.
	NM109	Receiver Primary Identifier		2	ADP’s Tax ID, “680290013”, must be supplied here.
<b>2000A</b>	<b>PRV</b>	<b>BILLING PROVIDER SPECIALTY INFORMATION</b>		1	Provider taxonomy codes do not impact adjudication of Drug Medi-Cal claims.
<b>2000A</b>	<b>CUR</b>	<b>FOREIGN CURRENCY INFORMATION</b>		4	Claims billed in foreign currencies are not supported in Drug Medi-Cal.
<b>2010AC</b>	<b>NM1</b>	<b>PAY-TO PLAN NAME</b>		4	Subrogation payment requests are not supported in Drug Medi-Cal.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
<b>2000B</b>	<b>HL</b>	<b>SUBSCRIBER HIERARCHICAL LEVEL</b>		6	The patient is always the subscriber in Drug Medi-Cal.
2000B	HL04	Hierarchical Child Code	0	6	The patient is always the subscriber in Drug Medi-Cal.
<b>2000B</b>	<b>SBR</b>	<b>SUBSCRIBER INFORMATION</b>		2	
2000B	SBR02	Individual Relationship Code	18	1	The patient is always the subscriber in Drug Medi-Cal.
	SBR03	Subscriber Group or Policy Number		3	This data element is not used in Drug Medi-Cal.
	SBR04	Subscriber Group Name		3	This data element is not used in Drug Medi-Cal.
	SBR05	Insurance Type Code		3	This data element is not used in Drug Medi-Cal.
	SBR09	Claim Filing Indicator Code	MC	6	As Drug Medi-Cal is a component of Medi-Cal (California's Medicaid program); "MC" is the only valid value.
<b>2000B</b>	<b>PAT</b>	<b>PATIENT INFORMATION</b>			
2000B	PAT07	Unit of Basis or Measurement Code		4	Claims involving Medicare Durable Medical Equipment Regional Carriers Certificate of Medical Necessity (DMERC CMN) 02.03, 10.02, or DME MAC 10.03 are not supported in Drug Medi-Cal.
	PAT08	Patient Weight		4	Claims involving Medicare Durable Medical Equipment Regional Carriers Certificate of Medical Necessity (DMERC CMN) 02.03, 10.02, or DME MAC 10.03 are not supported in Drug Medi-Cal.
	PAT09	Pregnancy Indicator		1	The pregnancy indicator is required where the client is known to the provider to be either pregnant or postpartum as defined in 22 CCR § 51341.1(b) (18). The indicator will be used for statistical purposes, and for adjudicating claims for which the client's perinatal eligibility is relevant.
<b>2010BA</b>	<b>NM1</b>	<b>SUBSCRIBER NAME</b>			
2010BA	NM102	Entity Type Qualifier	1	6	Drug Medi-Cal beneficiaries are always individuals. "1" is the only acceptable value.
	NM108	Identification Code Qualifier		1	Drug Medi-Cal beneficiaries are always individuals. This data element must be sent.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
	NM109	Subscriber Primary Identifier		2	The primary identifier for all Drug Medi-Cal beneficiaries is the 9-digit Medi-Cal Client Index Number (CIN).
<b>2010BA</b>	<b>N3</b>	<b>SUBSCRIBER ADDRESS</b>		1, 3	The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent. This information is not considered in the adjudication of Drug Medi-Cal claims.
2010BA	N301	Subscriber Address Line		2	"HOMELESS" or "UNKNOWN" may be used if appropriate.
<b>2010BA</b>	<b>N4</b>	<b>SUBSCRIBER CITY, STATE, ZIP CODE</b>		1, 3	The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent. Where the patient is homeless or the correct city, state, and zip are unknown, use the information for the billing provider in this segment. This information is not considered in the adjudication of Drug Medi-Cal claims.
2010BA	N401	Subscriber City Name		2	If unknown or in case of homeless subscribers, use the billing provider's city.
	N403	Subscriber Postal Zone or ZIP Code		2	If unknown or in case of homeless subscribers, use the billing provider's postal code.
<b>2010BA</b>	<b>DMG</b>	<b>SUBSCRIBER DEMOGRAPHIC INFORMATION</b>		1	The patient is always the subscriber for Drug Medi-Cal, so this segment must be sent.
<b>2010BA</b>	<b>REF</b>	<b>SUBSCRIBER SECONDARY IDENTIFICATION</b>		1	No additional identification number beyond that provided in NM109 is required to identify subscribers in Drug Medi-Cal. This segment should not be sent.
<b>2010BA</b>	<b>REF</b>	<b>PROPERTY AND CASUALTY CLAIM NUMBER</b>		4	ADP does not support property and casualty claims.
<b>2010BA</b>	<b>PER</b>	<b>PROPERTY AND CASUALTY SUBSCRIBER CONTACT INFORMATION</b>		4	ADP does not support property and casualty claims.
<b>2010BB</b>	<b>NM1</b>	<b>PAYER NAME</b>			
2010BB	NM103	Payer Name		2	"CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" should be supplied here.
	NM109	Payer Identifier		2	ADP's Tax ID, "680290013", must be supplied here.
<b>2000BB</b>	<b>N3</b>	<b>PAYER ADDRESS</b>		3	Information provided in this segment does not impact processing Drug Medi-Cal claims.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2000BB	REF	PAYER SECONDARY IDENTIFICATION		1	No additional payer identifier is necessary to identify ADP as the payer. This segment should not be sent.
2000C	HL	PATIENT HEIRARACHICAL LEVEL		1	The patient is always the subscriber for Drug Medi-Cal, so this segment must not be sent.
2300	CLM	CLAIM INFORMATION			
2300	CLM07	Assignment or Plan Participation Code	A	6	Any entity billing Drug Medi-Cal must have a Drug Medi-Cal contract with ADP, so this must be "A" for all valid DMC claims.
	CLM11	Related Causes Information		3	Information provided in this data element does not impact adjudication of Drug Medi-Cal Claims.
	CLM12	Special Program Code		1	The special circumstances, programs, and projects identified in this data element are not applicable to Drug Medi-Cal. This data element should not be sent.
	CLM20	Delay Reason Code	1, 2, 4, 7, 8, 10, 11, 15	1	Drug Medi-Cal claims are late when the original claim is submitted later than 30 days after the end of the month of service.  –Delay reason codes must only be used when there is good cause for late submission as defined in 22 C.C.R. §§ 51008, 51008.5.  Only the following delay reason codes will be taken into consideration in adjudication of DMC claims: 1, 2, 4, 7, 8, 10, 11, 15. Other delay reason codes will be accepted but will not be considered in adjudication.
2300	DTP	DATE – INITIAL TREATMENT DATE		1	The Initial Treatment Date does not impact adjudication of any Drug Medi-Cal Claims.
2300	DTP	DATE – ACCIDENT		3	Information sent in this segment does not impact the processing of Drug Medi-Cal claims.
2300	DTP	DATE – DISABILITY DATES		3	Information sent in this segment does not impact the processing of Drug Medi-Cal claims.
2300	DTP	DATE – LAST WORKED		1	This information is not necessary for adjudication of Drug Medi-Cal claims.
2300	DTP	DATE – AUTHORIZED RETURN TO WORK		1	This information is not necessary for adjudication of Drug Medi-Cal claims.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2300	DTP	DATE – ADMISSION		1	Neither ambulance nor inpatient services are covered by Drug Medi-Cal.
2300	DTP	DATE – DISCHARGE		1	Inpatient claims are not covered by Drug Medi-Cal.
2300	PWK	CLAIM SUPPLEMENTAL INFORMATION		3	Information provided in this segment does not impact the processing of Drug Medi-Cal claims.
2300	AMT	PATIENT AMOUNT PAID			
2300	AMT02	Patient Amount Paid		2	This amount includes any amount actually paid as well as any amount for which the provider accepts the patient's obligation to pay to clear share of cost.
2300	REF	SERVICE AUTHORIZATION EXCEPTION CODE		1	No services covered by Drug Medi-Cal require specific prior authorization.
2300	REF	REFERRAL NUMBER		1	ADP does not assign referral numbers.
2300	REF	PRIOR AUTHORIZATION		1	ADP does not assign authorization numbers.
2300	REF	CLAIM IDENTIFICATION FOR TRANSMISSION INTERMEDIARIES		3	Information provided in this segment does not affect processing of Drug Medi-Cal claims and is not returned in any other transaction set.
2300	REF	DEMONSTRATION PROJECT IDENTIFER		1	There are no atypical claims processed in Drug Medi-Cal which this information is necessary to identify.
2300	NTE	CLAIM NOTE		3	Information provided in this segment does not affect the processing of Drug Medi-Cal claims.
2300	HI	HEALTH CARE DIAGNOSIS CODE			ADP only accepts certain diagnosis codes as the primary diagnosis.
2310A	NM1	REFERRING PROVIDER NAME		3	Information provided in this loop does not affect the processing of Drug Medi-Cal claims.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2310B	NM1	RENDERING PROVIDER NAME		2, 3	ADP requires identification, either here or in Loop 2420A, of the counselor as Rendering Provider for Outpatient Drug Free Group and Individual counseling services, and for NTP Group and Individual counseling services. In other circumstances information provided in this loop does not impact processing of Drug Medi-Cal claims.
2310B	NM102	Entity Type Qualifier	1, 2	2	Where this segment is mandatory under the segment level notes above, an individual counselor must be identified.
	NM109	Rendering Provider Identifier		2	Where this segment is mandatory under the segment level notes above, the counselor's NPI must be provided.
2310B	PRV	RENDERING PROVIDER SPECIALTY INFORMATION		1	Rendering provider taxonomy code does not impact the adjudication of Drug Medi-Cal claims.
2310B	REF	RENDERING PROVIDER SECONDARY IDENTIFICATION		1	An identification number other than an NPI is not necessary to identify rendering providers for Drug Medi-Cal.
2310C	NM1	SERVICE FACILITY LOCATION NAME			Because county-operated service locations, and all service locations of direct contract providers are subparts of the entity billing for services, this loop must only be used when services provided at a county-contracted facility are being billed by a county (and, for such services, either this loop at the claim level or Loop 2420C at the service level must be used.)
2310C	NM108	Identification Code Qualifier	XX	2	As all Drug Medi-Cal providers must have NPIs, this data element is always required when this segment is used.
	NM109	Laboratory or Facility Primary Identifier		2	As all Drug Medi-Cal providers must have NPIs, this data element is always required when this segment is used.
2310C	REF	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION		1	As all Drug Medi-Cal providers must have NPIs, NM109 in the NM1 Service Facility Location Name segment in this loop will always be used.
2320	AMT	COORDINATION OF BENEFITS TOTAL NON-COVERED AMOUNT		1	Circumstances in which Drug Medi-Cal claims may be submitted bypassing otherwise prior payers are identified in ADP Bulletin #11-01.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2400	SV1	<b>PROFESSIONAL SERVICE</b>		2	
2400	SV101-01	Product or Service ID Qualifier	HC	6	All Drug Medi-Cal services are described exclusively with HCPCS codes, so only "HC" should be used here.
	SV101-02	Procedure Code	H0004, H0005, H0015, H0018, H0019, H0020	6	Procedure codes map to DMC-covered services as follows: "H0004": Individual Counseling (Outpatient Drug Free [ODF] or Narcotic Treatment Program [NTP].) "H0005": Group Counseling (ODF or NTP) "H0015": Daycare Rehabilitative "H0018", "H0019": Perinatal Residential (must always have the HD modifier, below.) S5000, S5001: Naltrexone "H0020": Methadone Dosing
	SV101-03	Procedure Modifier	HG, HD, H9, 59, 76, 77	6	Services provided in the DMC perinatal program must report the "HD" modifier in one of SV101-03 through SVC101-06.  NTP and NAL services must report the "HG" modifier in one of SV101-03 through SV101-06.  Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify "59", "76", or "77", as appropriate, in one of SVC101-03 through SV101-06.
	SV101-04	Procedure Modifier	HG, HD, H9, 59, 76, 77	6	Services provided in the DMC perinatal program must report the "HD" modifier in one of SV101-03 through SVC101-06.  NTP and NAL services must report the "HG" modifier in one of SV101-03 through SV101-06.  Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify "59", "76", or "77", as appropriate, in one of SVC101-03 through SV101-06.
	SV101-05	Procedure Modifier	HG, HD, H9, 59, 76, 77	6	Services provided in the DMC perinatal program must report the "HD" modifier in one of SV101-03 through SVC101-06.  NTP and NAL services must report the "HG" modifier in one of SV101-03 through SV101-06.  Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify "59", "76", or "77", as appropriate, in one of SVC101-03 through SV101-06.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
	SV101-06	Procedure Modifier	HG, HD, H9, 59, 76, 77	6	<p>Services provided in the DMC perinatal program must report the "HD" modifier in one of SV101-03 through SVC101-06.</p> <p>NTP and NAL services must report the "HG" modifier in one of SV101-03 through SV101-06.</p> <p>Services provided as an allowable Drug Medi-Cal additional unit of service on the same calendar as a previously-provided unit of service, as permitted under 22 C.C.R. § 51341.1(i)(4) must identify "59", "76", or "77", as appropriate, in one of SVC101-03 through SV101-06.</p>
	SV103	Units or Basis for Measurement Code	UN	6	Drug Medi-Cal services must always be billed in units of service. "UN" is the only acceptable value.
	SV104	Service Unit Count		9	Drug Medi-Cal claims are processed in whole units of service. If a decimal is used, the fractional units will be denied and the whole number portion considered for reimbursement.
2400	PWK	LINE SUPPLEMENTAL INFORMATION			Information provided in this segment does not impact adjudication of Drug Medi-Cal claims.
2400	DTP	DATE – SERVICE DATE			
2400	DTP03	Service Date		6	A date range in which the "To and From" dates are not the same is only acceptable for NTP Methadone Dosing and Perinatal Residential services. Billing such a date range for other services will result in service denial.
2400	NTE	LINE NOTE		3	Information provided in this segment does not impact processing of Drug Medi-Cal claims.
2410	LIN	DRUG IDENTIFICATION		3	Information provided in this loop does not impact processing of Drug Medi-Cal claims.
2420A	NM1	RENDERING PROVIDER NAME		2	ADP requires identification, either here or in Loop 2310B, of the counselor as Rendering Provider for Outpatient Drug Free Group and Individual counseling services, and for NTP Group and Individual counseling services. In other circumstances information provided in this loop does not impact processing of Drug Medi-Cal claims.
2420A	NM108	Entity Type Qualifier	1, 2	2	Where this segment is mandatory under the segment level notes above, an individual counselor must be identified.
	NM109	Rendering Provider Identifier		2	Where this segment is mandatory under the segment level notes above, the counselor's NPI must be provided.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2420A	PRV	RENDERING PROVIDER SPECIALTY INFORMATION		1	Rendering provider taxonomy code does not impact adjudication of DMC claims.
2420A	REF	RENDERING PROVIDER SECONDARY IDENTIFICATION		1	An identification number other than an NPI is not necessary to identify rendering providers for Drug Medi-Cal.
2420C	NM1	SERVICE FACILITY LOCATION NAME			Because county-operated service locations, and all service locations of direct contract providers are subparts of the entity billing for services, this loop must only be used when services provided at a county-contracted facility are being billed by a county (and, for such services, either this loop at the service level or Loop 2310C at the claim level must be used.)
2420C	NM108	Identification Code Qualifier	XX	2	As all Drug Medi-Cal providers must have NPIs, this data element is always required when this segment is used.
	NM109	Laboratory or Facility Primary Identifier		2	As all Drug Medi-Cal providers must have NPIs, this data element is always required when this segment is used.

**005010X221 Health Care Claim Payment/Advice**

Loop ID	Reference	Name	Codes	Cat	Notes/Comments
	BPR	FINANCIAL INFORMATION			
	BPR01	Transaction Handling Code	H, I	8	All payments for Drug Medi-Cal are made via warrants issued by the State Controller's Office, so all 835s detailing payment will use code "I".  All other 835s for Drug Medi-Cal will use code "H".
	BPR03	Credit/Debit Flag Code	C	8	As all Drug Medi-Cal payments are made by warrant, ADP will always send "C".
	TRN	REASSOCIATION TRACE NUMBER			
	TRN04	Originating Company Supplemental Code		8	ADP will send "DRUG MEDI-CAL" for all Drug Medi-Cal 835s.
	CUR	FOREIGN CURRENCY INFORMATION		10	All Drug Medi-Cal payments are made in U.S. dollars. This segment will not be sent.
	REF	RECEIVER IDENTIFICATION		10	The receiver for all Drug Medi-Cal 835s will be the payee. This segment will not be sent.

Loop ID	Reference	Name	Codes	Cat	Notes/Comments
<b>1000A</b>	<b>N1</b>	<b>PAYER IDENTIFICATION</b>			
1000A	N102	Payer Name		8	ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element.
	N103	Identification Code Qualifier		10	This element will not be sent.
	N104	Payer Identifier		10	This element will not be sent.
<b>1000B</b>	<b>N1</b>	<b>PAYEE IDENTIFICATION</b>			
1000B	N102	Payee Name		8	This element will be populated with the legal name of the payee as reflected in ADP records.
	N103	Identification Code Qualifier	XX	8	ADP will always send "XX" in this element.
	N104	Payee Identification Code		8	This will be the NPI provided to ADP to identify the payee; for organizations with more than one NPI it will be the one provided to ADP to identify the entity at the highest level.
<b>1000B</b>	<b>REF</b>	<b>PAYEE ADDITIONAL IDENTIFICATION</b>			
1000B	REF01	Reference Identification Qualifier	TJ	8	ADP will always send "TJ" in this element.
<b>2100</b>	<b>CLP</b>	<b>CLAIM PAYMENT INFORMATION</b>			
2100	CLP02	Claim Status Code	1, 2, 3, 4, 22	8	As ADP does not forward claims to additional payers, or do predetermination pricing, only codes "1", "2", "3", "4", and "22" will be used by ADP.
	CLP06	Claim Filing Indicator Code	MC	8	ADP will always send "MC" in this element.
	CLP08	Facility Type Code		10	As ADP does not modify the Facility Code Type in adjudication, this element is never sent.
<b>2100</b>	<b>REF</b>	<b>OTHER CLAIM RELATED IDENTIFICATION</b>			
2100	REF01	Reference Identification Qualifier	1L, F8	8	On every DMC claim reported on an 835 where the identified client was located on MEDS, ADP will return one iteration of this loop with the qualifier "1L".  On every DMC Replacement claim reported on an 835, ADP will return one iteration of this loop with the qualifier "F8". Other correction claims will always retain the PCCN of the prior claim.
	REF02	Reference Identification		8	When REF01 is "1L", this will contain a concatenation of the two-digit aid code used in adjudication and the two-digit code identifying the county of responsibility.

Loop ID	Reference	Name	Codes	Cat	Notes/Comments
2100	REF	RENDERING PROVIDER IDENTIFICATION		10	Additional rendering provider identification numbers do not affect adjudication of DMC claims. This segment will not be sent.
2100	DTM	STATEMENT FROM OR TO DATE		10	Statement From and To Dates will always be provided at the service line level. This segment will not be sent.
2100	DTM	CLAIM RECEIVED DATE		8	ADP will send this segment for all claims.
2100	AMT	CLAIM SUPPLEMENTAL INFORMATION			
2100	AMT01	Amount Qualifier Code	AU, F5	8	Qualifiers "AU" and "F5" are the only values that will be sent for this element.
2100	QTY	CLAIM SUPPLEMENTAL INFORMATION QUANTITY		10	The quantities reported in this segment do not apply to DMC. This segment will not be sent.
2110	AMT	SERVICE SUPPLEMENTAL AMOUNT			
2110	AMT01	Amount Qualifier Code	B6	8	The only value that will be sent for this data element is "B6".

**005010X212 Health Care Claim Status Request**

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2100A	NM1	PAYER NAME			
2100A	NM109	Payer Identifier		6	ADP's Tax ID, "680290013", must be supplied here.
2100B	NM1	INFORMATION RECEIVER NAME		2	This is the County or Direct Provider requesting to receive the status information.
2100B	NM109	Identification Code			Provide the Tax ID of the county or direct contractor submitting the claim status request.
2000D	HL	SUBSCRIBER LEVEL			
2000D	HL04	Hierarchical Child Code	0	6	The subscriber is always the patient for ADP. "0" is the only acceptable value.
2000D	DMG	SUBSCRIBER DEMOGRAPHIC INFORMATION		1	In Drug Medi-Cal, the subscriber is always the patient. This segment must always be sent.
2100D	NM1	SUBSCRIBER NAME			
2100D	NM102	Entity Type Qualifier	1	6	In Drug Medi-Cal, the subscriber is always an individual. "1" is the only acceptable value.

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
	NM108	Identification Code Qualifier	MI	6	The Medi-Cal Client Index Number (CIN), which is a Member Identification Number, is the only acceptable Drug Medi-Cal client identifier.
	NM109	Subscriber Identifier		2	The primary identifier for all Drug Medi-Cal beneficiaries is the 9-digit Medi-Cal Client Index Number (CIN).
2200D	TRN	CLAIM STATUS TRACKING NUMBER			In Drug Medi-Cal, the subscriber is always the patient. This segment must always be sent.
2200D	REF	APPLICATION OR LOCATION SYSTEM IDENTIFIER			ADP does not have application or location system identifiers. This segment should not be sent.
2200D	REF	GROUP NUMBER			Information provided in this segment is not used by ADP in Claim Status Request processing.
2200E	HL	DEPENDENT LEVEL			In Drug Medi-Cal, the patient is never a dependent without a unique identification number. This loop should not be sent.

**005010X212 Health Care Information Status Notification**

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
2100A	NM1	PAYER NAME			
2100A	NM103	Payer Name		8	ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element.
2100A	NM108	Identification Code Qualifier	PI	8	SD/MC will always send "PI".
2100A	NM109	Payer Identifier		8	ADP will always send ADP's Tax ID.
2000D	HL	SUBSCRIBER LEVEL			
2000D	HL04	Hierarchical Child Code	0	8	The subscriber is always the patient for DMC. ADP will always send "0".
2200C	TRN	PROVIDER OF SERVICE TRACE IDENTIFIER			
2200C	TRN02	Provider of Service Information Trace Identifier			ADP will always send "0" in this data element.
2200D	STC	CLAIM LEVEL STATUS			

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
		<b>INFORMATION</b>			
2200D	STC08	Remittance Date			ADP will provide the date of a non-payment 835 when one has been issued.
	STC09	Remittance Trace Number			ADP will provide the Trace Number of a non-payment 835 when one has been issued.
<b>2200D</b>	<b>REF</b>	<b>VOUCHER IDENTIFIER</b>		10	ADP does not assign a voucher identifier to Drug Medi-Cal claims as part of the DMC payment process. This segment will not be sent.
	NM109	Payer Identifier		8	ADP will always send ADP's Tax ID.

**005010X228 Health Care Claim Pending Status Information**

Loop ID	Reference	Name	Codes		Notes/Comments
<b>2100A</b>	<b>NM1</b>	<b>PAYER NAME</b>			
2100A	NM103	Payer Name		8	ADP will always send "CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS" in this element.
	NM108	Identification Code Qualifier	PI	8	SD/MC will always send "PI"
	NM109	Payer Identifier		8	ADP will always send ADP's Tax ID.

**005010X231 Implementation Acknowledgement**

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
<b>AK2</b>	<b>IK5</b>	<b>TRANSACTION SET RESPONSE TRAILER</b>			
AK2	IK501	Transaction Set Acknowledgment Code	A, R, E	6	ADP rejects data at the lowest level to which errors can be isolated. Where errors exist that can be isolated to a level lower than the transaction set, ADP will accept the transaction set with errors, reporting an "E" in this segment, and reject any claims impacted by the error via Health Care Claim Acknowledgement (277) transaction set.  In all other circumstances, ADP will accept ("A") or reject ("R") the transaction set in its entirety.
	<b>AK9</b>	<b>FUNCTIONAL GROUP RESPONSE TRAILER</b>			
	AK901	Functional Group Acknowledge Code	A, R, E	6	ADP rejects data at the lowest level to which errors can be isolated. Where errors exist that can be isolated to a level lower than the functional group, ADP will accept the functional group with errors, reporting an "E" in this segment.  In all other circumstances, ADP will accept ("A") or reject ("R") the functional group in its entirety.

## 4 TI Additional Information

### 4.1 Business Scenarios

No business scenarios are needed.

### 4.2 Payer Specific Business Rules and Limitations

#### 4.2.1 837 Transaction Set Claim Limitation

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

#### 4.2.2 Claim Overpayment Recovery

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

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

##### 4.2.3.1 General Rule

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

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

## **4.2.3.2 Billing DMC without OHC billing results**

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

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

1. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 CAS–Claim Level Adjustment segment.
2. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 AMT–Coordination of Benefits (COB) Payer Paid Amount segment.
3. Because ADP policy allows bypassing claim submission to the OHC carrier, provide the Loop 2320 AMT-Coordination of Benefits (COB) Total Non-Covered Amount segment.
4. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 AMT–Remaining Patient Liability segment.
5. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2320 MOA-Outpatient Adjudication Information segment.
6. Because the OHC carrier has not adjudicated the claim, do not provide the Loop 2330B DTP-Claim Check or Remittance Date, or any other segment in Loop 2330B with a situational rule referring to information provided by the other payer or relating to the other payer's adjudication of the claim.
7. Do not provide any of the loops providing provider information specific to the other payer (Loop 2330C, 2330D, 2330E, 2330F, and 2330G.)

8. Because the OHC carrier has not adjudicated the claim, do not provide service line level COB information (Loop 2420) for the bypassed payer for the service lines in this claim.

#### **4.2.3.2.2 Methadone Maintenance Treatment Services**

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

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

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

#### **4.2.3.2.4 Presumed Denials**

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

##### **4.2.3.2.4.1 Delayed or No OHC response**

Trading partners may presume that a claim submitted to an OHC carrier has been denied by the OHC carrier when the provider has billed the

service to the carrier, as required, and at least 90 days have passed without a response from the OHC, provided that the requirements in ADP Bulletin #11-01 (in items #1 and #2 under “Delayed or No OHC Response”) are met.

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

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

#### **4.2.3.2.4.2 Prospective Denial Letter**

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

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

Certain OHC policies are known to the State to categorically exclude coverage of the services provided through the DMC program, including Medicare and certain other OHC policies identified in State eligibility records with coding indicating that they do not have the type of coverage which might include DMC services. Which OHCs do and do not apply to DMC services is discussed in detail in ADP Bulletin #11-01. DMC services provided to clients with OHC that does not apply to DMC do not need to be billed to the OHC,

and no information about the OHC needs to appear in DMC claims for such services.

### 4.2.3.3 Presumed Denials

#### 4.2.3.3.1 General Rule for Presumed Denials

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

### 4.2.4 ICD-9 Codes

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

### 4.2.5 Adjustment Reason Codes

Group Code	Adjustment Reason Code	Health Remark Code	Adjustment Reason Code Description
CO	10	N/A	Beneficiary identified as perinatal-eligible (Loop 2000B PAT09 is "Y"), but MEDS indicates this client is male.
CO	11	N/A	Perinatal service billed, but beneficiary is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided), or Daycare Rehabilitative service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible (Loop 2000B PAT09 of "Y" not provided.)
CO	16	N354	The claim (Original/Void/Replacement) is an invalid bridge resubmission claim.
CO	18	N/A	This service is not allowed on the same date as a previously-approved service for this beneficiary without a valid multiple service procedure modifier.
CO	22	N/A	MEDS indicates this client has non-Medicare other health coverage, and the claim does not indicate that that coverage has been billed first.
CO	23	N/A	Coordination of benefits adjustment.
CO	29	N/A	Claim denied for late submission.
CO	31	N/A	Beneficiary aid code(s) do not indicate eligibility for DMC services.
CO	45	N/A	Charges reduced because they exceed the maximum allowed given the established rate and the billed units of service.
CO	89	N/A	Administrative Fees retained by State.
CO	109	N/A	Claim denied because perinatal and non-perinatal services are billed together. Re-bill perinatal and non-perinatal services on separate claims.
CO	110	M52	Service date cannot be later than submission date.
CO	119	N345	Service line denied because a service (other than NTP counseling) was billed with a number of units different from the number of days billed.
CO	119	N362	Service denied because it would exceed limit of 20 units of NTP counseling service per month for beneficiary.
CO	129	N/A	The submitted Void or Replacement claim is not eligible to be Voided or Replaced.
CO	138	N/A	Claim denied because service dates on claim include more than one calendar month. Re-bill in separate claims for each calendar month of service.
CO	143	N/A	Portion of payment for approved services deferred due to insufficient contract balance.

Group Code	Adjustment Reason Code	Health Remark Code	Adjustment Reason Code Description
CO	163	N/A	Claim denied because it was submitted late, a delay reason code requiring certification was provided and a certification attachment was referenced in the claim, but the certification attachment either was not received or did not cover this claim.
CO	167	M76	Service line denied because no diagnosis pointer provided in SV107 references a covered diagnosis code for DMC services.
CO	177	N/A	Claim denied because client is ineligible per MEDS.
CO	208	N257	Claim denied because Billing Provider EIN and NPI combination is not valid per ADP provider records.
CO	A1	M51	Service line denied because the procedure codes and modifiers provided do not identify a DMC service.
CO	A1	M59	Service line denied because service "to" date precedes "from" date.
CO	A1	M80	This service is not allowed on the same date as one or more previously-approved services for this beneficiary.
CO	A1	N63	Service line denied because a service other than NTP Methadone Dosing was billed with a date range rather than a single date of service.
CO	A1	N142	Void/Replacement claim denied because the original claim is an invalid resubmission claim.
CO	A1	N421	Service line denied due to disallowance from post-service, post-payment utilization review.
CO	B7	N/A	Service line denied because the Service Facility Location was not a DMC-certified site for the identified service on the date(s) of service.
CO	B7	MA114	Service line denied because the Service Facility Location is not one for which the Billing Provider may submit claims for the date(s) of service.  If Service Facility Location provider type is 'Sole Proprietor' and the zip code +4 of SFL provider on claim/service line does not equal zip code +4 in ADP's provider file then deny service line.
PR	1	N/A	Service line reimbursement adjusted due to share of cost collected reported by provider.

### 4.3 Frequently Asked Questions

There are no frequently asked questions.

#### **4.4 Other Resources**

Drug Medi-Cal billing information can be found on ADP's Drug Medi-Cal billing webpage at [http://www.adp.ca.gov/dmc/dmc\\_billing.shtml](http://www.adp.ca.gov/dmc/dmc_billing.shtml).

## **5 TI Change Summary**

This is the first companion guide issued for the use of the X12 version 5010 transaction sets in Drug Medi-Cal billing.

## 6 Appendix C – Communication / Connectivity Instructions (CCI) Template

Control Segments:

Loop ID	Reference	Name	Codes	Cat.	Notes/Comments
	<b>ISA</b>	<b>INTERCHANGE CONTROL HEADER</b>		2	All outbound EDI from ADP will use the following separators: “*” (Asterisk) Data Element Separator “.” (Colon) Component element Separator “~” (Tilde) Segment Terminator “^” (Caret) Repetition Separator
	ISA01	Authorization Information Qualifier		3	This data element is not processed by SDMC.
	ISA02	Authorization Information		3	This data element is not processed by SDMC.
	ISA03	Security Information Qualifier		3	This data element is not processed by SDMC.
	ISA04	Security Information		3	This data element is not processed by SDMC.
	ISA05	Interchange ID Qualifier	30	2	ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively.
	ISA06	Interchange Sender ID		2	ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively. On EDI submitted to ADP, always identify the county or direct contract provider on whose behalf the EDI is being submitted. Trading partners must not include hyphens in the Tax ID.
	ISA07	Interchange ID Qualifier	30	2	ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively.
	ISA08	Interchange Receiver ID		2	ADP requires Interchange Senders and Receivers to be identified by Federal Tax ID exclusively.
	ISA11	Repetition Separator		2	All outbound EDI from ADP will use the caret (“^”) as the Repetition Separator.
	ISA16	Component Element Separator		2	All outbound EDI from ADP will use the colon (“.”) as the Component Element Separator.
	<b>GS</b>	<b>FUNCTIONAL GROUP HEADER</b>			

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

## 6.1 Communication/Connectivity Instructions

### 6.1.1 Preparing EDI for Upload

EDI to be submitted to ADP must:

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

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

where:

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

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

### **6.1.2 Submitting EDI via ITWS**

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

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