



Department of Alcohol & Drug Programs

Companion Guide Appendix

May 18, 2009

Version 3.0

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1.0 Change Record

Version	Author	Date	Changes, Comments
Version 1.0		11/07/2008	Original
Version 2.0		1/16/2009	<ul style="list-style-type: none"> - Updated Adjustment Reason Codes - Added PLB Adjustment Table - Updated Void & Replace Scenarios - Added Submitting Files to ADP section - Added PLB Segment Information - Added 277U Information
Version 3.0		5/18/2009	<ul style="list-style-type: none"> - Revised File Naming Conventions - Finalized Adjustment Reason Codes List - Included Additional Void and Replacement Scenario for Split Claims - Added Split Claims Information Section - Added EPSDT Information Section - Added Additional 835 Data Section

2.0 Submitting files to ADP

2.1 Preparing Files for Upload

- Files must be named using the following naming convention.
ADP-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].DAT for the unzipped ASCII file (also referred as internal file)
ADP-[CC or DDDD]-[TXN]-[MMDDYYYY]-[NNN].ZIP for the compressed zip file (also referred as external file).
 - CC = County Code or DDDD = Direct Provider Code.
 - TXN = 837P or 276
 - MMDDYYYY = EDI file submission date from county, MONTH/ DAY/ YEAR
 - NNN = Any three digit number to maintain a unique file name
- The external zip file name must match the internal ASCII filename (except for the file extension)
- The zipped file must contain only one internal file.
- The zipped file must be password protected using the standard password. The standard password is available in the ITWS “System Messages” section of the system.

2.2 Uploading EDI Files via ITWS

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

3.0 Submitter’s EIN – ISA06, GS02

ISA06 and GS02 are required data elements that will be strictly enforced by checking to make sure they are correct based on the ITWS submitter. The Interchange Sender ID must be the county’s or direct provider’s EIN, which will be verified and the claim will be denied if incorrect.

4.0 Split Claims

When a claim is submitted with multiple service lines, the situation may arise where one or more of the service lines are approved, while the remaining service lines may be denied. In order to provide timely notification to submitters regarding denied service lines SDMC Phase 2 will automatically split claims of this nature and return back the denied service lines immediately. The approved service lines will continue in the payment cycle. This process is best described by an example.

4.1 Split Claim Example

A claim is submitted with four service lines (A, B, C, and D). Service lines A and C are denied, while B and D are approved. Within the SDMC Phase 2 system two claims are created from the single claim submitted: one approved claim (with services Band D) and one denied claim (with services A and C). Notification of the denied claim is returned to the submitter via an 835 transaction. The approved claim continues in the payment cycle until payment information is sent to the submitter via the 835 transaction.

4.2 Claims with One Service Line

Split claiming would not apply to claims submitted with only one service line.

4.3 Split Claims and Void and Replace

Claims that have been split can be subsequently voided or replaced per existing void and replacement functionality. A separate Payer Claim Control Number (PCCN) is supplied for both of the split claims. A detailed scenario is included in section 12.3.

5.0 Claim Supplemental Information - PWK Segment

The PWK segment, Claim Supplemental Information, on the 837 is used to identify that the claim requires manual review of eligibility documentation. This will allow ADP to identify claims that need additional information sent, hold the claim until the paperwork is received, and to complete a manual override of a claim.

6.0 EPSDT Information

Per the 837P HIPAA Implementation Guide, submitters are required to populate the EPSDT Indicator (Loop 2400 SV111) if *“Medicaid services are the result of a screening referral.”* Submitters should be aware that SDMC Phase 2 does not use this field during adjudication. SDMC Phase 2 adjudication uses the aid code of the beneficiary as the basis for determining whether the claim is classified as being EPSDT or not. The result of this determination is returned to the submitter on the 835 (Loop 2100, Segment NM1*74 – Corrected Patient/Insured Name, field NM109).

7.0 Payer Claim Control Number

Every claim reported on an 835 or 277 transaction will identify a Payer Claim Control Number (PCCN) in the fields described for that purpose in the appropriate Implementation Guide. The PCCN is the unique ID for the claim in ADP’s system.

8.0 Provider Level Adjustments - PLB Segment

In Phase II, the PLB segment in the 835 will be used to convey provider level adjustment information. Provider level adjustments occur when there is a blanket reduction at the provider level that cannot be tied to a specific claim line or service line amount. For example, ADP may make PLB adjustments during cost settlement, an audit or a legal attachment (such as from an IRS levy). These adjustments are not tied to a specific claim or service line amount, but they are tied to a provider. The table containing all PLB adjustments is in section 14.4 on page 21.

9.0 277 Unsolicited Claim Status Information

The 277U is an unsolicited claim status transaction. This means that the 277U will be sent without the trading partner requesting it to be sent. For ADP, a 277U will be sent based on three business rules: (1) Awaiting manual override – immediately after status occurs. (2) Awaiting fax validation after 7 days from the date the file was uploaded to ITWS. (3) Awaiting payment information – immediately after the claim is adjudicated and approved.

10.0 Additional 835 Data

ADP will make use of the 835 to communicate a number of pieces of information that Trading Partners may find helpful.

In the 835 2100 Loop, Segment NM1*74 Corrected Patient/Insured Name, Data Element NM109, the following information will be provided:

- County Code (2 bytes alphanumeric) – the county code of the submitting county.
- Approved Aid Code (2 bytes alphanumeric) – the aid code used to adjudicate the claim.
- CIN (9 bytes alphanumeric) – the CIN of the beneficiary on the claim.
- County of Responsibility (2 bytes alphanumeric) – the county code of the county identified on MEDS as being responsible for the beneficiary.
- EPSDT Indicator (1 byte alphanumeric) – indicates whether the claim was identified as an EPSDT claim or not. This field is determined during adjudication and is based upon the aid code of the beneficiary. Valid values are “Y” or “N”.
- Submission File Name (37 bytes alphanumeric) – the file name of the 837 submission file on which this specific claim was submitted on. ITWS appends the actual date of submission to the front of the file name (file naming conventions are described in section 2.1).

11.0 Void Claims

A void claim allows Counties and Direct Providers to request that ADP treat a previously-approved claim as null and void. Trading partners should void claims when the trading partner identifies that a claim that was submitted and paid should not have been billed to Drug Medi-Cal. If some of the claim information was inaccurate, but the claim should still have been billed, see Replacement Claims below.

Claims can only be voided when they have been approved and finalized (that is, when an 835 has been issued indicating the claim is approved and paid or approved but payment deferred.) The voiding claim is identified with a Claim Frequency Type Code (CLM05-3) of “8”. The PCCN of the claim being voided must be placed as data element REF02 in the Original Reference Number segment of the voiding claim. Once a claim has been voided, it cannot be voided again, nor can it be replaced.

The Claim Payment Information (Loop 2100) reported for the Void claim on the 835 mirrors the

approved claim with the exception of all dollar, units of time, and units of service fields. Claim Payment Information (Loop 2100) will also contain the Payer Claim Control Number of the voiding claim as an Original Reference Number for the voided claim, to indicate why the voided claim was being reversed. These fields will be the negative of the original approved claim. The only exception to this rule is the Maximum Allowed Amount, which will remain positive.

12.0 Replacement Claims

A replacement claim allows Counties or Direct Providers to replace a previously finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835 transaction) claim. Trading partners should replace claims when they have identified either that the previously-submitted claim was submitted with incorrect information, or that service lines were erroneously included in or omitted from the claim.

The replacement claim is identified with a Claim Frequency Type Code (CLM05-3) of "7". The PCCN of the claim being replaced must be placed as data element REF02 in the Original Reference Number segment of the replacement claim. The successful replacement of an original approved claim will create a system-generated transaction that is similar to a void. The replacement claim will be adjudicated as an original claim, except that it will retain the original received date. All replacement claims will be reported on the 835.

13.0 Void and Replacement Scenarios

Following are a number of scenarios that describe specific data elements on both the submitted 837 and the corresponding 835 transaction involved in Void and Replacement transactions.

13.1 Key Data Elements

Key data elements used in the scenarios are listed below, along with a description of their purpose.

HEADING	TXN	DESCRIPTION
Seq. #	N/A	Number assigned to each transaction in the scenario indicating sequence of events.
Txn		Identifies which transaction is being represented
CLM05-3 (Claim Type)	837	Identifies the transaction as an original (1), replacement (7), or void (8) (other valid values are 2,3 or 4 each is treated as not being a replacement or a void claim)
Claim Amount	837 (*)	Representative of the value of the claim.
Services	837 (*)	Reflects the presence of one more service in alphabetical increments (A = service 1, B = service 2, etc.)
Units of Service	837	Identifies the units of service (SV104 for Professional)
Rec. Date	837 (*)	The claim received date via ITWS.
Calc. Date	837 (*)	The date the target claim was received by the State. This feature, pertaining only to replacement claims, allows those claims to preserve the original claim's received date.
CLM01	837	This is the Unique ID submitted for the claim. This number is NOT used for Void and Replacement processing.

ORN	837	The Original Reference Number is Payer Claim Control Number from the 835 of the target claim. Every void or replacement claim is matched to its target using the ORN.
Adjudication Result	N/A	The status assigned to the claim as a result of processing (App = Approved, Den = Denied, V = Void). To build the scenarios, the status is important for the next step, not the reason for the status; therefore, no reasons for denied claims are included.
835 Date	835 (*)	Representative of when the 835 was produced.
CLP01	835	This is Claim Submitter’s Identifier (Unique ID) on the 835 that is echoed back from CLM01 value submitted on the 837.
CLP02	835	The status of the claim as reported on the 835 (1 = Approved, 4 = Denied, 22 = Reversal)
CLP03	835	Total Claim Charge Amount – the amount billed on the claim.
CLP04	835	Claim Payment Amount – the amount actually to be paid.
CLP07	835	This is the Payer Claim Control Number generated by the claims processing system for each approved or denied claim. The number is used in the Original Reference Number segment for void and replacement claims.
SVC05	835	Number of units paid.

Negative numbers are enclosed by parentheses (nn)

* Not an actual implementation guide defined field, representational use only.

13.2 Original Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$100	A	4	4/1/09	4/1/09	3456		Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	4/2/09	3456	4	\$100	\$0	8881	0

13.3 Original Approved, Void Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$100	A	4	4/1/09	4/1/09	123		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	123	1	\$100	\$100	9991	4

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
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3	837	8	\$100	A	4	6/1/09	6/1/09	333	9991	Approved
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Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	333	22	(\$100)	(\$100)	9991	(4)

13.4 Void Denied

Using the scenario 12.3 as a basis, a Void is submitted to void transaction #9991 when it is already in a voided state.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	8	\$100	A	4	7/1/09	7/1/09	323	9991	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	7/2/09	323	4	\$100	\$0	9994	0

13.5 Original Approved, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$100	A	5	4/1/09	4/1/09	456		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	\$100	\$100	7771	5

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	\$150	A	8	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	(\$100)	(\$100)	7771	(5)
4	835	7/1/09	333	1	\$150	\$150	7772	8

13.6 Original Approved, Replacement Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$200	A	1	4/1/09	4/1/09	678		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP04	CLP07	SVC05
2	835	5/1/09	678	1	\$200	5551	1

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	\$175	A	3	6/1/09	4/1/09	679	5551	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	678	22	(\$200)	(\$200)	5551	(1)
4	835	7/1/09	679	4	\$175	\$0	5552	0

13.7 Replacement of a Denied Claim

Using the result of scenario 12.6, a replacement claim is submitted to replace the claim that was denied.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	7	\$125	A	1	7/15/09	4/1/09	680	5552	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	8/15/09	680	1	\$125	\$125	5553	1

13.8 Original Approved with Multiple Service Lines, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$250	A B	2 3	4/1/09	4/1/09	456		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	\$100	\$100	7771	A = 2 B = 3

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	\$275	A C D	2 2 1	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	(\$250)	(\$250)	7771	A = (2) B = (3)
4	835	7/1/09	333	1	\$275	\$275	7772	A = 2 C = 2 D = 1

13.9 Original with Multiple Service Lines Approved, Replacement Approved

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$250	A - \$100 B - \$150	2 3	4/1/09	4/1/09	456		A = Approved B = Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	456	1	\$250	\$250	7771	A = 2 B = 3

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM 01	ORN	Result
3	837	7	\$250	A - \$100 B - \$150	2 2	6/1/09	4/1/09	333	7771	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	7/1/09	456	22	(\$250)	(\$250)	7771	A = (2) B = (3)
4	835	7/1/09	333	1	\$250	\$250	7772	A = 2 B = 2

13.10 Original Approved, Voided, and Replacement Denied

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$200	A	1	4/1/09	4/1/09	678		Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	5/1/09	678	1	\$200	\$200	5551	1

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	8	\$200	A	1	4/1/09	4/1/09	679	5551	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	5/1/09	679	1	(\$200)	(\$200)	5551	(1)

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
5	837	7	\$225	A	3	6/1/09	4/1/09	680	5551	Denied

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
6	835	6/2/09	680	4	\$225	\$0	5552	0

13.11 Replacement of a Denied Claim

Using the result of scenario 12.10, a replacement claim is submitted to replace the claim that was denied.

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
7	837	7	\$225	A	4	7/15/09	4/1/09	680	5552	Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
8	835	8/15/09	680	1	\$225	\$225	5553	1

13.12 Original Partially Approved, Claim Split, Replacement of Denied Services

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
1	837	1	\$385	A - \$100 B - \$150 C - \$75 D - \$60	2 3 3 1	4/1/09	4/1/09	9876		A = Approved B = Denied C = Denied D = Approved

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
2	835	4/2/09	9876	4	\$225	\$0	7501	B = 0 C = 0

Seq. #	Txn	CLM05-3	Claim Amount	Services	Units	Rec. Date	Calc. Date	CLM01	ORN	Result
3	837	7	\$225	B - \$150 C - \$75	4 3	4/09/09	4/1/09	9888	7501	Approved (B & C)

Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
4	835	5/1/09	9876	1	\$160	\$160	7505	A = 2

								D = 1
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Seq. #	Txn	835 Date	CLP01	CLP02	CLP03	CLP04	CLP07	SVC05
5	835	5/15/09	9888	1	\$225	\$225	7509	B = 4 C = 3

14.0 Unique ID

A Unique ID is required for each service line. The identification for each service line is the Line Item Sequence Number (LX01 in Loop 2400). In the 837P, if the Line Item Control Number (REF02 in Loop 2400) is populated, the SD/MC Phase 2 system will echo this service line identifier back on the corresponding 835 transaction, otherwise, the value from LX01 will be used on the 835.

The Line Item Sequence Number must begin with 1 for the first service line, and be incremented by one for each succeeding service line.

The Line Item Control Number (located in Loop 2400, REF Segment) may consist of any combination of upper and lower case characters. The system converts all characters to upper case for purposes of matching and duplicate edits. The remaining characters must be alphanumeric or any of the American Standard Code for Information Interchange (ASCII).

15.0 Crosswalk Mappings and Other Tables

15.1 Table A - Delay Reason Code

HIPAA Delay Reason Code	HIPAA Descriptions	Description
1	Proof of Eligibility Unknown or Unavailable	Patient or legal representative's failure to present Medi-Cal identification
7	Third Party Processing Delay	Billing involving other coverage including, but not limited to Medicare, Ross-Loos or CHAPMUS
8	Delay in Eligibility Determination	Circumstances beyond the control of the local program/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county.
4, 11	4 = Delay in Certifying Provider 11 = Other	Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances

HIPAA Delay Reason Code	HIPAA Descriptions	Description
		that have been reported to the appropriate law enforcement or fire agency, when applicable.
10	Administrative Delay in Prior Approval Process.	Special circumstances that cause a billing delay such as a court decision or fair hearing decision.
2	Litigation	Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC).
		Do not override late billing

15.2 Table B - 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

15.2.1 Applying the “Fifth Digit”

The ICD-9-CM augments the DSM III/IV determination by requiring a fifth digit indicating the client's pattern of use. The available “fifth digits” and corresponding patterns of use are indicated in the following table:

Code	Pattern of Use	Alcohol Use	Drug Use
0	Unspecified	Not specified in documentation.	Not specified in documentation.
1	Continuous	Daily intake of large amounts of alcohol or regular heavy drinking on weekends or days off from work.	Daily, or almost daily, use of drugs.
2	Episodic	Alcoholic binges lasting weeks or months followed by long periods of sobriety.	Short periods between drug use, or use on weekends.
3	Remission	A complete cessation of alcohol intake or a period of time during which a decrease toward cessation is taking place.	A complete cessation of drug intake or a period of time during which a decrease toward cessation is taking place.

The following table provides a comparative illustration of ICD-9 fifth digit parameters with DSM III fifth digit parameters. The DSM III fifth digit definitions are not distinct for alcohol use and drug use.

Code	Course/ Pattern of Use ¹	DSM III/IV Definition	ICD-9 Definition	
			Alcohol Use	Drug Use
0	Unspecified	Course unknown or first signs of illness with respect to course uncertain.	Not specified in documentation.	Not specified in documentation.

Code	Course/ Pattern of Use ¹	DSM III/IV Definition	ICD-9 Definition	
			Alcohol Use	Drug Use
1	Continuous	More or less regular maladaptive use for over six months.	Daily intake of large amounts of alcohol or regular heavy drinking on weekends or days off from work.	Daily, or almost daily, use of drugs.
2	Episodic	A fairly circumscribed period of maladaptive use, with one or more similar periods in the past.	Alcoholic binges lasting weeks or months followed by long periods of sobriety.	Short periods between drug use, or use on weekends.
3	Remission	<p>Previous maladaptive use, but not using substance at present.</p> <p>The differentiation of remission from no longer ill and from the other course categories requires consideration of the period of time since the last period of disturbance, the total duration of the disturbance and the need for continued evaluation for prophylactic treatment.</p>	A complete cessation of alcohol intake or a period of time during which a decrease toward cessation is taking place.	A complete cessation of drug intake or a period of time during which a decrease toward cessation is taking place.

1 - The DSM-III uses the term "Course."

15.3 Table C - Adjustment Reason Codes

Group Code	Adjustment Reason Code	Health Remark Code	Rule
CO	18	N/A	If a service line is for the same service, with same beneficiary (CIN), on same date of service as a previously approved service line in history, and combined same day services require a valid override code of 59, 76, or 77, and a valid override code is not present, then deny service line.
CO	18	M80	Lockout = Deny 2nd and subsequent service lines; O/R = Deny Service line if valid override code (59; 76; or 77) is not present or if instance exceeds two on same date.
CO	23	N/A	Coordination of benefits adjustment.
CO	29	N/A	<p>If the last day of calendar month of Dates of Service on claim is greater than 30 days, but less than 1 year, prior to receipt of the 837 transaction file (by ITWS), and a "Delay Reason Code" does not equal 1, 2, 4, 7, 8, 10, or 11 (in Segment CLM20, Loop 2300), then deny claim as "late."</p> <p>If the last day of calendar month of DOS on claim is greater than 1 year prior to receipt of the 837 transaction file (by ITWS) and Delay Reason Code does not = "1, 2 or 10," then deny claim as "late."</p> <p>If the last day of calendar month of DOS on claim is greater than 1 year and 60 days prior to receipt of the 837 transaction file (by ITWS) and Delay Reason Code does not = 2 or 10, then deny claim as "late."</p>
CO	31	N/A	If Approved Aid Code is not a valid ADP Aid Code (per Aid Code Table), then deny claim.
CO	45	N/A	Line Item Charge Amount greater than the State Maximum Allowed.
CO	89	N/A	Claims that include Direct Provider Admin Fees as adjustments to the service lines.

Group Code	Adjustment Reason Code	Health Remark Code	Rule
CO	109	N/A	If a claim contains service lines with both Non-perinatal services AND perinatal services, deny claim. (Perinatal services contain "HD" in one of the Modifier fields, whereas Non-Perinatal services do not contain "HD" in any modifier fields).
CO	110	M52 & M59	If any date on service line is greater than transaction file receive date (ITWS), then deny service line.
CO	119	N362	<p>If service type equals NTP Counseling (Group, Individual SACPA or Perinatal) and service line units of service exceeds 20, then deny service line.</p> <p>If a service line is for NTP Counseling services (Procedure Code + Modifiers = H0004_HG, H0004_HG_H9, H0004_HD_HG, H0004_HD_HG_H9; H0005_HG, H0005_HG_H9, H0005_HD_HG, or H005_HD_HG_H9, then compare service line to all approved service lines in history for NTP Counseling (with same PC Modifiers as above), and deny service line if combined aggregate units of service for same calendar month exceeds 20 units for same beneficiary.</p>
CO	119	N345	<p>If service type equals Naltrexone (S5000 or S5001), or Day Care Rehabilitative (H0015), and units billed on service line are greater than 1, then deny service line.</p> <p>If service type equals Methadone (H0020), and the number of units billed on service line does not equal the number of days in the service date range, then deny service line.</p> <p>If a service line is for the same service, with same beneficiary (CIN), on same date of service as a previously approved service line in history, and combined same day services require a valid override code of 59, 76, or 77 (per Lockout Table), and the instance exceeds two for that date (i.e. only 1 override allowed), then deny service line.</p>
CO	129	N/A	If Beneficiary OHC Indicator on FAME response does not = 'N,' 'O,' or Null, then the Claim Filing Indicator Code (field SBR09) of 'Other Subscriber Information' (loop 2320) must equal "MB", else deny claim.

Group Code	Adjustment Reason Code	Health Remark Code	Rule
CO	138	N/A	If all dates of service on the claim are not within the same calendar month, deny claim.
CO	143	N/A	Claims that include interim settlement payments as adjustments.
CO	164	N/A	Claim denied for being in the fax validation queue longer than 30 days.
CO	167	M76	At least one of the four diagnosis code pointers (SV107 field) must point to a valid ADP Diagnosis Code (1,2,3,4,5,6,7 or 8) at claim level, else deny service line.
CO	177	N/A	If beneficiary eligibility on FAME response indicates "STATUS-FAME" = any value except '0' or '6', then deny claim.
CO	208	M51	If the combination of the Billing Provider EIN (Loop 2010AA, Element REF02) and the Billing Provider NPI (Loop 2010AA, Element NM109) on the claim, does not match the combination of the Billing Provider EIN and Billing Provider NPI in the provider file, then deny Claim.
CO	A1	M52 & M59	If service line "To date" is not greater than or equal to "From date," then deny service line.
CO	A1	N63	If a service line is not billed using a single date, then deny service line, except service lines for Methadone (Procedure Code=H0020), which can be billed using a date range or a single date of service.
CO	A1	M51	If the service line procedure code, modifier(s) or line note are not valid ADP procedure codes, modifiers or line note (per service code table), then deny service line.
CO	A1	M80	If a service line is for the same service, with same beneficiary, on same date of service as a previously approved service line in history, and combined services are not allowed in the same day, per Lockout Table, then deny service.
CO	A1	N421	Claims that include retroactive adjustments.
CO	B7	N/A	If Service Facility Location provider NPI is not eligible to provide service based on procedure code, modifier(s), place of service, and line note, on date of service, then deny service line.

Group Code	Adjustment Reason Code	Health Remark Code	Rule
CO	B7	MA114	<p>If the Service Facility Location provider NPI associated with the service line is not permitted to bill for services with the Billing Provider NPI, then deny service line.</p> <p>If Service Facility Location provider Type is 'Sole Proprietor' (TB_Provider_Entity Type Qualifier =1) and zip code +4 of Service Facility Location provider (TB_Provider Address) does not equal zip code +4 in provider file, then deny service line.</p>
PR	1	N/A	Patient Responsibility: Deductible Amount
PR	2	N/A	Patient Responsibility: Co-insurance Amount
PI	22	N/A	Payer Initiated Reduction: This care may be covered by another payer per coordination of benefits.

15.4 Table D -PLB Adjustments

Adjustment Code	Rule
LE	IRS Levy
FB	Forwarding Balance
WO	Overpayment Recovery
72	Authorized Recovery
IS	Interim Settlement
PL	Payment Final: Blanket reduction due to an audit

15.5 Table E –Service Codes

Use HD in any procedure modifier position to indicate that the service is perinatal. Do not use HD if the service is not perinatal. Use H9 in any procedure modifier position to indicate that the service is provided for the Substance Abuse and Crime Prevention Act (SACPA).

Service Group	Service	Procedure Code (Req)	Procedure Modifier 1 (Req)	Procedure Modifier 2 (Opt)
DCR	Day Care Rehabilitative	H0015	HD	
NTP	NTP-Individual Counseling	H0004	HD	HG
NTP	NTP-Group Counseling	H0005	HD	HG
NTP	NTP-Methadone	H0020	HD	HG
ODF	ODF-Individual Counseling	H0004	HD	
ODF	ODF - Group Counseling	H0005	HD	
RES	Perinatal Residential (RES)	H0018	HD	
RES	Perinatal Residential (RES)	H0019	HD	
DCR	Day Care Rehabilitative	H0015		
NAL	Naltrexone (NAL) generic	S5000	HG	
NAL	Naltrexone (NAL) brand name	S5001	HG	
NTP	NTP-Individual Counseling	H0004	HG	
NTP	NTP-Group Counseling	H0005	HG	
NTP	NTP-Methadone	H0020	HG	
ODF	ODF-Individual Counseling	H0004		
ODF	ODF - Group Counseling	H0005		

15.6 Table F -Duplicate Billing Edit Procedure Modifiers

Procedure Modifier	Modifier Description
59	Distinct Procedural Service
76	Repeat Procedure by Same person
77	Repeat Procedure by Different person