

DMC:

Drug Medi-Cal Programs

Including highlights of SD/MC ii

Drug Medi-Cal (DMC)

The Drug Medi-Cal (DMC) program provides medically necessary substance abuse treatment services for eligible Medi-Cal beneficiaries (California Code of Regulations, Title 22, Section 51341.1, 51490.1, and 51516.1)

Service Information

Narcotic Treatment Program (NTP): Modality using methadone directed at stabilization and rehabilitation of persons who are opiate addicted and have substance abuse diagnoses. This program does not include detoxification treatment. Services within NTP include: intake, treatment planning, medical direction, body specimen screening, physician and nursing services related to substance abuse, medical psychotherapy, individual and/or group counseling, admission physical examinations and laboratory tests, and medication services. Services also include the provision of methadone as prescribed by a physician to alleviate symptoms of withdrawal from opiates rendered in accordance with the requirements set forth in Title 9, California Code of Regulations (CCR), Chapter 4, commencing with Section 10000.

In order for a provider to receive reimbursement for DMC substance abuse services, the services shall be provided by or under the direction of a physician.

Group counseling shall be conducted with no less than four and no more than ten clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

Day Care Rehabilitative (DCR): Modality designed to provide outpatient counseling and rehabilitation services at least three hours per day, three days per week to persons with substance abuse diagnoses, who are pregnant or in the postpartum period, and/or to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries. DCR services include: intake, admission physical examinations, medical direction, treatment planning, individual and group counseling, body specimen screens, medication services, collateral services, and crisis intervention, provided by staff who are lawfully authorized to provide, prescribe, and/or order these services within the scope of their practice or licensure. DCR services shall be provided only to pregnant and postpartum women and/or to EPSDT eligible beneficiaries. The service shall consist of regularly assigned, structured, and supervised treatment.

Outpatient Drug Free (ODF): Modality designed to stabilize and rehabilitate persons with substance abuse diagnoses in an outpatient setting. Services within ODF include: admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group and individual counseling, provided by staff who are lawfully authorized to provide, prescribe, and/or order these services within the scope of their practice or licensure, subject to the following:

Group counseling sessions focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse or a return to substance abuse. Each beneficiary receives at least two group counseling sessions per month. Group counseling shall be conducted with no less than four and no more than ten clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.

Individual counseling is limited to intake, crisis intervention, collateral services, treatment and discharge planning.

Perinatal Residential: Service modality is a non-institutional, non-medical residential program that provides rehabilitation services to pregnant and postpartum women with substance abuse diagnoses. Each beneficiary lives on the premises and is supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs provide a range of activities and services for pregnant and postpartum women. Supervision and treatment services are available day and night, seven days a week. Services include: intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff¹ who are lawfully authorized to provide, and/or order these services within the scope of their practice or licensure. Perinatal residential substance abuse services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

The services include:

- Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative childcare).
- Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
- Education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant.
- Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

Perinatal residential substance abuse services are provided in a residential facility licensed by ADP. The services are reimbursed through the Medi-Cal

¹ For a provider to receive reimbursement for DMC substance abuse services, those services shall be provided by or under the direction of a physician [22, CCR, 51341.1(h)].

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program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program. For a provider to receive reimbursement for DMC substance abuse services, those services shall be provided by or under the direction of a physician.

Funding Information

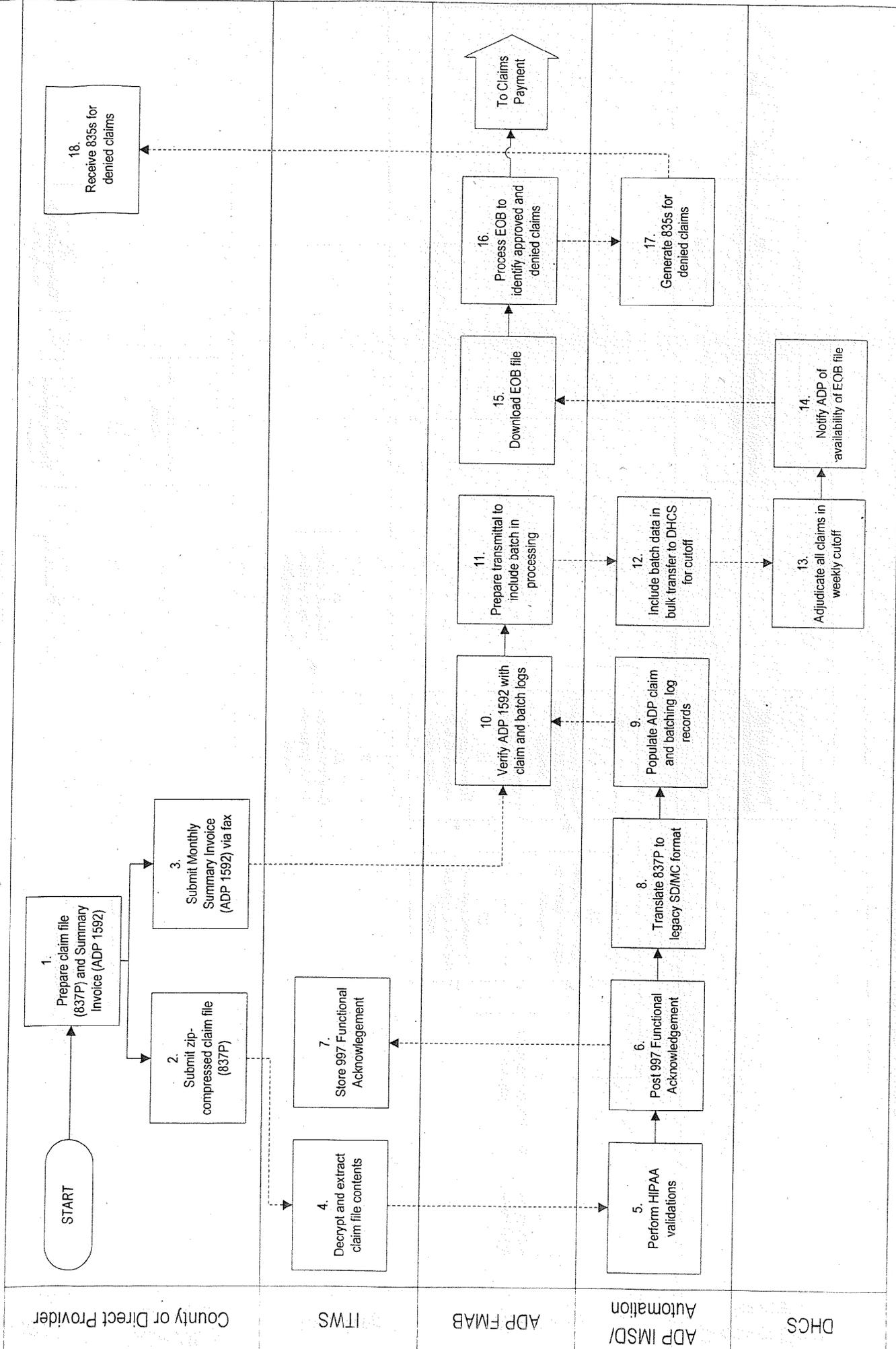
DMC funding is administered through a contract between the Department of Alcohol and Drug Programs (ADP) and counties or direct contract providers. The reimbursement is 50% State General Fund (SGF) and 50% Federal Financial Participation (FFP), or 100% SGF if the DMC service is for a medi-cal beneficiary who qualifies under the minor consent program.

Maximum allowance rates are established for each service type, which is the maximum that can be billed or reimbursed. While a rate is established, the DMC program is a cost reimbursement program. At the end of each fiscal year, cost data is provided from the counties and direct contract providers. Costs above the maximum allowance rate are not reimbursed and costs below the rate are only reimbursed at the cost.

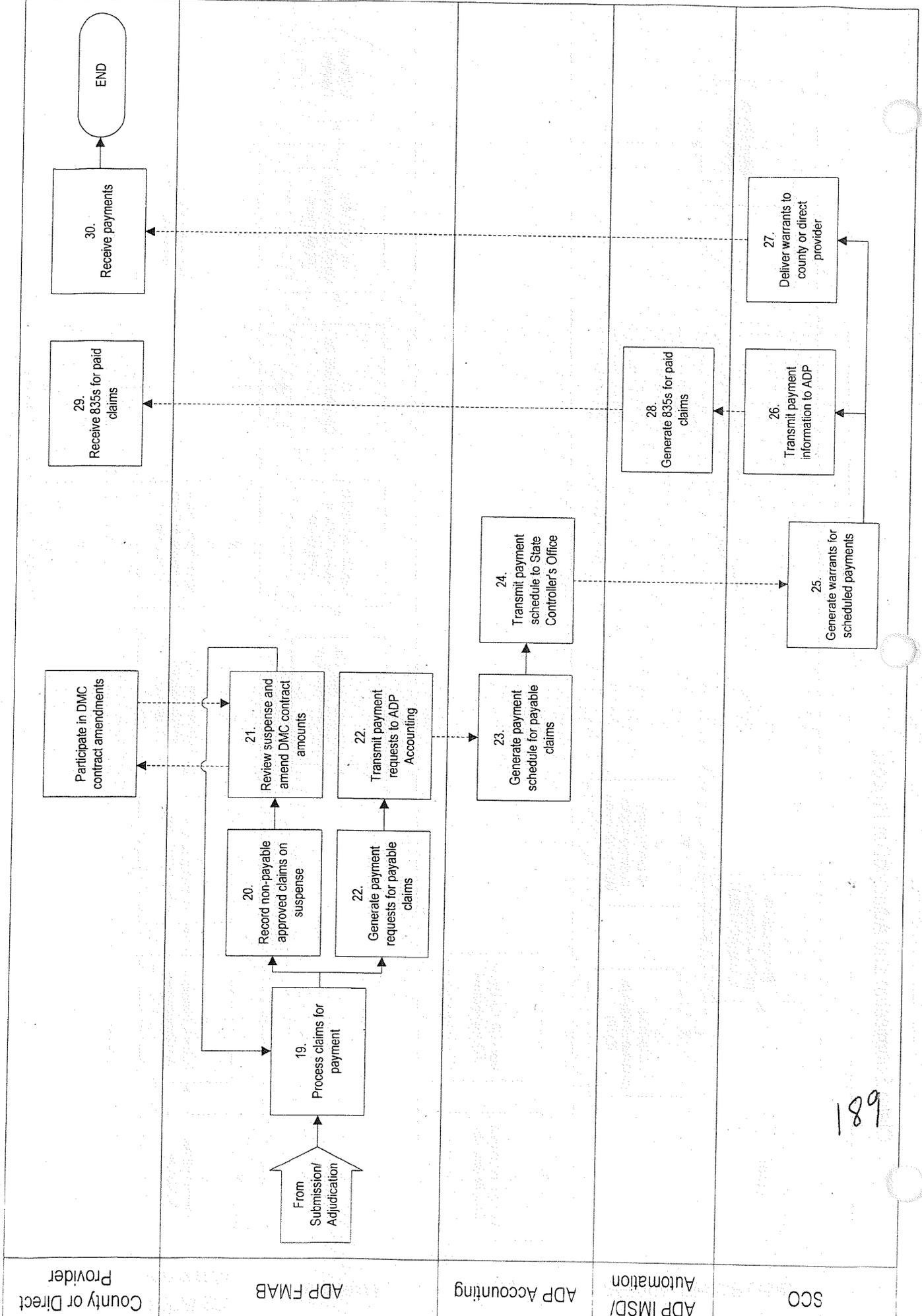
Reporting Requirements

The DMC services are provided by providers and then the claims are submitted electronically to ADP by the counties or by providers with whom ADP has a direct contract. Claims are normally submitted on a monthly basis as they are due within 30 days from the end of the service month. An invoice (ADP Form 1592) must accompany each claim, which is a summary of the detailed claim data. The summary information includes provider information, month and year of service, type of service provided, and the billed amount. While the invoice is not submitted electronically, it is tied in summary to the client data within the claim. The claims are processed through the Department of Health Care Services' Short-Doyle/ Medi-Cal system for adjudication. Upon ADP's receipt of approved claim information, ADP request from the State Controller's Office to issue reimbursement to the counties or direct contract providers.

Claim Submission and Adjudication Process



Claim Payment Process



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INSTRUCTIONS FOR SUBMITTING THE ADP 1592
(Revised February 2008)

I. GENERAL

The Drug Medi-Cal Monthly Summary Invoice, ADP 1592, is required by Alcohol and Drug Programs (ADP) to report Drug Medi-Cal (DMC) units of service, claim amounts, revenues and adjustments, and net claim amounts by county and direct contract providers having a contract with ADP. The information for all boxes/fields required and must be complete and accurate for the claim to be processed.

II. HEADING INSTRUCTIONS

a. Check one: COUNTY CONTRACT or DIRECT CONTRACT

- **DIRECT CONTRACT** - check only for provider contracting with and submitting directly to ADP

b. ITWS - 837P FILE NAME - enter a single ITWS file name for claims summarized on this ADP 1592 Invoice.

- For county contracts: ADP_SDM_CO_P_837_YYYYMM_##, with or without the extension of zip or text.
- For direct contracts: ADP_SDM_PROV_P_837_YYYYMM_##, with or without the extension of zip or text.
- Claim summary information for each ITWS file should be summarized on a separate ADP 1592.

c. COUNTY - name of contracting county or name of direct provider's county

d. COUNTY CODE - enter the county's two digit code.

e. REPORT MO/YR - enter the month/year of the claim being submitted

- The latest Month and Year of the services in the claim file should be entered in this box.
- The ITWS file must only include claims, and the ADP 1592 Invoice must only summarize services for the same fiscal year.

f. CONTRACT NUMBER - enter the applicable Contract Number for either a County Contract or a Direct Contact based on the fiscal year's services.

g. Program Code - (check one) select the appropriate box for non-Perinatal DMC Program 20 or Perinatal DMC Program 25 services.

- A separate ADP 1592 Summary Invoice must be completed for each program code, and
- Each ADP 1592 must include the ITWS File Name, however
- Services for both programs may be submitted in a single ITWS File.

h. Fiscal Year - enter fiscal year for the services in the ITWS File named; only one Fiscal Year is allowed in an ITWS file and on an ADP 1592.

i. Date - enter the date this form is being completed and submitted, mailed/faxed, to ADP.

j. Page ___ of ___ - enter each page number and total number of pages for this ADP 1592; example of a 3-page submission: Page 1 of 3, Page 2 of 3, Page 3 of 3.

III. INSTRUCTIONS FOR ENTERING PROVIDER CLAIM INFORMATION

a. PROVIDER NAME - enter name of provider/program providing services.

b. FACILITY/PROVIDER NPI - enter the ten- (10-) digit National Provider Identifier (NPI).

c. SDMC NUMBER - enter four- (4-) digit SDMC Number assigned by ADP and formerly named the DMC Number

d. SFC - enter two- (2-) digit DMC service code:

- 20 for NTP Methadone Dose or 22 NTP Methadone Dose (SACPA)
- 26 NTP Individual Counseling or 27 NTP Individual Counseling (SACPA)
- 28 NTP Group Counseling or 29 NTP Group Counseling (SACPA)
- 30 Day Care Habilitative or 39 Day Care Habilitative (SACPA)
- 40 Perinatal Residential or 49 Perinatal Residential (SACPA)
- 50 Naltrexone or 59 Naltrexone (SACPA)
- 80 ODF Individual Counseling or 84 ODF Individual Counseling (SACPA)
- 85 ODF Group Counseling or 89 ODF Group Counseling (SACPA)

e. UNITS OF SERVICE - enter units per provider/SFC; per SFC listing rollup/summarize units under one SFC

f. AMOUNT CLAIMED - enter amount per provider/SFC; per SFC listing rollup/summarize amounts under one SFC

g. ADJUSTMENTS TO CLAIMED AMOUNT - enter applicable amounts in REVENUES or ADJUSTMENTS column(s)

- Enter any revenues collected and/or any adjustments reported for each provider/SFC
- Revenues and Adjustments must apply to the current fiscal year on the ADP 1592; no prior year adjustments should be included.
- Any non-SHARE OF COST (SOC) revenues should be listed under OTHER
- **PSPP SITE VISIT** - adjustments based on Post-Service/Post-Payment monitoring of claims
- List any other adjustments under **CLAIM ADJUST** column.

h. TOTAL REVENUE AND ADJUSTMENTS - enter total of the four (4) REVENUES and ADJUSTMENTS columns.

i. NET CLAIM - enter the CLAIM AMOUNT minus TOTAL REVENUE AND ADJUSTMENTS.

j. PAGE TOTALS - enter column totals for units of service, amount claimed, total revenue and/or adjustments and net claim.

k. GRAND TOTALS - on the last page of the monthly invoice, enter the grand totals of amount claimed, total revenue and/or adjustments and net claim.

IV. PREPARER'S NAME - the legible name and phone number (including the area code) of the responsible county/contractor representative for contact purpose.

V. CERTIFICATION STATEMENTS - sign the appropriate certification statement.

a. COUNTY CERTIFICATION - for a county contract only, enter the signature of the County Alcohol/Drug Program Administrator.

b. DIRECT CONTRACT PROVIDER - for a direct contract provider only, enter the signature of the Contract Administrator.

VI. FISCAL OFFICER - for contracting county or contracting direct provider

a. Enter the signature of the County Auditor Controller or Finance Officer for county; also enter the date and location where signed.

b. Enter the signature of the Direct Contractor Finance Officer for direct provider; also enter the date and location where signed.

c. Two (2) original signatures are required on the ADP 1592, the administrator and the financial officer.

d. Signatures are required on any page(s) that have the grand total(s) entered.

VII. Submission of ADP 1592 - ADP 1592 with original signatures and dates may either be faxed to 916-322-1176, or mailed to:

Department of Alcohol and Drug Programs
Fiscal Management and Accountability Branch
1700 "K" Street, 4th Floor
Sacramento, CA 95811-4037

VIII. If there are adjustments to claims, please mail/fax the completed Adjustments by Provider, ADP 5035C with original signatures with the ADP 1592.

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INSTRUCTIONS FOR ADJUSTMENTS BY PROVIDER ADP 5035C

GENERAL

- The ADP Adjustments by Provider form is used by a Drug/Medi-Cal Provider to report adjustable units of service for the County/Provider.
- Report only one fiscal year (FY) on a page
- Report adjustments for only one provider and one service function code per page
- Submit only one month per line

HEADING INSTRUCTIONS

- a. FISCAL YEAR - enter the FY that adjustments are for
- b. COUNTY - enter the county name in which the provider is located
- c. PROVIDER NAME - enter the name of the program submitting the adjustments
- d. PROVIDER NUMBER - enter the four-digit provider number assigned to the program by the Department of Alcohol and Drug Programs (ADP)
- e. SERVICE FUNCTION CODE (SFC) - enter the two digit SFC:

20-21 NTP Methadone Dose	or	22 NTP Methadone Dose (SACPA)
23-24 NTP LAAM Dose	or	25 NTP LAAM Dose (SACPA)
26 NTP Individual Counseling	or	27 NTP Individual Counseling (SACPA)
28 NTP Group Counseling	or	29 NTP Group Counseling (SACPA)
30-38 Day Care Habilitative	or	39 Day Care Habilitative (SACPA)
40-48 Perinatal Residential	or	49 Perinatal Residential (SACPA)
50-58 Naltrexone	or	59 Naltrexone (SACPA)
80-83 ODF Individual Counseling	or	84 ODF Individual Counseling (SACPA)
85-88 ODF Group Counseling	or	89 ODF Group Counseling (SACPA)
- f. PROGRAM CODE - enter one of the following two-digit codes to indicate the program code:

20 - Alcohol/Drug Services	25 - Perinatal Services
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- g. PAGE - enter this page number and the total number of pages being submitted per provider, FY, and service function code

COLUMN INSTRUCTIONS

- a. CLIENT NAME - enter the client name: last name, first initial
- b. CHART NUMBER - enter the client chart number
- c. REFERENCE CLAIM I.D. NUMBER - enter the number preceded by a "D", located in the upper right corner of the Drug/Medi-Cal Eligibility Worksheet ADP 1584 and the line number where the claim appears. For tape submissions use the number on the first column of the facsimile ADP 1584 that is preceded by an "A" (the last two digits are the line number)
- d. ADJUSTMENT DATES - enter the beginning and ending dates of the adjustment.
- e. ADJUSTMENT REASON - enter the reason for the adjustment using the codes from the lower front of this form
- f. CLAIM FOR MO/YR - enter the four-digit code that indicates the month/year (mo/yr) from the header of the ADP 1592 in which the services were billed
- g. UNITS OF SERVICE (U/S) - enter the number of units (visits) to be adjusted for each month of service

DOLLARS ADJUSTED

- a. TOTAL - enter the dollar amount, including cents, to be adjusted for each line.

PAGE TOTALS

- a. Tabulate the total for the U/S column and enter the total at the bottom of the column
- b. Tabulate the total for dollars, including cents, adjusted and enter at the bottom of the page

GRAND TOTALS

If more than one page per provider and FY, enter grand totals at the bottom of the last page.

PROGRAM SUBMISSION INSTRUCTIONS

- Upon identifying an adjustment of unit(s), the provider shall complete this form, forward the original and one copy to the county fiscal office, one copy to ADP, and retain one copy.

COUNTY SUBMISSION INSTRUCTIONS

- The county fiscal office shall process the ADP 5035C by deducting the grand total amount from the next monthly claim to be submitted to ADP and attach the original and two copies of the ADP 5035C to the monthly claim
- If the adjustment is for a prior year, the county shall forward the original and two copies of the ADP 5035C to ADP

MAIL TO: Department of Alcohol and Drug Programs
 Fiscal Management and Accountability Branch
 1700 K Street
 Sacramento, CA 95814-4037

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Reset Form

Print Form

Rejected File for Fiscal Year _____

Drug Medi-Cal (DMC) Information Technology Web Services (ITWS) Rejected Claim Form

This Rejected Claim form provides information to document a Rejected Drug Medi-Cal (DMC) claim being resubmitted to ADP through the ITWS, ADP-SDMC system. Please complete the information below to identify the Rejected ITWS file and provide information documenting the Rejection of the claim file.

Once the Rejected Claim is corrected and resubmitted on ITWS, the Rejected Claim form should be completed and faxed to ADP immediately after uploading the corrected ITWS 837P file. The Rejected Claim form must be faxed or mailed to document the timeliness of a claim being resubmitted due to ITWS or ADP rejection.

Entire ITWS, DMC claims may be rejected for the following reasons:

1. ITWS rejects due to file format or password errors;
2. ITWS rejects due to HIPAA Translator errors;
3. ADP rejects at the request of county/direct provider; or
4. ADP rejects claim due to incomplete or incorrect documentation (ADP Invoice does not match summary of information in 837P claim file).

County Code and Contract Number: _____

Rejected Date: _____

Rejected ITWS File: _____

New ITWS File: _____

If rejected by the ITWS, please include a printout of the ITWS Processing Status page listing the file and the date rejected and resubmitted.

If ADP rejected the claim, please fax a copy of the e-mail communication regarding the rejection, or note the FMAB analyst, on line with the 'Rejected Date' above.

ADP-FMAB Analyst Processing Information

Rejected Batch Number in TAPS (if applicable): _____

New Batch Number (if same Batch# used, write 'Same'): _____

DHCS CutOff/EOB date Rejected/resubmission is scheduled for: _____

Instructions for Completing Rejected Claim Form

1. Write in the fiscal year, at the top of the form, that the services were for in the Rejected Claim.
2. Write in the submitter's County Code and Contract Number.
3. Write in either the date the ITWS rejected the file; the submitter requested the claim to be rejected; or ADP rejected the claim.
4. Write in the name of the ITWS file that was rejected by ITWS, per submitter's request, or by ADP.
5. Write in the file name of the 837P file that is being corrected and replacing the Rejected Claim file. Most files replacing the ITWS rejected file will have the same name as the Rejected 837P file; please rewrite the ITWS file name being resent to maintain clear communication.
6. Fax, or mail the Rejected Claim form, and any additional documentation of the Rejected claim to ADP immediately after uploading the corrected ITWS claim file.
7. If the Rejected Claim was not a Resubmission of previously Denied Claims, the ADP 1592 Summary Invoice, if the new ITWS file name is different from the rejected ITWS file, should be revised/edited to reflect the new file name and must be faxed with the Rejected Claim information.
8. Please contact the county fiscal analyst if there are questions regarding the Rejected Claim process or if assistance is required.
9. Do not write below the asterisks; that area is for FMAB processing information.

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Reset Form

Print Form

Resubmission for Fiscal Year _____

Drug Medi-Cal (DMC) Information Technology Web Services (ITWS) Resubmission Claim Form

This Resubmission form provides information to document denied Drug Medi-Cal (DMC) services being resubmitted to ADP through the ITWS, ADP-SDMC system. Please complete all of the information below to identify the previously submitted and denied services, and to identify the corrected services being resubmitted. This Resubmission must be submitted within six (6) months following the date the claims were processed and denied, per the hard copy Denied Claims Report, or the explain of balance (EOB), or 835P data.

Denied Claims Report (or date in EOB/835) Date: _____

Original ITWS File Name: _____

ADP Batch Number (if known) claims denied in: _____

Contract Number: _____

Information of Resubmission Claims:

ITWS File Name (new) of resubmission: _____

- file name should be for same claim year & month as original
- file name should have the next, unique sequence number

Claim Mo/Yr (per Batch #): _____ Program Codes: _____

Provider Number(s): _____

Service Code(s): _____

Total Units of Service being resubmitted: _____

Total Records being resubmitted: _____

Total Amount of Resubmission file: _____

ADP-FMAB Analyst Processing Information

Resubmission (new) Batch Number: _____

Original ADP Batch Number (if not included above): _____

DHCS CutOff date claims are resubmitted/scheduled for : _____

Instructions for Completing Resubmission Form

1. Write in, at the top of the form, the fiscal year of the denied services being resubmitted.
2. Write in the date the claims were denied; this is the date the claims were adjudicated/denied, per the Denied Claims Report, or the 835P/EOB file's denied date.
3. Write in the ITWS file name the original 837P claims were submitted in on ITWS. This is not the file name of the Resubmission 837P to be resubmitted.
 - All denied claims being resubmitted in a single ITWS file must have been submitted and denied from the same Original 837P.
4. Write in the Batch Number, if known, of the denied claims; this may be found on the Denied Claims Report or in the EOB file.
 - Batch Number is assigned by ADP for processing;
 - Batch Number is not included in the 835P;
 - If unknown, must include the ITWS file name of original 837P (see #3 above).
5. Write in the Contract Number that is applicable for the fiscal year, service year and month of the denied claims.
6. Write in the file name of the new 837P file to be uploaded to submit the Resubmission of denied claims. This should have the same year and month as the original 837P file, but with the next unique sequence number.
7. Write in the claim/service year and month of the claims being resubmitted; this should match the claim/service year of the original 837P or in the Batch Number the claims were denied under.
8. Identify all Program Codes of the denied services being resubmitted in the same ITWS 837P claim file.
9. Identify the Provider Number(s) that the services are being resubmitted for in the same ITWS 837P claim file.
10. Identify the service codes of the denied claims being resubmitted.
11. Identify the total units being resubmitted in the 837P claim file; this is for all providers, program codes, and service codes in the one identified ITWS file.
12. Identify the total number of records for all of the denied claims being resubmitted.
13. Identify the total amount being billed for the denied claims being resubmitted.
14. Do not write below the asterisks; that area is for FMAB processing information.

Do not submit an additional ADP 1592 Summary Invoice for Resubmissions. The invoice, billing documentation, was submitted with the upload of the original claims that were denied and are now being resubmitted.

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Short-Doyle Medi-Cal Phase II - Overview

The purpose of the change to the new system is because the current Phase 1 system does not comply with federal HIPAA requirements. The SD/MC Phase II will replace the current Phase I system for processing Drug Medi-Cal Claims.

Collaborative effort between ADP, DMH, and DHCS

Previous changes in preparation to SD/MC Phase II
2/1/08 NPI Only Implementation
5/1/08 Warrant information on the 835

Beta Testing will begin in Sept/Oct 2009

ADP targeted cut-over date is sometime in February 2010

What Phase II does:

- Remove the proprietary translator needed for processing Drug Medi-Cal Claims.
- Brings Federal mandated HIPAA compliance

What to look for:

- Week of March 23, 2009 there will be an information packaged distributed through ITWS.
 - Project Schedule Overview
 - Claims Process Overview
 - Phase II Data Conversion Overview
 - Phase I Claim Resubmission Requirement
 - Phase I to II Transition Tactics
 - Phase II and Cost Settlement Information
 - Phase II Testing
 - Phase II Good Cause Requirements
 - Phase II Documentation (what, when, and where to find it)

Where to find more information:

- <http://www.adp.ca.gov/hp/hipaa.shtml>
- HIPAA1@adp.ca.gov - for additional questions and information

Jeffrey Trapnell

From: ITWS Admin [itws@adp.state.ca.us]
Sent: Friday, February 27, 2009 4:48 PM
To: Jeffrey Trapnell
Subject: Update to SD/MC Phase II Schedule Extension

ADP SD/MC Counties and Trading Partners:

This email provides the latest information related to the Short-Doyle/Medi-Cal Phase II (SD/MC II) schedule extension.

Recently, the State notified counties and trading partners that the implementation date of the new SD/MC II system is being extended. The Department of Alcohol and Drug Programs (ADP), Department of Mental Health (DMH), and Department of Health Care Services (DHCS) have drafted a new project schedule that will allow time for counties and trading partners to make necessary system modifications, to test thoroughly, and to transition to the new SD/MC II system.

Following are some significant activities and timeframes in the proposed schedule.

- Beta Testing for vendors and some counties is anticipated to occur in September and October 2009.
- County/Trading Partner Testing and Implementation activities are slated to occur from November 2009 through late February 2010.
- The Phase I system is scheduled to be shut off in late February 2010.

Counties and trading partners will receive an overview of the updated implementation plan, and will be given an opportunity to provide input into the new plan. Towards that end, ADP, DMH, and DHCS are compiling a SD/MC II information package which will be distributed the week of March 23, 2009. Meetings will be scheduled (dates and locations still being determined) to review and discuss the package contents. It is also anticipated that the information package will be discussed at other forums/venues (e.g. CMHDA, CADPAAC). The information package will cover the following topics:

- Project Schedule Overview
- Claims Process Overview (submission to receiving 835)
- Phase II Data Conversion Overview
- Phase I Claim Resubmission Requirement
- Phase I to II Transition Tactics
- Phase II and Cost Settlement
- Phase II Testing
- Phase II Good Cause Requirements
- Phase II Documentation (what, when, and where to find it)

Please share this update with your program and IT staff and vendors.

Sincerely,

3/4/2009

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DMC Cost Reports for Short-Doyle Medi-Cal Phase 2

The transition to the Short-Doyle Medi-Cal Phase 2 (SDMC-P2) system for processing Drug Medi-Cal (DMC) claims will not affect the reporting of costs in the Negotiated Net Amount (NNA) / DMC County Cost Reports or the DMC Direct Provider Cost Reports. ADP trading partners (counties and direct providers) do need to be aware, however, of impacts how the changes in the billing system impact the reporting of unit counts in the cost reports.

For each Drug Medi-Cal provider (by DMC number, including the parent and associated satellite locations, if any), service (ODF Group Counseling, ODF Individual Counseling, Day Care Rehabilitative, Perinatal Residential, Narcotic Treatment Program), and program (Perinatal or Non-Perinatal) combination, providers must report Submitted, Denied, and Adjusted units for each Title XIX (federally funded) and Minor Consent (state funds-only) clients on the Drug Medi-Cal worksheets that accompany the cost report. This document provides information on the meaning of these categories and their relation to billing information. Information is provided for relating cost report information to the SDMC-P2 billing information, as well as notes for the special issues that will arise in FY 2009-2010 cost reports which will involve both SDMC-P1 and SDMC-P2 billing information.

Submitted Units

Submitted units are the total number of distinct units of service that were actually provided by the provider and submitted for DMC adjudication.

SDMC-P2 Billing Information

When reporting units processed by SDMC-P2 on the cost report, submitted units include the total number of units submitted in Original claims, *plus* the total number of units submitted on Replacement claims, *minus* the total number of units submitted on claims that were subsequently replaced or voided.

FY 2009-2010 Bridge-Year Considerations

For FY 2009-2010, submitted units include those units processed by SDMC-P2 described above, *plus* the units submitted on SDMC-P1 Original and Resubmission claims, *plus* the number of units submitted on Bridge Resubmission claims, *minus* the number of units denied on SDMC-P1 claims for which Resubmission or Bridge Resubmissions were submitted.

Denied Units

Denied units are the total number of distinct units of service that were provided by the provider, submitted for DMC adjudication, and denied.

SDMC-P2 Billing Information

When reporting units processed in SDMC-P2 on the cost report, denied units include the total number of units reported as denied on 835 Health Care Claim Payment/Advice transactions issued by SDMC-P2, *minus* the total number of denied units on claims that

were later replaced or voided. Note that in any circumstances where information on more than one 835 has been received for the same claim, only the information on the most recent 835 should be considered. Also note that trading partners should submit Void claims for any claims denied which do not represent distinct services that were provided (for instance, if claims for the same service were inadvertently submitted twice, the second submission would usually be denied because the second identical service was not permitted; this denied claim should be voided) because in cost report settlement, ADP will consider unvoided denied claims to represent services that were provided and which must therefore be funded by non-DMC funds in the cost report.

FY 2009-2010 Bridge Year Considerations

For FY 2009-2010, denied units include those units processed in the Phase II system described above, *plus* the number of units reported as denied on SDMC-P1 835 transactions, *minus* the total number of units denied on SDMC-P1 claims for which Resubmission or Bridge Resubmission claims were submitted. Additionally, because it is not possible to void units in the Phase 1 system, trading partners will need to identify in cost report documents the number of Phase 1 denied units that do not correspond to distinct services that were provided.

Adjusted Units

Adjusted units are units that are approved in the billing system, but which have been identified as being improperly approved and which are therefore denied external to the billing system. In SDMC-P1, these include claims identified by ADP as erroneous and recouped via the Post-Service Post-Payment (PSPP) reviews conducted by ADP's Licensing and Certification Division, and claims identified by trading partners as having been billed incorrectly and adjusted via the submission of ADP 5035C forms. Because SDMC-P2 supports ADP-initiated adjustments and trading-partner-initiated voiding and replacement of previously-adjudicated claims, there will not be adjusted units for claims processed in SDMC-P2.

SDMC-P2 Billing Information

Claims submitted and processed in SDMC-P2 will not be reported as adjusted units. Trading partners that determine that claims in SDMC-P2 that were approved were billed improperly should retract those claims with Void claims or correct them with Replacement claims. When PSPP review determines that claims were improperly approved, ADP will issue a new 835 through SDMC-P2 denying the improperly-billed services.

FY 2009-2010 Bridge Year Considerations

For FY 2009-2010, adjusted units will include any units processed in SDMC-P1 for which the trading partner has submitted ADP 5035C forms or which ADP's LCD has recouped through PSPP reviews. ADP trading partners are advised that they should continue to report any claims discovered to be erroneous that were submitted in the SDMC Phase 1 system on ADP 5035C forms, even after SDMC-P2 is in place, since SDMC-P1 claims cannot be voided or replaced through SDMC-P2.

Attachments

Included with this document are:

- An illustrative sample of cost report unit calculations for the Bridge Year (FY 2009-2010).

Additional information with respect to Thursday conference calls, release of documents and general updates can be found at:

[https://mhitws.cahwnet.gov/systems/sdmc/docs/public/short_doyle - medical phase ii.asp](https://mhitws.cahwnet.gov/systems/sdmc/docs/public/short_doyle_-_medical_phase_ii.asp)

Additional information to follow in the next 30 days

- Examples of how those unit calculations would be used to populate the appropriate unit of service fields on the cost report documents, with one sample showing Narcotic Treatment Program (NTP) forms, and the other showing Daycare Rehabilitative forms as a representative of the non-NTP forms, which use similar structure. The sample forms are based on the forms used for FY 2007-2008.
- A crosswalk between the cost report program and service codes and code sets used in the SDMC-P1 billing system and the code sets used in the SDMC-P2 system.

FY 2009-2010 Cost Reporting
DMC Unit Calculations for cost reporting on DMC Forms (Excel Workbook) - County Version

1st Reporting Period 2nd Reporting Period Total FY 2009-2010
July-September October-June July-June

	1st Reporting Period July-September	2nd Reporting Period October-June	Total FY 2009-2010 July-June	
Submitted Units:				
A	82	28	110	Phase 1 submitted original, supplemental, and resubmitted units (include Minor Consent)*
B	0	374	374	Phase 2 submitted original, supplemental, and resubmitted units (include Minor Consent)*
C	-1	-3	-4	Less Phase 1 resubmitted units
D		-5	-5	Less Phase 2 resubmitted units
E	0	-17	-17	Less Phase 2 replaced units
F	0	-25	-25	Less Phase 2 void units submitted
G	0	12	12	Plus Phase 2 replacement units submitted
	81	364	445	Net total submitted units reported on DMC form data entry worksheet
H	-3	-5	-8	Less Phase 1 Minor Consent
I	0	-34	-34	Less Phase 2 Minor Consent**
	0	0	0	Less Phase 1 Non-Minor Consent eligible for 100% State General Fund (SGF) reimbursement
	0	0	0	Less Phase 2 Non-Minor Consent eligible for 100% State General Fund (SGF) reimbursement
J	78	325	403	Net total submitted units reported on DMC form data entry worksheet (exclude Minor Consent)

	1st Reporting Period July-September	2nd Reporting Period October-June	Total FY 2009-2010 July-June	
Denied Units:				
K	44	55	99	Phase 1 denied units (including Minor Consent units and resubmitted units that were denied)*
L	0	116	116	Phase 2 denied units (including resubmitted, replacement, and PSPP units that were denied)*
M	-3	-5	-8	Less Phase 1 Minor Consent
N	-1	-3	-4	Less Phase 1 resubmitted units (note: to offset original denied units)
O				
P	0	-5	-5	Less Phase 2 resubmitted units (to offset denied units in Phase 1)
Q				
R	0	-12	-12	Less Phase 2 voided denied units
S	0	-9	-9	Less Phase 2 replaced denied units
T				
U				
V	40	137	177	Net total denied units (breakout shown below):
W	39	135	174	Net total denied units reported on DMC form data entry worksheet- for DMC Regular
X	1	2	3	Net total denied units reported on DMC form data entry worksheet- for Minor Consent
Y	0	0	0	Net total denied units reported on DMC form data entry worksheet- for Non-Minor Consent 100% SGF

Z Denied units included in "Net total denied units" above for which services were not provided (if any)

	1st Reporting Period July-September	2nd Reporting Period October-June	Total FY 2009-2010 July-June	
Adjusted Units (refer to note below)				
AA	1	2	3	Phase 1 Units Adjusted via Form 5035C
AB	4	5	9	Phase 1 Units Adjusted due to PSPP
AC	5	7	12	Net total adjusted units (breakout shown below):
AD	3	5	8	Net total adjusted units reported on DMC form data entry worksheet- for DMC Regular
AE	2	2	4	Net total adjusted units reported on DMC form data entry worksheet- for Minor Consent
AF	0	0	0	Net total adjusted units reported on DMC form data entry worksheet- for Non-Minor Consent 100% SGF

	1st Reporting Period July-September	2nd Reporting Period October-June	Total FY 2009-2010 July-June	
Minor Consent Units submitted:				
AG	3	5	8	Phase 1 Minor Consent units submitted (note: Minor Consent in Phase 1 is reported as denied units for Title XIX)
AH	0	34	34	Phase 2 Minor Consent units submitted (note: Minor Consent in Phase 2 is reported as approved units)**
AI	3	39	42	Total Minor Consent Units reported on all DMC service forms on the data entry worksheet as submitted except for NTP forms. For NTP forms, the entry for column "Minor Consent Non-Title XIX" is Minor Consent units submitted, less Minor Consent units denied, less Minor Consent adjustments (i.e., 42 units submitted - 3 units denied - 4 units adjusted = 35 units approved) (AI - X - AE).

	1st Reporting Period July-September	2nd Reporting Period October-June	Total FY 2009-2010 July-June	
Non-Minor Consent 100% SGF Units submitted:				
AJ	0	0	0	Phase 1 non-Minor Consent 100% SGF units submitted (note: non-Minor Consent 100% SGF in Phase 1 is reported as denied units for Title XIX)
AK	0	0	0	Phase 2 non-Minor Consent units submitted (note: non-Minor Consent in Phase 2 is reported as approved units)**
AL	0	0	0	Total non-Minor Consent 100% SGF Units reported on all DMC service forms on the data entry worksheet as submitted except for NTP forms. For NTP forms, the entry for column "Other Non-Title XIX" is non-Minor Consent 100% SGF units submitted, less non-Minor Consent 100% SGF units denied, less non-Minor Consent 100% SGF adjustments (i.e., like the calculation for Minor Consent above) (AL - Y - AF).

AM Approved Title XIX units (J-W-AD)

<input type="text" value=""/>	= unit count required on all DMC service forms (Excel workbooks) on the data entry worksheet
<input type="text" value="XX"/>	= unit count required on all DMC service forms (Excel workbooks) on the data entry worksheet except DMC NTP service forms
<input type="text" value=""/>	= unit count required on only DMC NTP service forms (Excel workbooks) on the data entry worksheet

*Note: Trading Partners can determine if their claims were submitted in Phase 1 or Phase 2 based on the claim submission date.

**Note: Aid codes, the CIN, the County of Responsibility, an EPSDT indicator and the file-name of the transaction file will all be provided on the 835 in Loop 2100: Corrected Patient/Insured Name, NM109.