



Drug Medi-Cal Provider Billing Manual

Program Services Division

Fiscal Management and Accountability
Branch

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ABOUT THIS DRAFT

This document is a preliminary draft of the *Drug Medi-Cal Provider Billing Manual* covering the billing processes that the Department of Alcohol and Drug Programs (ADP) will have in place for Drug Medi-Cal claims to accompany the transition to the Short-Doyle Medi-Cal Phase 2 claims processing system on January 1, 2010. It is being released at this time to assist counties and providers in preparing for the transition to the new systems and processes that will be in place at that time. ADP will release additional drafts as this manual is refined.

Questions and concerns regarding this manual should be reported to ADP by email; send questions to ADP's HIPAA Branch at hipaa1@adp.ca.gov and to Chris Dicely in ADP's Fiscal Management and Accountability Branch at cdicely@adp.ca.gov.

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1. INTRODUCTION

DRAFT

1 Introduction

This manual provides information for counties and providers contracting with the California Department of Alcohol and Drug Programs (ADP) regarding the submission of claims for Drug Medi-Cal (DMC) services rendered by certified DMC providers as required by California Health and Safety Code Section 11758.46(c)(1).¹

- [Definitions of Key Terms](#)
- [About This Manual](#)
- [Program Background and Authorities](#)
- [DMC Beneficiaries](#)
- [DMC Services](#)

1.1 Definitions of Key Terms

The following terms are relevant to the information provided in this chapter and this manual:

- **County:** A county that submits DMC claims. ADP primarily contracts with counties (who in turn operate and/or contract with providers) for DMC services.²
- **Direct Provider (DP):** An alcohol and drug service provider that contracts directly with ADP and submits DMC claims. If a county refuses to contract with a DMC-certified provider, ADP will contract directly with the provider.³
- **Trading partners:** Counties and DPs that submit DMC claims.
- **Covered Entity:** According to the Administrative Simplification standards adopted by the U.S. Dept. of Health & Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),⁴ a covered entity is:⁵
 - a health care provider that conducts certain transactions in electronic form
 - a health care clearinghouse, or
 - a health plan

Additional helpful information about determining covered entity status can be found on the “Are You a Covered Entity?” page of the U.S. Dept. of Health & Human Services Centers for Medicare & Medicaid Services website.⁶

¹ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46 (2008).

² Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40 (2008).

³ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.43 (2008).

⁴ Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., 2nd sess., (Aug. 21, 1996).

⁵ 45 C.F.R., subtitle A, part 162 (current through current through Oct. 1, 2008).

⁶ U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, “Are You a Covered Entity?” http://www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp (accessed April 29, 2009).

1.2 About This Manual

1.2.1 Objectives

The objectives of the manual are to:

- Provide uniform guidance to ADP trading partners on DMC billing procedures and requirements
- Provide references to documents and sources containing information useful to ADP trading partners, including:
 - Relevant California and federal laws and regulations
 - ADP Bulletins and ADP Letters⁷
 - Other relevant reference documents

1.2.2 Scope

This manual provides information about processes and procedures related to DMC billing. For detailed information on the format and content of the electronic claims, remittance advices, status request/response transactions and unsolicited claims status used in the DMC billing process, consult the companion guides posted on the “HIPAA Privacy and Security” page of the ADP website.⁸ The companion guides supplement the information in the corresponding Accredited Standards Committee (ASC) X12N Implementation Guides.

1.3 Program Background and Authorities

1.3.1 Medicaid Program

Medicaid is a federal program established in 1965 as Title XIX of the Social Security Act designed to enable states to furnish medical assistance to families with dependent children, as well as aged, blind, and disabled individuals who lack the financial means to meet the cost of necessary medical services, and to provide rehabilitative and other services to such families and individuals.⁹ Under Medicaid, each participating state must establish a state plan for medical assistance possessing certain mandatory features.¹⁰ The federal government pays a portion of the eligible costs of covered services (the Federal Medical Assistance Percentage or FMAP) with the remainder paid by the state.¹¹ FMAP is calculated annually by state based on the *per capita* income of the state compared to that of the United States as a whole.

⁷ Cal. Dept. of Alcohol and Drug Programs, “Bulletins & Letters,” http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml (accessed April 29, 2009).

⁸ Cal. Dept. of Alcohol and Drug Programs, “HIPAA Privacy & Security,” <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

⁹ 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

¹⁰ 42 U.S.C. chap. 7, subchap. XIX, §1396a(a) (current through Jan. 3, 2007).

¹¹ 42 U.S.C. chap. 7, subchap. XIX, §1396(b) (current through Jan. 3, 2007).

1.3.2 California Medical Assistance Program (Medi-Cal)

Medi-Cal,¹² administered by the Department of Health Care Services (DHCS), includes California's participation in the federal Medicaid program.

1.3.3 Drug Medi-Cal

With the broader Medi-Cal program, ADP administers the Medi-Cal Drug Treatment program also known as Drug Medi-Cal (DMC). DMC provides reimbursement to certified providers of specified substance abuse treatment services to Medi-Cal beneficiaries.¹³ ADP primarily contracts with counties (who in turn operate and/or contract with providers) for DMC services,¹⁴ but if a county refuses to contract with a DMC-certified provider ADP will contract directly with the provider for DMC services.¹⁵

1.3.3.1 Privacy, Security, and Confidentiality and DMC Client Information

The federal Public Health Service Act and related regulations provide for strict confidentiality of patient records in substance abuse programs, including the DMC program, allowing disclosure only in specific circumstances and providing for criminal penalties for violations.¹⁶

In addition, HIPAA and the regulations implementing it have established rules to ensure the privacy and security of all patient medical records (not just those of patients in substance abuse programs).¹⁷

The privacy rule prohibits the use and disclosure of protected health information (PHI) by health plans, health care providers, and other covered entities except as specifically permitted.¹⁸ Even for purposes where use or disclosure of PHI is permitted, the rule in most cases requires that the covered entity "make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose."¹⁹

The security rule requires each covered entity to "(1) Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits," to "(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information," to "(3) Protect against any reasonably anticipated uses or disclosures of such information that are not permitted [...]" and to ensure compliance with the security rule by the entity's workforce.²⁰

¹² Cal. Welf. & Inst. Code, div. 9, part 3, chap. 7 (2008).

¹³ Cal. Health & Safety Code, div. 10.5, chap. 3.4 (§11758.40 *et seq.*) (2008).

¹⁴ Cal. Health & Safety Code §11758.40 (2008).

¹⁵ Cal. Health & Safety Code §11758.43 (2008).

¹⁶ 42 U.S.C. §290dd-2 (current through Jan. 3, 2007); 42 C.F.R. part 2 (current through Oct. 1, 2008).

¹⁷ *Id.* at §264; 45 C.F.R. part 164, subpart C (§164.302 *et seq.*) [security rule], and 45 C.F.R. part 164, subpart E (§164.500 *et seq.*) [privacy rule] (current through Oct. 1, 2008).

¹⁸ 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(a) (current through Oct. 1, 2008).

¹⁹ 45 C.F.R., subtitle A, vol. 1, part 164, §164.502(b)(1) (current through Oct. 1, 2008).

²⁰ 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(a) (current through Oct. 1, 2008).

The security rule provides a number of implementation specifications that covered entities are required to fulfill. Some require implementation. Others require assessment and implementation when reasonable and appropriate for the particular environment or adoption of an equivalent alternative measure if one exists plus documentation of the reasons why it is not reasonable and appropriate.²¹

ADP-certified DMC providers should read ADP's "Confidentiality Statement for DMC Patient Data."²² Additional information and resources regarding HIPAA rules is available from ADP's "HIPAA Rules, Procedures, and Information" web page.²³

1.3.3.2 Health Care Transactions and Code Sets

HIPAA and its implementing regulations also require that every covered entity that performs specified business transactions electronically must use specified standard transactions, code sets, and identifiers.²⁴ The transactions which ADP, in the DMC program, conducts electronically for which standard transactions exist and the applicable standards are:

- Professional health care claims (all DMC claims): ASC X12N 837—Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098, and Addenda to Health Care Claims: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.²⁵
- Health Care Claim Status (electronic requests for DMC claim status and the responses to such requests): ASC X12N 276/277—Health Care Claim Status Request and Response, Version 4010, May 2000, Washington Publishing Company, 004010X093, and Addenda to Health Care Claim Status Request and Response, Version 4010, October 2002, Washington Publishing Company, 004010X093A1.²⁶
- Health Care Remittance Advice (provides information on DMC payments and denied DMC claims): The ASC X12N 835—Health Care Claim Payment/Advice, Version 4010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.²⁷

The companion guides posted on the ADP website supplement the information in the corresponding ASC X12N Implementation Guides.²⁸

²¹ 45 C.F.R., subtitle A, vol. 1, part 164, §164.306(d) (current through Oct. 1, 2008).

²² Cal. Dept. of Alcohol and Drug Programs, "Confidentiality Statement for Drug Medi-Cal Patient Data," <http://www.adp.ca.gov/dmc/pdf/confidentiality.pdf> (accessed April 29, 2009).

²³ Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

²⁴ 45 C.F.R., subtitle A, vol. 1, part 162, §162.923 (current through Oct. 1, 2008).

²⁵ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1102(b)(3) (current through Oct. 1, 2008).

²⁶ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1402(b) (current through Oct. 1, 2008).

²⁷ 45 C.F.R., subtitle A, vol. 1, part 162, §162.1602(b) (current through Oct. 1, 2008).

²⁸ ²⁸ Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

Each standard transaction implementation specification identifies the code sets which are used in the transaction. The Healthcare Common Procedure Coding System (HCPCS) used to identify clinical procedures,²⁹ and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) used to identify diagnoses, are important code sets used in standard transactions.

Standard identifiers are used to identify individuals or organizations on standard transactions. The two standard identifiers mandated under HIPAA rules are the National Provider Identifier (NPI) as the standard unique health identifier for health care providers³⁰ and the Employer ID Number (EIN)³¹ as the standard unique employer identifier.³²

The use of these identifiers in standard transactions is mandatory. Entities entering into DMC contracts with ADP must have an EIN and all DMC-certified providers must have an NPI for each certified location. Individual service providers such as counselors who are identified on standard transactions (for example as rendering providers) must also have NPIs. Both EINs and NPIs must be provided to ADP.

1.4 DMC Beneficiaries

Clients who are eligible for Drug Medi-Cal include clients eligible for federal Medicaid, for whom services are reimbursed from federal and state funds, and clients eligible for state-only Medi-Cal, for whom services are reimbursed from state funds only.

Clients may establish Medi-Cal eligibility through a number of Medi-Cal programs, and are assigned Aid Codes based on the program(s) under which they have established eligibility.³³

1.4.1 Aid Codes

The ADP Aid Code list provides useful information including:³⁴

- Aid Code and description
- Type of benefits
- Share of Cost, if any
- FFP type
- Indication of reimbursement

²⁹ U.S. Dept. of Health & Human Services, Centers for Medicare & Medicaid Services, "HCPCS General Information," <http://www.cms.hhs.gov/MedHCPCSGenInfo> (accessed April 29, 2009).

³⁰ 45 C.F.R., subtitle A, vol. 1, part 162, §162.406 (current through Oct. 1, 2008).

³¹ Also known as the Federal Tax Identification Number, see U.S. Department of the Treasury, Internal Revenue Service. "Employer ID Numbers (EINs)," January 27, 2009.

<http://www.irs.ustreas.gov/businesses/small/article/0,,id=98350,00.html> (accessed March 30, 2009).

³² 45 C.F.R., subtitle A, vol. 1, part 162, §162.605 (current through Oct. 1, 2008).

³³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2, art. 5 (§50201 *et seq.*) (current through March 6, 2009).

³⁴ SPACEHOLDER FOR ADP AID CODE LIST

1.4.2 *Minor Consent Beneficiaries*

Currently, the only state-only Medi-Cal clients eligible for DMC services are Minor Consent clients with Aid Codes 7M, 7N, and 7P. Minor Consent services are services to which a minor may consent independently and confidentially under various provisions of California law and for which their parent(s) or guardians are not held financially responsible.³⁵

1.4.3 *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Beneficiaries*

Medicaid-eligible clients under 21 years of age are also eligible under the EPSDT program, and as such are eligible for DMC services and other Medi-Cal services for which other youth may not be eligible.³⁶

1.5 **DMC Services**

The following services may be reimbursed from DMC funds when provided by certified providers in accordance with the laws and regulations governing the DMC program.

1.5.1 *Narcotic Treatment Program (NTP) Services*

“Narcotic treatment program services, utilizing methadone and/or levoalphacetyl-methadol (LAAM) as narcotic replacement drugs, including 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, medication services, and the provision of methadone and/or LAAM, as prescribed by a physician to alleviate the symptoms of withdrawal from opiates, rendered in accordance with the requirements set forth in Chapter 4 commencing with Section 10000 of Title 9, CCR³⁷ are permitted DMC services. However LAAM, formerly available in the United States under the brand name ORLAAM[®], has been withdrawn from the market by the manufacturer and at this time is not currently produced in or imported into the United States.³⁸

1.5.2 *Outpatient Drug Free (ODF) Services*

“Outpatient drug free treatment services including admission physical examinations, intake, medical direction, medication services, body specimen screens, treatment and discharge planning, crisis intervention, collateral services, group counseling, and individual counseling, provided by staff that are lawfully authorized to provide, prescribe

³⁵ Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1, §14010 (2008).

³⁶ Cal. Dept. of Alcohol and Drug Programs, “Fact Sheet: Drug Medi-Cal (DMC) Early and Periodic Screening Diagnosis and Treatment (EPSDT),” http://www.adp.ca.gov/FactSheets/EPSDT_Fact_Sheet_v4.pdf (accessed April 29, 2009).

³⁷ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(1) (current through March 6, 2009).

³⁸ U.S. Food and Drug Administration, Center for Drug Evaluation and Research, “Drug Shortage: Drug to Be Discontinued, Letter from Roxane,” <http://www.fda.gov/cder/drug/shortages/orlaam.htm> (accessed April 29, 2009).

and/or order these services within the scope of their practice or licensure” are permitted DMC services.³⁹

1.5.2.1 ODF Group Counseling

“Group counseling sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance abuse or a return to substance abuse. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month.”⁴⁰

1.5.2.2 ODF Individual Counseling

“Individual counseling shall be limited to intake crisis intervention, collateral services, and treatment and discharge planning.”⁴¹

1.5.3 Day Care Rehabilitative (DCR) Services

“Day care habilitative services including 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 that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure are permitted DMC services. Day care habilitative 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”⁴² are permitted DMC services. Note particularly that the limitation of day care rehabilitative (DCR) services to “pregnant and postpartum women and/or to EPSDT-eligible beneficiaries” means that clients who are eligible for DMC services only through Minor Consent eligibility (who are, by definition, not EPSDT-eligible) and who also are not pregnant/postpartum women, are not eligible for DCR services.

1.5.4 Perinatal Residential Services

“Perinatal residential substance abuse services including intake, admission physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide and/or order these services within the scope of their practice or licensure”⁴³ are permitted DMC services, when provided in an ADP-licensed residential facility with a treatment capacity of 16 beds or less.⁴⁴

³⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2) (current through March 6, 2009).

⁴⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2)(A) (current through March 6, 2009).

⁴¹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(2)(B) (current through March 6, 2009).

⁴² 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(3) (current through March 6, 2009); note that Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(a)(2) (current through 2008) uses the term *rehabilitative* rather than *habilitative*.

⁴³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(4) (current through March 6, 2009).

⁴⁴ *Ibid.*

1.5.5 *Naltrexone Treatment Services*

“Naltrexone treatment services including intake, admission physical examinations, treatment planning, provision of medication services, medical direction, physician and nursing services related to substance abuse, body specimen screens, individual and group counseling, collateral services, and crisis intervention services, provided by staff that are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice or licensure”⁴⁵ are permitted DMC services, but may only be provided to a beneficiary who “(A) Has a confirmed, documented history of opiate addiction; (B) Is at least (18) years of age; (C) Is opiate free; and (D) Is not pregnant.”⁴⁶

⁴⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(d)(5) (current through March 6, 2009).

⁴⁶ *Ibid.*

2. GETTING STARTED

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2 Introduction

This chapter provides the requirements that must be met before submitting claims, including:

- [Licensing and Certification of DMC Providers](#)
- [Alcohol and Drug Counselor Certification](#)
- [Contracts with ADP](#)
- [Submission and Receipt of Claims Information](#)
- [Getting Help](#)

2.1 Licensing and Certification of DMC Providers

LCD is responsible for assuring that quality services are provided to all program participants in a safe and healthful environment through the licensure, certification, regulation, and oversight of a statewide system of alcohol and other drug recovery and treatment facilities, programs and counselors.

2.1.1 National Provider Identifiers (NPIs)

Federal HIPAA regulations require that individual health care providers and organizations obtain NPIs. ADP Bulletin 07-04 explains how ADP expects DMC providers to use NPIs when submitting claims.⁴⁷ DHCS maintains a website explaining how to request an NPI.⁴⁸

Once an NPI has been obtained, trading partners must provide it to ADP so it is on file.

2.1.2 California Outcomes Measurement System (CalOMS) Number and DMC Provider Number

As part of the ADP licensing and certification process, all DMC-certified providers are assigned both a CalOMS number and a DMC provider number.

The CalOMS number is a six (6)-digit number (the two (2)-digit county code and a four (4)-digit number assigned by ADP). CalOMS Treatment is a statewide client-based data collection and outcomes measurement system.⁴⁹

The DMC provider number is a four (4)-digit number assigned by ADP.

⁴⁷ Cal. Dept. of Alcohol and Drug Programs, "Bulletin 07-04," http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_07-04.pdf (accessed April 29, 2009).

⁴⁸ Cal. Dept. of Health Care Services, Medi-Cal, "NPI," <http://files.medi-cal.ca.gov/pubsdoco/npi/npi.asp> (accessed April 29, 2009).

⁴⁹ Cal. Dept. of Alcohol and Drug Programs, "CalOMS Treatment," <http://www.adp.state.ca.us/CalOMS/CalOMSmmain.shtml>

2.1.2.1 Requesting a Provider Identification Number (PIN)

All certified DMC providers requesting verification of a client's Medi-Cal eligibility for reimbursable services must have an eight (8)-digit provider identification number (PIN) issued by Electronic Data Systems (EDS).

Any certified DMC provider that has not yet received a PIN may request one by submitting a written request and faxing it to (916) 322-1176 or mailing it to:

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

2.1.2.2 Requesting a Temporary PIN

Temporary PINs valid until midnight of the day of issuance are available for providers who do not yet have a permanent PIN or have misplaced their permanent PIN.

Temporary PINs can only be used on the Supplemental Automated Eligibility Verification System (SAEVS) by calling 800-427-1295 to verify eligibility and perform Share of Cost (SOC) transactions. To request a temporary PIN, call the Point of Service (POS) Help Desk at (800) 541-5555.

2.1.3 DMC Certification Requirement

Providers must be currently certified by ADP to provide DMC services, bill, and receive reimbursement for DMC services.⁵⁰

Provider certification is unique to a particular facility location, and details the DMC services which may be provided at that location. Certification also distinguishes between services which may be provided within the regular (non-perinatal) DMC program, and those which may be provided within the perinatal DMC program for substance abuse services for pregnant and postpartum women.⁵¹ For more specific certification information, contact LCD.⁵²

If a provider intends to relocate and/or to provide additional DMC services, it must be certified for the new location and/or services to provide services eligible for DMC reimbursement. DMC services are only allowed/effective beginning on the recertification date.

Applicants submitting an ADP DMC Certification application must write the ADP Administrator of the county in which the clinic will be located informing the county that they are submitting an application. A copy of the letter must be attached to the DMC application.

⁵⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1 §51000.30 (current through March 6, 2009); 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 3, §51200 (current through March 6, 2009).

⁵¹ See 22 C.C.R. § 51341.1(c) regarding DMC services for pregnant and postpartum women.

⁵² LCD may be contacted by telephone at (916) 322-2911, and provides DMC certification information on the web at http://www.adp.ca.gov/Licensing/Drug_MediCal.shtml.

Prospective applicants for DMC certification should first attend a free DMC orientation session provided by ADP.⁵³ The orientation will explain the requirements in the application process and the procedures once a provider is DMC certified. The session also serves as a source of technical assistance through the application process. Upon completion of the orientation, the applicant is issued a Certificate of Completion, which must be attached to the DMC application.

2.1.4 *Mandatory Post-DMC Certification Training*

Providers that received DMC certification in the past fiscal year must attend a mandatory DMC Certification Training provided by LCD.⁵⁴ The training is posted on the ADP Calendar of Events.⁵⁵ Providers may send up to three staff members to this training, and must pre-register attendees by email to DMCanswers@adp.ca.gov.

2.1.5 *Mandatory Licensing of Residential Facilities*

Any facility which is maintained and operated to provide 24-hour, residential, non-medical, alcoholism or drug abuse recovery or treatment services to adults must be licensed by ADP.⁵⁶ Contact LCD for information regarding facility licensing.

2.1.6 *Voluntary Facility Certification*

LCD also provides a voluntary facility certification process to identify those residential and nonresidential programs that exceed minimum levels of service quality and are in substantial compliance with state program standards.⁵⁷

2.1.7 *Licensing and Certification Documents and Forms*

License and certification forms and related documents are available from ADP's online Document Library and from LCD's "Drug Medi-Cal" web page.⁵⁸

2.2 **Alcohol and Drug Counselor Certification**

Regulations governing certification of alcohol and other drug (AOD) counselors⁵⁹ require that by April 1, 2010, at least 30 percent of the staff providing counseling service in any AOD program (including any DMC program) must either be licensed or be certified by an organization approved by ADP to register and certify AOD counselors, and any staff members that are neither licensed nor certified must be registered for certification with

⁵³ Contact the ADP LCD Residential and Outpatient Programs Compliance Branch (ROPCB) at (916) 322-2911.

⁵⁴ *Ibid.*

⁵⁵ Cal. Dept. of Alcohol and Drug Programs, "Calendar of Events," <http://www.adp.ca.gov/calendar.shtml> (accessed April 29, 2009).

⁵⁶ Cal. Health & Safety Code §§ 11834.01–11834.02, 11834.30 (2008); 9 Cal. Code Regs., div. 4, chap. 5, subchap. 1, art. 2, §10501(a)(27) (current through March 6, 2009).

⁵⁷ Cal. Dept. of Alcohol and Drug Programs, Licensing, "Facility Certification," <http://www.adp.ca.gov/Licensing/certification.shtml> (accessed April 29, 2009).

⁵⁸ Cal. Dept. of Alcohol and Drug Programs, "Document Library," <http://www.adp.ca.gov/Library/index.shtml> (accessed April 29, 2009);

⁵⁹ Cal. Code Regs., tit. 9, div. 4, chap. 8 (§ 13000 *et seq.*)

an organization approved by ADP to register and certify AOD counselors within six months of their date of hire.⁶⁰ These regulations also impose continuing education requirements on licensed and certified AOD counselors.⁶¹ Contact LCD for information regarding counselor certification requirements.

2.3 Contracts with ADP

A county must have a signed contract with ADP to receive DMC reimbursement.⁶²

ADP DMC-certified providers must either have a signed, approved contract with their county or a signed, approved contract with ADP to provide, bill and receive reimbursement for DMC services.⁶³

2.4 Submission and Receipt of Claims Information

All DMC claims submissions, claim status requests, solicited and unsolicited claims status information, and remittance advices detailing claim payment and denial information are exchanged between DMC trading partners and ADP through the Information Technology Web Services (ITWS) portal operated by the Department of Mental Health (DMH) using the transactions described in Chapter 1 of this manual at Section 1.3.3.2.

Each organization (DMC trading partner or vendor authorized on behalf of a DMC trading partner) using the ITWS for DMC billing purposes must designate approvers for ITWS, who are persons authorized to approve ITWS enrollment requests for staff members of that organization; vendors authorized on behalf of a DMC trading partner must be designated as such on the trading partner's approver certification prior to designating their own approvers. Approver certification forms are available on ITWS.⁶⁴

Once the organization has designated approvers for the ITWS, users who will access the ITWS must enroll (staff must enroll as users to have access to the ITWS even if they are already designated as approvers.)

Appendix B of this manual provides step-by-step details on ITWS enrollment. For further information contact ADP's Fiscal Management and Accountability Branch (FMAB) at (916) 323-2043.

The Information Technology Web Services (ITWS) is a collection of web applications maintained by the DMH that allow ADP and DMH trading partners to access information securely over the Internet. Requests for access to specific areas of ITWS are approved by approvers appointed by each county director.⁶⁵

⁶⁰ Cal. Code Regs., tit. 9, §§ 13005, 13010, 13035(f) (current through March 20, 2009).

⁶¹ Cal. Code Regs., tit. 9, §§ 13015, 13055 (current through March 20, 2009).

⁶² Cal. Health & Safety Code, div. 10.5, chap. 3, §11758.20 (2008); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.40 (2008).

⁶³ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(g)(1)-(2) (2008).

⁶⁴ Cal. Dept. of Mental Health ITWS, "ADP Approver Certification Forms," https://mhhitws.cahwnet.gov/docs/public/authforms_adp.asp (accessed April 29, 2009).

⁶⁵ *Ibid.*

2.5 Getting Help

2.5.1 ADP Website

The ADP website can answer many questions, and trading partners are advised to use it as a primary resource.⁶⁶

⁶⁶ Cal. Dept. of Alcohol and Drug Programs, <http://www.adp.ca.gov> (accessed April 29, 2009).

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3. CLIENT ELIGIBILITY

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3 Introduction

This chapter includes information about the Medi-Cal eligibility and client financial liability. It includes:

- [Client Medi-Cal Eligibility](#)
- [Identity and Eligibility Verification Requirements](#)
- [Medi-Cal Eligibility Verification Systems](#)
- [Technical Assistance For Medi-Cal Eligibility Verification Systems](#)

3.1 Client Medi-Cal Eligibility

The following sections describe Medi-Cal Eligibility Determination and Medi-Cal Identity and Eligibility Verification Requirements.

3.1.1 Eligibility Determination

The determination and collection of client eligibility data typically lies with the county welfare department. Procedures for determining Medi-Cal eligibility are the responsibility of DHCS. Detailed information regarding eligibility criteria may be obtained through the DHCS website.⁶⁷

Some helpful Medi-Cal eligibility concepts include:

- Client Medi-Cal eligibility data should be verified at least monthly.
- Clients must be eligible for Title XIX federal Medicaid reimbursement and/or 100 percent SGF Medi-Cal reimbursement.⁶⁸
- Some Medi-Cal beneficiaries must meet a specified SOC for medical expenses before Medi-Cal will pay claims for services provided in that month.⁶⁹ SOC is determined by the county welfare department and is based on the beneficiary's or family's income and living arrangement. Members of the family may have the same or different share of cost amounts. The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.⁷⁰
- Verification of client Medi-Cal eligibility is often reviewed by external auditors after the claimed month of service. For this reason trading partners must maintain proof of client Medi-Cal eligibility in their records.
- Medi-Cal eligibility may be established retroactively through decisions resulting from court or administrative hearings.

⁶⁷ Cal. Dept. of Health Care Services, "Providers & Partners," <http://www.dhs.ca.gov/mcs/mcpd/meb/ACLs/Index/2007ACWDLs/10thru19.htm> (accessed April 29, 2009).

⁶⁸ 42 U.S.C., chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

⁶⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 2 (current through March 6, 2009).

⁷⁰ Cal. Dept. of Alcohol and Drug Programs. "ADP Bulletin 99-39," http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_99-39.pdf (accessed April 29, 2009).

3.2 Identity and Eligibility Verification Requirements

3.2.1 Medi-Cal Identification Cards

All Medi-Cal beneficiaries have identification cards. DHCS issues a plastic Benefits Identification Card (BIC) to each Medi-Cal beneficiary. In exceptional situations, county welfare departments may issue temporary paper identification cards for Immediate Need and Minor Consent program beneficiaries.⁷¹

All DMC claims must be submitted using the client's ID number as listed on the client's BIC or paper Medi-Cal ID card. Claims must not contain a client's social security number.⁷²

Mere possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month.

3.2.2 Good Faith Effort to Verify Identity

It is the provider's responsibility to verify that the person is the individual to whom the BIC was issued. Identification verification should be performed prior to rendering service.

If a recipient is unknown, the provider must make a good faith effort to verify the recipient's identification before rendering Medi-Cal services. *Good faith effort* means verifying the recipient's identification by matching the name and signature on the BIC against the signature on a valid California driver's license, a California identification card issued by the Department of Motor Vehicles, another acceptable picture ID card, or other credible document of identification.⁷³

3.2.3 Eligibility Review

Programs that provide DMC services are responsible for verifying the Medi-Cal eligibility of each client for each month of service prior to billing for DMC services to that client for that month. Medi-Cal eligibility verification should be performed prior to rendering service.

To verify the Medi-Cal eligibility of a client, the DMC provider must first have an 8-digit Provider Identification Number (PIN).⁷⁴ Refer to Chapter 2 sections 2.1.2.1 and 2.1.2.2 of this manual for details.

⁷¹ Cal. Welf. & Ins. Code, Div. 9, Part 3, Chap. 7, Art. 1.3, §§14043–14045 (current through 2008); Cal. Dept. of Alcohol and Drug Programs, Bulletin 08-01, http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf (accessed April 29, 2009).

⁷² Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1.3, §§14043–14045 (2008); Cal. Dept. of Alcohol and Drug Programs, "Bulletin 08-01," http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf (accessed April 29, 2009).

⁷³ Cal. Dept. of Health Care Services, "Eligibility: Recipient Identification Cards," Dec. 2006, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/eligreccrd_z01.doc (accessed April 29, 2009).

⁷⁴ Cal. Dept. of Health Care Services, Medi-Cal, "FAQs," <http://files.medi-cal.ca.gov/pubsdoco/faq.asp> (accessed April 29, 2009).

3.3 Medi-Cal Eligibility Verification Systems

The three options for verifying the eligibility of a Medi-Cal beneficiary are described in the following sections.

3.3.1 Automated Eligibility Verification System (AEVS)

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers having a valid PIN to access recipient eligibility via a touch-tone telephone. User instructions and other information regarding the AEVS are available in the *DHCS AEVS User Guide*.⁷⁵ Providers should document and retain the Eligibility Verification Confirmation returned by AEVS in the client's file to document eligibility verification.

3.3.2 Point of Service (POS) Device

The POS device is an automated transaction device which allows checking eligibility by swiping the client's BIC or by manually entering information. Use instructions and other information regarding the AEVS are available in the *DHCS Point of Service (POS) Device User Guides*.⁷⁶

The POS device can perform additional functions besides eligibility verification, some of which (such as claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

A POS device may be requested by completing the following forms:

1. Medi-Cal Eligibility Verification Enrollment Form⁷⁷
2. POS Device Usage Agreement⁷⁸
3. Medi-Cal Point of Service Network/Internet Agreement⁷⁹

Mail all three forms to:

POS Help Desk
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

⁷⁵ Available online at <http://files.medi-cal.ca.gov/pubsdoco/userguides.asp> (accessed April 3, 2009).

⁷⁶ Cal. Dept. of Health Care Services, Medi-Cal, POS Device User Guides, http://files.medi-cal.ca.gov/pubsdoco/pos_home.asp (accessed April 29, 2009).

⁷⁷ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Eligibility Verification Enrollment Form, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrms_z01.doc (accessed April 29, 2009).

⁷⁸ Cal. Dept. of Health Care Services, Medi-Cal, POS Device Usage Agreement, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/part1/pointfrm2dev_z01.doc (accessed April 29, 2009).

⁷⁹ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal POS Network/Internet Agreement, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/pointfrm1net_z01.doc (accessed April 29, 2009).

3.3.3 Transaction Services on the DHCS Medi-Cal Website

Medi-Cal Transaction Services allow Medi-Cal providers to perform a variety of secure transactions over the internet, including eligibility verification. Additional information about the Medi-Cal Transaction Services system, including the required forms and usage information, is available in the *DHCS Medi-Cal Website Quick Start Guide*.⁸⁰ Note that Medi-Cal Transaction Services system can perform additional functions besides eligibility verification, some of which (notably, claim submission) cannot be used for Drug Medi-Cal, though they are used in other Medi-Cal components.

3.4 Technical Assistance for Medi-Cal Eligibility Verification Systems

If you have questions regarding the AEVS or the interpretation of AEVS and POS return codes and messages, contact the Telephone Service Center (TSC) at (800) 541-5555. For faster access to resources, refer to the *Main Menu Prompt Options Guide*⁸¹ and the *TSC Specialized Operator Reference Guide*.⁸²

If you need assistance using the POS device or have questions regarding the shipment of a POS device or other materials, contact the POS Help Desk at (800) 541-5555.

You may need to provide the operator your NPI, a PIN, and the fact that your NPI is certified by ADP in the SDMC system as an *Other Intermediary 02*. Help desk operators will provide a work request number as well as their names. Please retain this information until the issue is resolved.

If further assistance is needed, please send details to:

POS Help Desk
3215 Prospect Park Drive
Rancho Cordova, CA 95670-6017

⁸⁰ Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Website Quick Start Guide, <http://www.medi-cal.ca.gov/pubs/quickstart.htm> (accessed April 29, 2009).

⁸¹ Cal. Dept. of Health Care Services, Medi-Cal, Telephone Service Center, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm1ref_z01.pdf (accessed April 29, 2009).

⁸² Cal. Dept. of Health Care Services, Medi-Cal, Medi-Cal Specialized Operator Reference Guide, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/provrefrm2_z01.pdf (accessed April 29, 2009).

4. DRUG MEDI-CAL CLAIMS PROCESSING OVERVIEW

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4 Introduction

This chapter provides an overview to claims processing and includes:

- [SDMC Phase 2 System Claim Cutover](#)
- [Claim Submission Deadlines](#)
- [Standard Transaction Sets used in DMC Billing](#)
- [Claims Processing Overview](#)
- [Factors Affecting Reimbursement](#)

4.1 SDMC Phase 2 System Claim Cutover

ADP trading partners will cutover to the new SDMC Phase 2 system as follows:

- Phase 1 claims will be accepted through December 31, 2009.
- Final 835s for all Phase 1 claims will be available on ITWS for trading partner download no later than January 8, 2010.
- Phase 1 835 denials will be generated and be available on ITWS no later than January 8, 2010.
 - One-time 835s will be generated from the Phase 1 system for any Phase 1 claims that are approved but awaiting a warrant as of January 8, 2010. These 835s will contain all approved but not yet paid service lines, and will show the full amount for each line adjusted with a payment deferred code (CO/143).
 - A Phase 2 835 will be sent containing warrant information for Phase 1 claims when the State Controller's Office (SCO) issues a warrant. The specifics of how this 835 will be formatted are contained in the *ADP Companion Guide Appendix*.⁸³
 - Data conversion from Phase 1 to Phase 2 will occur between January 6, 2010 and January 10, 2010.
- ADP trading partners may start submitting Phase 2 claims on January 1, 2010, but no claims will be adjudicated until the successful completion of Phase 1 to Phase 2 data conversion activities.
- During the time that the county's final Phase 1 claims are adjudicated and the final Phase 1 835 and EOB files are transmitted, the county's Phase 2 claims will be held in a queue awaiting Phase 2 claims adjudication. The county will receive the 997 reply from the SDMC system indicating the status of the Phase 2 837 file receipt. However, the county will not receive any Phase 2 835 response to the Phase 2 837 until after the Phase 1 claims have been adjudicated.

⁸³ Cal. Dept. of Health Care Services, Companion Guide Appendix v.2.0 (2009).

4.1.1 Handling SDMC Phase 1 Claims

ADP trading partners may resubmit claims for services that were denied in the Phase 1 system in the Phase 2 system. Because the Phase 2 system will not support replacement of Phase 1 claims, these resubmissions of Phase 1 claims in the Phase 2 system (known as *bridge resubmissions*) will be identified on the 837 as original claims in Phase 2.

To assure traceability and proper processing, procedures similar to those used for resubmissions in Phase 1 will be applied to bridge resubmissions:

- Bridge resubmissions will need to be submitted in a separate ITWS file from any other claims. Each bridge resubmission ITWS file must contain resubmission for no more than one Phase 1 claim batch. If a bridge resubmission is for multiple Phase 1 batches, a separate bridge resubmission ITWS file will be required for each batch resubmitted.
- Bridge resubmissions must be identified as such on the Claim Submission Certification Form, and the Phase 1 batch number on which the claims were denied must also be identified on the Claim Submission Certification Form.
- Bridge resubmissions must be submitted via ITWS within six months of the date of the Phase 1 denial. ADP will discontinue support for the bridge resubmission process six months after the last Phase 1 claim denials.

Additional information on the bridge resubmission process will be included in a future revision of the *ADP Companion Guide Appendix*.

Because the Phase 2 system will not support voids to Phase 1 claims, ADP trading partners will continue to use the ADP 5035C to report any identified adjustments identified to claims approved and paid in the Phase 1 system, even after the Phase 2 cutover. Additional information about the use of the ADP 5035C for adjustment of Phase 1 claims is provided in Chapter 6 of this manual.

4.2 Claim Submission Deadlines

4.2.1 Original Claims Deadlines

An original claim must be received by ADP no later than 30 days after the end of the month in which the service was provided unless the provider has good cause for late claim submission.⁸⁴ For each original 837P claim file submitted to ADP, an ADP Claim Submission Certification Form must also be submitted to ADP by mail or fax.

If a claim is submitted later than 30 days after the end of the month in which service was provided, the provider must have good cause for the late submission,⁸⁵ must prepare a Good Cause Certification (ADP 6065), and must include the appropriate delay reason code in the claim. Good Cause Reason Codes are used to document the reason that a DMC claim was submitted beyond the deadline of 30 days after the end of the month the service was provided (see Chapter 6 of this manual for details on their use).

⁸⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1 (current through March 6, 2009)

⁸⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).

Information on entering Good Cause Reason Codes in 827P claims is included in the *ADP—837P Companion Guide* under CLM—Claim Information Element ID CLM20.⁸⁶

4.2.2 Replacement Claim Deadlines

A Replacement Claim for a denied claim may be submitted up to 6 months after the date of the denial or payment. Extensions will not be granted.

4.3 Standard Transaction Sets Used in DMC Billing

4.3.1 837 Professional Health Care Claim Transaction

The 837P professional health care claim transaction is used to submit health care claim billing information. The structure and contents of each standard transaction are defined in 45 CFR Sections 162.1101-162.1802.⁸⁷

For health care claims (as well as related coordination of benefits), refer to ASC X12N 837—Health Care Claims: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098⁸⁸ and Addenda to Health Care Claims: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.⁸⁹

The structure and contents of 837P transactions for DMC service reimbursement submitted to SDMC are defined in the *ADP—837P Companion Guide*⁹⁰ and the *ADP Companion Guide Appendix*.⁹¹

There are three types of DMC 837P transactions:

- **Original Claims:** claims submitted for the first time (never adjudicated). If a negative 997 is received in response to the HIPAA validation process, submitter may submit a new claim correcting the errors detailed in the 997.
- **Replacement Claims:** allows trading partners to replace a previously finalized (approved and paid, approved and payment deferred, or denied, as reported on an 835 Remittance Advice) claim.
- **Voided Claims:** requests to treat a previously finalized claim as null and void.

Additional information on Void and Replacement claims follows.

4.3.1.1 Void Claims

A Void Claim allows trading partners to request that ADP treat a previously approved or denied 837P claim as null and void. Trading partners should submit a Void Claim when they have identified that a claim that was previously finalized should not have been billed to DMC.

⁸⁶ ADP Cal. Dept. of Health Care Services Companion Guide 837P (2009).

⁸⁷ 45 C.F.R., vol. 1, subtitle A, part 162, §§162.1101-162.1802 (current through Oct. 1, 2008).

⁸⁸ 45 C.F.R., vol. 1, subtitle A, part 162, §162.1102(B)(3) (current through Oct. 1, 2008).

⁸⁹ 45 C.F.R., vol. 1, subtitle A, part 162, §162.1802(B)(3) (current through Oct. 1, 2008).

⁹⁰ ADP Cal. Dept. of Health Care Services Companion Guide 837P (2009).

⁹¹ Cal. Dept. of Health Care Services, Companion Guide Appendix v.2.0 (2009).

Once a claim has been voided, it cannot be voided again, nor can it be replaced. If some claim information was inaccurate, but the claim should still have been billed, do not void the claim but instead submit a Replacement Claim (see next section). Guidelines on voiding claims and void scenarios are provided in the *ADP Companion Guide Appendix*.⁹²

4.3.1.2 Replacement Claims

A Replacement Claim allows trading partners to replace a previously finalized 837P claim.

Trading partners should replace claims when they have identified that either:

- a) The previously-submitted claim was submitted with incorrect information, or
- b) Service lines were erroneously included in or omitted from the claim

Guidelines on Replacement Claims and replacement scenarios are provided in the *ADP Companion Guide Appendix*.⁹³

4.3.2 997 Functional Acknowledgement

SDMC generates a 997 acknowledgement in response to each HIPAA-compliant transaction including receipt of a 276 Claim Status Request, and also when HIPAA validation of a submitted 837P is complete.

When HIPAA validation of a submitted 837P is complete, a 997 may communicate the acceptance or rejection of either the entire Functional Group or of individual transaction sets within the Functional Group as follows:

- **Positive 997:** transactions were validated without HIPAA errors. A Positive 997 file is posted on the submitter's ITWS "Transfer Files" page. The transactions are accepted by SDMC and adjudicated.
- **Negative 997:** transactions were found to contain HIPAA errors. A Negative 997 is posted on the submitter's ITWS "Transfer Files" page.

4.3.3 835 Health Care Claim Payment/Advice

Providers can download their 835 claim payment Remittance Advice records from ITWS (see Appendix D of this manual for details). The *835 Companion Guide*⁹⁴ should be consulted for specific details.

4.3.4 276 Claim Status Request/277 Claim Status Response

Claim status is provided via a request/response mechanism using the 276/277 Claim Status transaction sets.

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ Cal. Dept. of Health Care Services, Companion Guide 835, v.1.2.2 (2009).

- **276 Claim Status Request:** after submission of a claim or encounter information, claim submitters may use the 276 transaction to request claim status. The request may occur at the summary or service line detail level.
- **277 Claim Status Response:** this is the response to the 276 which is generated by SDMC.

See the *276 Companion Guide*⁹⁵ and the *277 Companion Guide* for details.⁹⁶

4.3.5 277 Unsolicited Claim Status

The 277 Unsolicited Claim Status (277U) transaction set is used to provide claim status based on certain claim status events without the requirement for a 276 Claim Status Request. SDMC will generate 277U transactions for DMC claims based on the following three business rules:

- Immediately when claims are identified as awaiting manual override.
- Immediately when claims are adjudicated and approved by SDMC, and
- When claims have been awaiting confirmation by ADP of the Claim Submission Certification Form for one week after having been received by DHCS SDMC.

4.4 Claims Processing Overview

4.4.1 DMC Claims Submission and Adjudication

1. Trading partner prepares claim file and supporting documentation.
 - a. Trading partner prepares file containing 837P transaction sets with DMC claims.
 - b. Responsible trading partner officials (programmatic and fiscal) review claims and sign off on Claims Submission Certification Form.
 - c. If any claims submitted in the file include delay reason codes, one or more Good Cause Certification (ADP 6065) forms are prepared to support the use of these delay reason codes.
 - d. If any claims submitted in the file include requests for manual eligibility override, supporting documentation for those manual overrides is assembled and prepared.
2. Trading partner submits claim file and supporting documentation to ADP.
 - a. Trading partner submits file containing 837P transaction sets via ITWS.
 - b. Trading partner submits Claim Submission Certification Form to ADP via fax.
 - c. If any claims submitted in the file include the use of delay reason codes requiring state approval, and/or requests for manual eligibility overrides, trading partner faxes documentation supporting the use of those delay

⁹⁵ Cal. Dept. of Health Care Services, Companion Guide 276, v.1.2.1 (2008).

⁹⁶ Cal. Dept. of Health Care Services, DMH-ADP Companion Guide 277, v.1.2.1 (2008).

reason codes and/or the eligibility of the clients for whom manual overrides are requested to ADP via fax or mail.

3. When SDMC receives the file from ITWS, the SDMC system validates that the file received is a validly-formatted file.
 - a. The SDMC system will produce and post a file containing a 997 transaction for every functional group identified in the submitted file, acknowledging the receipt of the functional group and identifying any syntactic errors identified in it.
4. If the file has been successfully validated, SDMC will place it in a queue of files pending review by ADP to assure that a corresponding Claim Submission Certification Form has been received certifying the contents of the file.
5. ADP will await receipt of a corresponding Claim Submission Certification Form for the file. If the file has not been released within 7 days, the claims it contains will be reported on a 277U indicating their status.
6. The file will be released by ADP when a corresponding Claim Submission Certification Form has been received. If none is received within 30 days of the file submission date, any claims within the file will be denied due to the absence of certification.
7. When the claim has been released following receipt of certification, SDMC will process the claims in the file to identify any claims requiring additional certification prior to adjudication.
 - a. Any claims using delay reason codes requiring state approval will be held for review of the documentation supporting those delay reason codes, and will be reported on a 277U transaction set.
 - b. Any claims requesting manual eligibility overrides will be held for review of the documentation supporting eligibility, and will be reported on a 277U transaction set.
8. ADP will await receipt of the appropriate certification documents for any claims requiring certification of the use of delay reason codes and/or manual eligibility overrides.
9. Claims requiring certification of the use of delay reason codes or manual eligibility overrides will be released by ADP when the corresponding certification has been reviewed and approved. If the certification of the use of a delay reason code or manual override is not approved by ADP, the claim will be adjudicated as without the delay reason code or manual override.
10. Claims that do not require delay reason certification or manual eligibility override, or which do require either or both of those and have had the required certification reviewed by ADP, will be adjudicated by the SDMC system.
11. After adjudication, any claims which do not require payment or recovery processing by ADP (denied original claims, and void and replacement claims for which no prior claim was located) will be reported on 835 transaction sets made available to trading partners via ITWS, while those claims that require payment or recovery processing prior to finalization will have their status reported on 277U transaction sets.
12. After adjudication, all claim information is reported to ADP by SDMC.

13. When ADP receives claim information from SDMC, the claim information will be stored in ADP's databases, and any claims requiring payment or recovery processing will be identified.

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 Chapter 4: DMC Claims Processing Overview

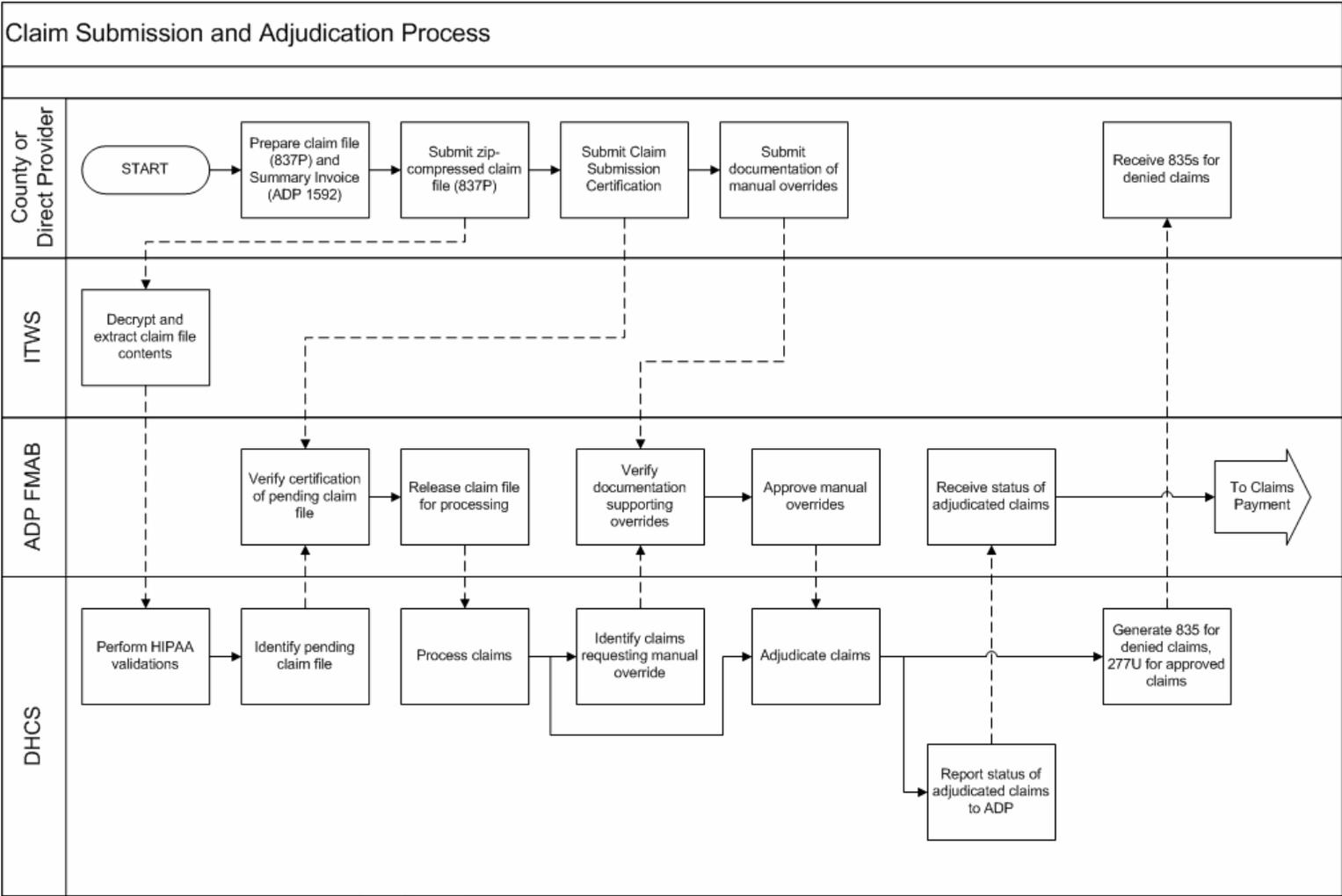


FIGURE 1: CLAIM SUBMISSION AND ADJUDICATION PROCESS

DRUG MEDI-CAL BILLING MANUAL
 Chapter 4: DMC Claims Processing Overview

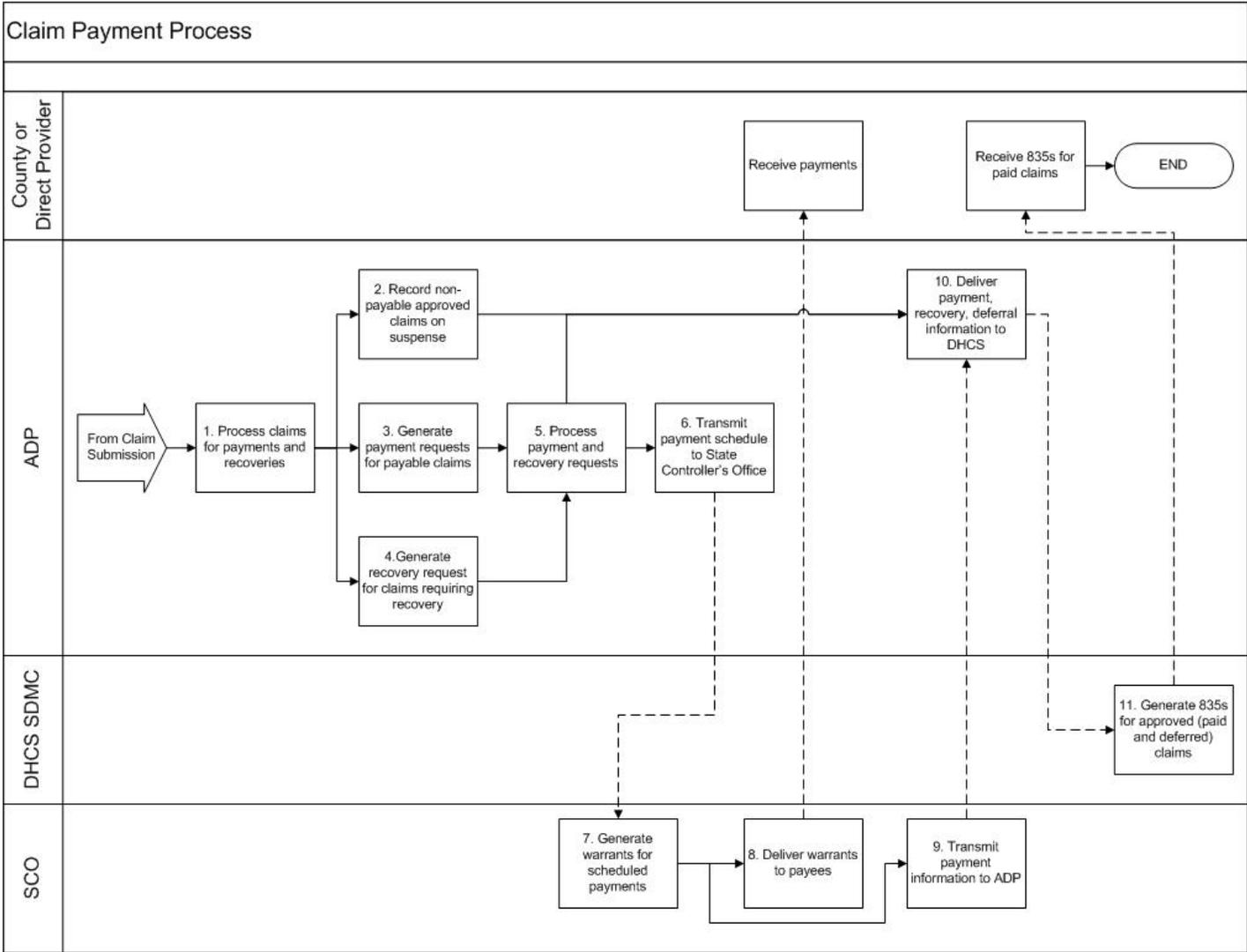


FIGURE 2: CLAIM PAYMENT PROCESS

4.4.2 ADP Claim Payment and Recovery Processing

1. In each weekly claim processing cycle, ADP reviews all claims requiring payment or recovery that has not yet been taken.
2. For each claim requiring a payment that cannot be made in full because of an insufficient contract balance, a payment hold, or other reason, the unpayable amount is identified as deferred; if no payment amount has been identified for this claim, the deferral of the entire payment will be transmitted to SDMC to be reported on an 835 if it has not already been. If a payment has been identified for this claim, the deferred amount will be reported along with the payment amount once the payment has been issued.
3. For each claim requiring a payment which can be made in part or in full, a payment request is generated for ADP's Accounting unit.
4. For each claim requiring a recovery, a recovery request is generated for ADP's Accounting unit.
5. ADP's Accounting unit will prepare payment schedules for all payment requests, offsetting against them outstanding recovery requests for the same trading partner; if the recoveries for a trading partner fully offset payments, the claims and adjustments involved will be transferred to SDMC to generate an 835, otherwise, the payments and adjustments will be listed together on an 835 once payment is issued.
6. ADP will transmit payment schedules to the State Controller's Office (SCO).
7. SCO will generate warrants for each trading partner according to the schedule submitted by ADP.
8. SCO will deliver payment warrants to trading partners.
9. SCO will transmit warrant information to ADP.
10. ADP will combine the warrant information with payment, recovery, and deferral information generated earlier in the process and transfer to SDMC.
11. SDMC will generate 835s detailing payments, recoveries, and deferred payments to trading partners via ITWS.

4.5 Factors Affecting Reimbursement

4.5.1 Statewide Maximum Allowances (SMA) and Uniform Statewide Daily Reimbursement (USDR)

The SMA for each DMC service are set annually by ADP and disseminated in ADP bulletins.⁹⁷

The SMA for non-NTP services and USDR for NTP services are developed in accordance with California Welfare and Institutions Code Section 14021.6 and Health and Safety Code Section 11758.42.⁹⁸

⁹⁷ Cal. Dept. of Alcohol and Drug Programs, "Bulletins & Letters," http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml (accessed April 29, 2009).

⁹⁸ Cal. Welf. & Ins. Code, div. 9, part 3, chap. 7, art. 1, §14021.6 (2008); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.42 (2008).

Reimbursements for non-NTP DMC services are settled to the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the SMA for services provided.

Reimbursements for NTP DMC services are settled to the lesser of the USDR or the provider's usual and customary charge to the general public for similar services.⁹⁹

4.5.2 Federal Funding Ratios

DMC services are reimbursed by ADP from both federal and state funds. For services to clients eligible for federal Medicaid reimbursement, the federal share of funds is determined by the Federal Medicaid Assistance Percentages (FMAP) determined for each federal fiscal year. The federal Social Security Act Title XIX specifies how FMAP is calculated and requires the U.S. Secretary of Health and Human Services to calculate and publish the FMAPs each year.¹⁰⁰ FMAP data may be found on the United States Assistant Secretary for Planning and Evaluation (ASPE) website.¹⁰¹

For DMC services to Minor Consent clients, reimbursement is made from SGF.

4.5.3 Payment Timeframe

California Health and Safety Code Section 11758.46¹⁰² specifies the reimbursement timeframe for DMC claims from both SGF and federal Medicaid Funds.

4.5.4 Post Service Post Payment Monitoring Review

Pursuant to federal and state law and regulation requiring utilization review and controls for Medicaid/Medi-Cal services¹⁰³ ADP conducts Post Service, Post Payment (PSP) utilization reviews at DMC provider sites to determine compliance with standards of care and other DMC requirements.¹⁰⁴ PSP reviews provide quality assurance and accountability for DMC services, assist counties and providers in identifying and resolving compliance issues, and provide opportunities for training and technical assistance to counties and providers.

At the conclusion of each PSP review, ADP issues a written report detailing any deficiencies found and identifying recovery for any payments made for units of service

⁹⁹ Cal. Code Regs., Title 22, Division 3, Subdivision 1, Chapter 3, Article 7, §51516.1(a) (current through March 6, 2009); Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(h)(1) (2008).

¹⁰⁰ 42 U.S.C., chap. 7, subchap. XXI, §1397ee (current through Jan. 3, 2007); Fed. Reg., vol. 71, No. 230, Thursday, Nov. 30, 2006, Notices.

¹⁰¹ U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm> (accessed April 29, 2009).

¹⁰² Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46(f)(1) and (2) (2008).

¹⁰³ 42 U.S.C., chap. 7, subchap. XIX, §1396(a)(30)-(33) (current through Jan. 3, 2007); 42 C.F.R., vol. 4, Chapter 4, §456.2-456.6 (current through Oct. 1, 2008); 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1 (current through March 6, 2009).

¹⁰⁴ Cal. Dept. of Alcohol and Drug Programs, "Licensing," <http://www.adp.ca.gov/Licensing/index.shtml> (accessed April 29, 2009).

which are found to be out of compliance. The county and/or provider are required to develop and implement a corrective action plan for each identified deficiency.¹⁰⁵

Additional information about PSPP reviews can be found on ADP's "Drug Medi-Cal Monitoring" web page.¹⁰⁶

4.6 Year-end Cost Report

Following the end of a fiscal year trading partners submit their Cost Reports or year-end reimbursement reports for ADP to reconcile and settle against DMC claims processed during the fiscal year.

Excel workbooks and supporting Cost Report documents are available on the ADP "Negotiated Net Amount" web page.¹⁰⁷ Additional details on the negotiated net amount can be found in ADP Bulletin 08-12.¹⁰⁸

ADP DMC monitors and/or auditors may review a provider's records for compliance and accountability. If exceptions are found, they are documented and the funds are recouped by ADP.

A crosswalk will be provided on the ADP "Negotiated Net Amount" page so trading partners can crosswalk codes used in claims submitted in Phase I containing proprietary codes to the Cost Report codes, and also crosswalk new codes in claims submitted in Phase II containing HCPCS codes to the Cost Report codes.¹⁰⁹

4.6.1 Cost Report Submission

Cost Reports can be submitted in a variety of formats, including hard copy, diskette, CD and e-mail. Cost Reports are due by November 1 following the end of the fiscal year.

If you have any questions or issues regarding the completion of the Cost Reports, please contact your FMAB analyst.

¹⁰⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1(m)-(o) (current through March 6, 2009).

¹⁰⁶ Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "DMC Provider Resource Tool-Kit Monitoring," http://www.adp.ca.gov/dmc/dmc_drug_medical_monitoring.shtml (accessed April 29, 2009).

¹⁰⁷ Cal. Dept. of Alcohol and Drug Programs, "Negotiated Net Amount (NNA)," <http://www.adp.ca.gov/NNA/nnamain.shtml> (accessed April 29, 2009).

¹⁰⁸ Cal. Dept. of Alcohol and Drug Programs, "Bulletin 08-12," http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-12.pdf (accessed April 29, 2009).

¹⁰⁹ Cal. Dept. of Alcohol and Drug Programs, "Negotiated Net Amount (NNA)," <http://www.adp.ca.gov/NNA/nnamain.shtml> (accessed April 29, 2009).

5. MULTIPLE SERVICE BILLINGS, LOCKOUTS & OVERRIDES

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5 Introduction

This chapter provides an overview to SDMC multiple service billings, lockouts and overrides and includes:

- [Multiple Service Billings](#)

5.1 Multiple Service Billings

Multiple service billings are claims for services for the same day and recipient that are approved for reimbursement, up to the maximum accumulation of units of service for each Service Category and subject to the Statewide Maximum Allowance (SMA), or maximum payment allowed per unit of service for each Service Category.

Generally only one DMC service may be provided to a Medi-Cal-eligible recipient per treatment date. However, multiple service billings are permissible in specific exceptional circumstances.¹¹⁰

A multiple service billing claim must include the appropriate HIPAA procedure modifier (see the *ADP Companion Guide Appendix* and the following sections of this chapter).¹¹¹

When a multiple service billing claim is submitted, the provider must prepare and retain in the beneficiary's patient record, a Multiple Billing Override Certification (ADP 7700) documenting the circumstances justifying the multiple service billing.

5.1.1 Restrictions

Multiple service billings are allowed for a single additional service in a day as identified in Title 22 for:¹¹²

- Outpatient drug-free or Naltrexone services¹¹³
- Daycare rehabilitative services¹¹⁴

Multiple service billings are not permitted for:

- Any DMC services other than outpatient drug-free or Naltrexone services or day care rehabilitative services
- Services provided by different providers on the same day
- Services provided from different DMC service types in the same day

¹¹⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d) (current through March 6, 2009).

¹¹¹ Cal. Dept. of Health Care Services, Companion Guide Appendix v.2.0 (2009).

¹¹² 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d) (current through March 6, 2009).

¹¹³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d)(1) (current through March 6, 2009).

¹¹⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1(d)(2) (current through March 6, 2009).

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Chapter 5: Multiple Service Billings, Lockouts & Overrides

5.2 Maximum Service Units and Lockouts

Table 5-1 describes maximum service units and lockout conditions for a specific recipient and date of service.

TABLE 5-1: LOCKOUTS, MAXIMUM MONTHLY ALLOWANCES & MULTIPLE-SERVICE OVERRIDES

For Same Beneficiary on Same Date of Service									
Service Name	NTP Methadone Dosing	NTP LAAM Dosing	NTP Individual Counseling	NTP Group Counseling	DCR	RES	NAL	ODF Individual Counseling	ODF Group Counseling
Narcotic Treatment Program (NTP) Methadone Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Levoalphacetylmethadol (LAAM) Dosing	NO	NO	NTP	NTP	NO	NO	NO	NO	NO
NTP Individual Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
NTP Group Counseling	NTP	NTP	NTP	NTP	NO	NO	NO	NO	NO
Day Care Rehabilitative (DCR)	NO	NO	NO	NO	YES	NO	NO	NO	NO
Perinatal Residential (RES)	NO	NO	NO	NO	NO	NO	NO	NO	NO
Naltrexone (NAL)	NO	NO	NO	NO	NO	NO	YES	NO	NO
Outpatient Drug Free (ODF) Individual Counseling	NO	NO	NO	NO	NO	NO	NO	YES	YES
Outpatient Drug Free (ODF) Group Counseling	NO	NO	NO	NO	NO	NO	NO	YES	NO

NO These services are not permitted to be reimbursed for the same client on the same day.

NTP These services are permitted to be reimbursed for the same client on the same day, subject to a limit of a total of 200 minutes (20 units) of NTP counseling per client per month.

YES These services are permitted to be reimbursed on the same day for the same client, subject to multiple billing restrictions. The appropriate multiple service billing procedure modifier must be identified for one of the two allowed services.

6. FORMS

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6 Introduction

This chapter provides an overview of ADP claim forms, which can be found on the “HIPAA Privacy and Security” page of the ADP website.¹¹⁵

- [Claim Submission Certification Form \(ADP XXXX\)](#)
- [Provider Report of Drug Medi-Cal Adjustments \(ADP 5035C\)-Transitional](#)
- [Multiple Billing Override Certification \(ADP 7700\)](#)
- [Good Cause Certification \(ADP 6065\)](#)

6.1.1 Claim Submission Certification Form (ADP XXXX)

A Claim Submission Certification Form must be submitted to ADP by mail or fax for each original 837P claim file submitted to ADP.

6.1.2 Provider Report of Drug Medi-Cal Adjustments (ADP 5035C)-Transitional

Because the SDMC Phase 2 system will not support voids to Phase 1 claims, ADP trading partners will continue to use the ADP 5035C to report any identified adjustments for claims approved and paid in the Phase 1 system, even after the Phase 2 cutover.

6.1.3 Multiple Billing Override Certification (ADP 7700)

ADP 7700 is used to certify that an additional, second unit of service for the same client was submitted for the same service date. ADP 7700 documents that the additional service was medically necessary and was not a hardship for the client's return.

The ADP 7700 must be signed by a person authorized to represent the county or provider to certify that the client record was reviewed, that the multiple service claim was valid per Section 51490.1 of Title 22,¹¹⁶ and that the ADP 7700 shall be prepared and retained in the beneficiary's patient record to be produced for monitoring and/or auditing purposes.

6.1.4 Good Cause Certification (ADP 6065)

The ADP 6065 is used by the provider and/or county to document and support the reason a claim is being submitted outside of the required due date. A late claim is any claim submitted later than 30 days after the last date of the service year and month; i.e., a timely claim for July 2009 should be submitted to ADP no later than August 30, 2009. The Good Cause, (Delay Reason code in the 837P) must be coded on any late claim to avoid being denied due to late submission.

¹¹⁵ Cal. Dept. of Alcohol and Drug Programs, “HIPAA Privacy and Security,” <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009)

¹¹⁶ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 6, §51490.1 (current through March 6, 2009).

Delay Reason Codes are required to justify all late submission. The reasons for justifying late submission are defined in CCR Title 22, Section 51008.5.¹¹⁷ If the late claim is submitted within the time limitation defined for the Good Cause, in Title 22, a Delay Reason code may be coded in the 837P claim submitted to ADP. Again, reference Title 22, Section 51008.5 for complete information on the regulation.

The ADP 6065 should be completed and signed by a person authorized to represent the county/direct provider certifying the validity of the billing. With exception of the Delay Reason code 4, 8 or 11, do not submit the form to ADP. The completed ADP 6065 must be retained on site for monitoring purposes.

The ADP 6065 for a Delay Reason code 4, 8 or 11 must be pre-approved by ADP. Once ADP has pre-authorized the ADP 6065, the provider or county will complete the form and fax to ADP for ADP's signature and approval. After approval is granted, the signed ADP 6065 will be faxed back to county/direct provider by ADP and retained on site for monitoring purposes.

6.1.4.1 Good Cause for Late Submission and Delay Reason Codes

The county/direct provider must determine the appropriate Delay Reason code to use on the ADP 6065. ADP cannot advise which Delay Reason code to use.

The Delay Reason code should be included in the late claim at the time of submission. If it is overlooked and the claim is denied, the Delay Reason Cause code may be used in the replacement claim.

Providers must meet one of the seven situations below in order to qualify for delay reason cause exemption. For a late submission situation to be applicable for a Delay Reason, it must adhere to all time limits and documentation requirements. Most Delay Reason codes have a time limitation of one year from the date of service to submit the claim. ADP has included a brief description of Delay Reason codes, but it is suggested that CCR Title 22, Section 51008.5 be reviewed for complete information and instructions.¹¹⁸

Reason Code 1 (time limit: one year plus 60 days)¹¹⁹

Delay is due to a failure of the client or legal representative, due to deliberate concealment or physical or mental incapacity, to present identification as a Medi-Cal beneficiary.

- Provider or county must identify the client as having been Medi-Cal eligible on the date of service within one year following the end of the month in which the service was rendered.
- Claims must be submitted to and received by ADP not later than 60 days from the date the client was first identified as a Medi-Cal beneficiary.

¹¹⁷ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).

¹¹⁸ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5 (current through March 6, 2009).

¹¹⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(1) (current through March 6, 2009).

- Provider and/or county must maintain documentation of the date of service and date the client was identified as a Medi-Cal beneficiary.
- Provider and/or county's documentation of date of service may include:
 - Medi-Cal ID card, Medi label or Proof of Eligibility (POE) label.
 - Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage by that carrier.
 - Photocopy of the Medi-Cal Beneficiary Card or Medi/POE labels.

Reason Code 2 (time limit: one year)¹²⁰

Delay is due to the initiation of legal proceedings to obtain payment from a liable third party pursuant to Section 14115 of the Welfare and Institutions Code.

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.

Reason Code 4 (time limit: one year)

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, where the circumstance is either delay in the certification or recertification of the provider to participate in the DMC program by the State or delay by DHCS in enrolling a provider.¹²¹

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.
- Documentation of justification for request of Good Cause must be forwarded to ADP by the county/direct contract provider, and must include:
 - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

Reason Code 7 (time limit: one year or 60 days)¹²²

Billing involving other coverage, including but not limited to Medicare, Kaiser, Ross-Loos, or CHAMPUS.

- Claims must be submitted to and received by ADP not later than the earliest of one year after the end of the month in which services were rendered and 60 days from the date of notification that third party payment was denied.
- Provider and/or county must maintain documentation of the date of service and the notification of the denial of payment by the third party.

¹²⁰ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(3) (current through March 6, 2009).

¹²¹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(E) (current through March 6, 2009).

¹²² 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(2) (current through March 6, 2009).

*Reason Code 8 (time limit: one year)*¹²³

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to a delay or error in the client/beneficiary's Medi-Cal eligibility being determined or certified by the state or county. This also applies to retroactive Medi-Cal eligibility.

- Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.
- Provider and/or county must maintain documentation of the date of service and a copy of application of Medi-Cal benefits (e.g., Supplemental Security Income [SSI] or State Supplementary Payment [SSP]) and copy of client retroactive eligibility determination.

*Reason Code 10 (time limit: 60 days from resolution of circumstances causing delay)*¹²⁴

Special circumstances that cause a billing delay such as a court decision or fair hearing decision.

- Claims must be submitted to and received by ADP not later than 60 days from the resolution of the circumstances justifying the delay.
- Provider and/or county must maintain documentation on file which includes:
 - Justification, cause and reason of delay.
 - Resolution of the delay, including the date of resolution.

Reason Code 11 (time limit: one year)

Determination by the Director of DHCS, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the provider's control, specifically due to:

- Damage to or destruction of the provider's business office or records by a natural disaster; includes fire, flood or earthquake,¹²⁵ or
- Circumstances resulting from such a disaster have substantially interfered with processing bills in a timely manner;
- Theft, sabotage or other deliberate, willful acts by an employee;
- Other circumstances which may be clearly beyond the provider and/or county's control and have been reported to the appropriate law enforcement or fire agency when applicable.

¹²³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(A) (current through March 6, 2009).

¹²⁴ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(b)(5) (current through March 6, 2009).

¹²⁵ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(a)(4)(B) (current through March 6, 2009).

Circumstances that *will not be considered* beyond the control of the provider include, but are not limited to:¹²⁶

- Negligence by employees
- Misunderstanding of or unfamiliarity with Medi-Cal regulations.
- Illness or absence of any employee trained to prepare bills.
- Delays caused by U.S. Postal Service or any private delivery service.

Claims must be submitted to and received by ADP not later than one year after the end of the month in which services were rendered.

- Documentation of justification for request of Good Cause must be forwarded to ADP by the county/direct contract provider, and must include:
 - Date of services and insurance claim reports, newspaper clippings, photographs of damages, etc.
- Documentation must be maintained by county and/or provider on site.

¹²⁶ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 1.3, §51008.5(b)(1-4) (current through March 6, 2009).

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APPENDIX A: GLOSSARY AND ACRONYMS

276	The Claim Status Request transaction used to obtain claim status information after claim submission.
277	The Claim Status Response transaction generated in response to the 276 Status Request transaction.
277U	An Unsolicited Claim Status transaction sent by SDMC without the trading partner's request.
837P	Health Care Claim Transaction for Professional Claims/Encounters.
835	The Health Care Claim Payment/Advice transaction (also known as a Remittance Advice or RA).
997	SDMC generates a 997 acknowledgement in response to each HIPAA-compliant transaction.
AB	Assembly Bill
Administrative Costs	A contractor's actual direct costs, as recorded in the contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, program review, and activities related to billing. Administrative costs may include contractor's overhead per the approved indirect cost rate proposal pursuant to Federal Office of Management and Budget Circular A-87 or A-122. ¹²⁷
ADP	Department of Alcohol and Drug Programs
AEVS	Automated Eligibility Verification System
ANSI	American National Standards Institute
AOD	Alcohol and Other Drugs
ASC	Accredited Standards Committee
ASPE	United States Assistant Secretary for Planning and Evaluation
Beneficiary	A person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the <i>Diagnostic and Statistical Manual of Mental Disorders III</i>

¹²⁷ U.S. White House Office of Management and Budget, "Circular A-87," http://www.whitehouse.gov/omb/circulars_a087_2004 (accessed April 29, 2009); U.S. White House Office of Management and Budget, "Circular A-122," http://www.whitehouse.gov/omb/circulars_a122_2004 (accessed April 29, 2009).

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Appendix A: Glossary and Acronyms

Revised (DSM), and/or DSM IV criteria; and (d) meets the admission criteria to receive DMC covered services.

BIC	Benefits Identification Card
CalWORKS	California Work Opportunity and Responsibility to Kids
CalOMS	California Outcomes Measurement System. A statewide client-based data collection and outcomes measurement system.
CCR	California Code of Regulations
CFR	Code of Federal Regulations; also, County of Financial Responsibility
CIN	Client Index Number (first 9 digits of the BIC).
Client	Anyone who is receiving alcohol or drug services.
County	A county that submits DMC claims.
Covered Services	Those DMC services authorized by Title XIX of the Social Security Act; ¹²⁸ Title 22 Section 51341.1; ¹²⁹ Health and Safety Code Section 11758.46; ¹³⁰ and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug-free treatment, narcotic replacement therapy, day care rehabilitative (for pregnant, postpartum, and EPSDT beneficiaries only), and perinatal residential AOD treatment (excluding room and board).
CMS	Centers for Medicare and Medicaid Services (U.S. Department of Health and Human Services)
Crosswalk	Cross-reference table
DCH	Day Care Habilitative
DCR	Day Care Rehabilitative
DHCS	Department of Health Care Services (formerly DHS)
DHS	Department of Health Care Services
DMC	Drug Medi-Cal. The state system wherein beneficiaries receive covered services from DMC-certified AOD treatment providers that are reimbursed for those services with a combination of State General Fund (SGF) and federal Medicaid funds.
DMH	Department of Mental Health
DP	Direct Provider. Applies to alcohol and drug service providers that contract directly with ADP and submit DMC claims.
DSS	Department of Social Services

¹²⁸ 42 U.S.C. chap. 7, subchap. XIX, §1396-1396v (current through Jan. 3, 2007).

¹²⁹ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51341.1 (current through March 6, 2009).

¹³⁰ Cal. Health & Safety Code, div. 10.5, chap. 3.4, §11758.46 (2008).

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Appendix A: Glossary and Acronyms

EDI	Electronic Data Interchange
EDS	Electronic Data Systems. The company currently contracted to provide Medi-Cal telephone support and other related services.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment. The federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries under 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.
EPSDT Supplemental Service	The supplemental individual outpatient drug-free (ODF) counseling services provided to beneficiaries eligible for the EPSDT program. Supplemental individual ODF counseling consists of any necessary individual AOD counseling not otherwise included in the ODF counseling under DMC.
EVC	Eligibility Verification Confirmation number. AEVS accesses the most current recipient information for a specific month of Medi-Cal eligibility and returns a 10-character EVC number if eligibility is confirmed. The EVC number may be entered in the remarks area of the claim, but it is not required. EVC information includes the client's eligible Aid Code(s).
FAQs	Frequently Asked Questions
FFP	Federal Financial Participation. The share of federal Medicaid funds for reimbursement of DMC services. The FFP sharing ratio is determined on an annual basis and known as the Federal Medical Assistance Percentages (FMAP). ¹³¹
FFS	Fee for Service
FMAB	Fiscal Management and Accountability Branch
FMAP	Federal Medicaid Assistance Percentages
FY	Fiscal Year
GF	General Fund
HCPCS	Healthcare Common Procedure Coding System. A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).

¹³¹ U.S. Dept. of Health & Human Services, "Federal Medical Assistance Percentages or Federal Financial Participation in State Assistance Expenditures (FMAP)," <http://aspe.hhs.gov/health/fmap.htm> (current through April 29, 2009).

HIPAA, Title II	Health Insurance Portability and Accountability Act of 1996 ¹³²
HIPAA Transaction Standards	<p>HIPAA transaction standards have five parts.</p> <p>Example: ASC X12N 837 004010 X098</p> <p>ASC—Source of a standard; in this case, the standard comes from the American National Standards Institute (ANSI) Accredited Standards Committee (ASC). This is occasionally shown as ANSI ASC or just ASC.</p> <p>X12N—A subcommittee of the ANSI ASC X12 committee; the X12N subcommittee defines EDI standards used in the insurance industry.</p> <p>837—A transaction set; in the case of the 837 transaction, Institutional, Professional, and Dental variations exist.</p> <p>004010—Version of the X12 standard; this is usually referred to as version 4010. It identifies version 4 of the standard, Release 1, sub release 0.</p> <p>X098—Internal reference numbers; in the case of the 837 transaction, three versions exist: 837I (Institutional), 837P (Professional), and 837D (Dental). Reference numbers X096, X097, and X098 identify these, respectively.</p>
IA	Interagency Agreement
ICD-9	International Classification of Diseases, 9th Edition
ITWS	Information Technology Web Services
LAAM	Levoalphacetylmethadol (a narcotic replacement drug which is currently unavailable in the United States)
LCD	The ADP Licensing and Certification Division
Medi-Cal	California's Medicaid program
Medical Necessity	AOD treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or in the case of EPSDT, services that meet the criteria specified in Title 22. ¹³³
MEDS	The DHCS Medi-Cal Eligibility Data System

¹³² Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Cong., 2nd sess., (Aug. 21, 1996).

¹³³ 22 Cal. Code Regs., div. 3, subdiv. 1, chap. 3, art. 4, §51340.1 (current through March 6, 2009).

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Appendix A: Glossary and Acronyms

Minor Consent DMC Services	Those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old upon their request without requiring parental consent or court consent ¹³⁴
NAL	Naltrexone
NCCA	National Commission for Certifying Agencies
Negative 997	A negative 997 is generated when HIPAA errors were identified in transactions during validation.
NPI	National Provider Identifier
NTP	Narcotic Treatment Program. An outpatient clinic licensed by the State to provide narcotic replacement therapy using methadone directed at stabilization and rehabilitation of persons who are opiate-addicted and have an AOD diagnosis.
ODF	Outpatient Drug Free
Perinatal DMC Services	Covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services. ¹³⁵
PHI	Patient Protected Health Information
PIN	Provider Identification Number
POE	Proof of Eligibility
POS	Point of Service
Positive 997	A positive 997 is generated when transactions were validated without HIPAA errors.
Postpartum	(As defined for DMC purposes) means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.
PSPP	Post Service Post Payment Utilization Review. The review for program compliance and medical necessity conducted by the State after service was rendered and the claim paid. State may recover prior payments if such review determines that the services did not comply with the applicable statutes, regulations, or standards.

¹³⁴ Cal. Family Code, div. 11, part 4, chap. 3, §6929 (2008).

¹³⁵ 22 Cal. Code Regs., div 3, subdiv. 1, chap. 3, art. 4, §51341.1(c)4 (current through March 6, 2009).

Projected Units of Service	The number of reimbursable DMC units of service the contractor expects to provide on an annual basis based on historical data and current capacity.
Protected Population	(1) EPSDT-eligible Medi-Cal beneficiaries under age 21; and (2) Medi-Cal-eligible pregnant and postpartum women.
Provider	A supplier of alcohol and drug treatment services in California.
Provider Master Chart	Lists all providers of services in California that are used by treatment programs.
Provider of DMC Services	Any person or entity that provides direct AOD treatment services and has been certified by State as meeting the standards for participation in the DMC program set forth in the DMC Certification Standards for Substance Abuse Clinics, Document 2E and Standards for Drug Treatment Programs (October 21, 1981), Document 2F.
RA	Remittance Advice. The 835 Health Care Claim Payment/Advice transaction.
RES	Residential (Perinatal)
ROPCB	The ADP Residential and Outpatient Programs Compliance Branch
SACPA	Substance Abuse and Crime Prevention Act
SAEVS	Supplemental Automated Eligibility Verification System
Satellite Site	The same meaning as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics document which can be found on the ADP "Support Files" page. ¹³⁶
SB	Senate Bill
SCO	State Controller's Office
SCHIP	State Children's Health Insurance Program
SDMC	The Short-Doyle/Medi-Cal Act of 1957.
SDMC System	Short-Doyle/Medi-Cal system. The claims processing system operated by the Department of Health Services to process SDMC claims.

¹³⁶ Cal. Dept. of Alcohol and Drug Programs, "Support Files," http://www.adp.state.ca.us/NNA/support_files.shtml (accessed April 29, 2009).

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Appendix A: Glossary and Acronyms

SGF	State General Funds
SMA	Statewide Maximum Allowances. The maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Rates are subject to change annually.
SOC	Share of Cost
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	State Supplementary Payment
Subcontract	An agreement between the Contractor and its Subcontractors. A Subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/client services.
Subcontractor	An individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a direct provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations.
TAPS2	Tracking and Payment System. An ADP database which holds claim status information.
Title IX	Portion of California Code of Regulations covering alcohol and drug services
Trading partners	Counties and direct providers that contract with ADP and submit DMC.
TSC	Telephone Service Center
UOS	Unit of Service. A face-to-face contact on a calendar day for outpatient drug free, day care rehabilitative, perinatal residential, and Naltrexone treatment services. Only one face-to-face service contact per day is covered by DMC except in the case of emergencies when an additional face-to-face contact may be covered for intake crisis intervention or collateral service. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and each contact shall be clearly documented in the beneficiary's record.
UR	Utilization Review
USC	United States Government Code

USDR

Uniform Statewide Daily Reimbursement Rate. The rate for NTP services based on a unit of service that is a daily treatment service provided.

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APPENDIX B: ITWS ENROLLMENT INSTRUCTIONS

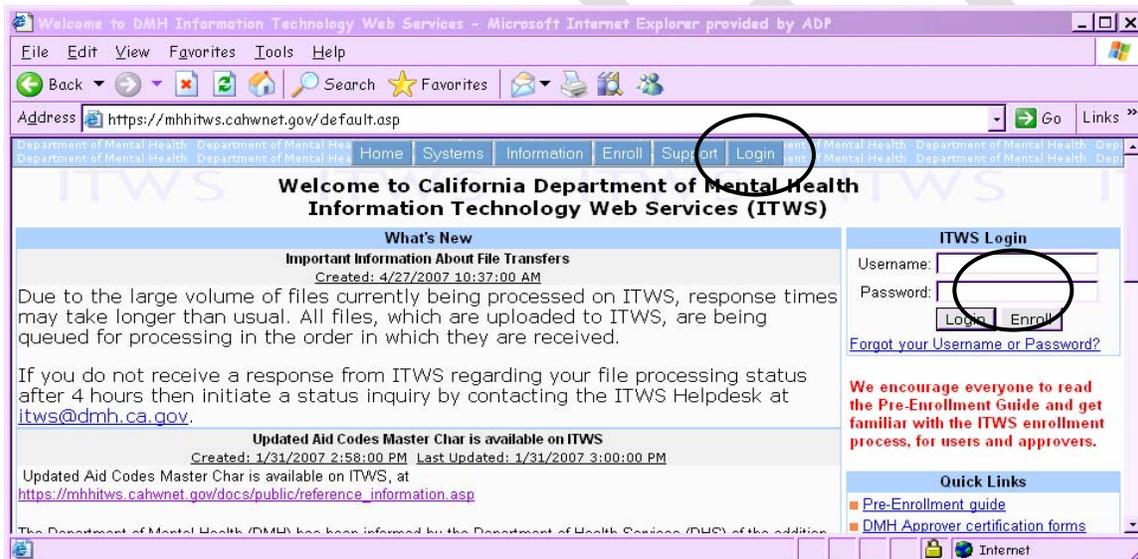
ADP's certified DMC trading partners must submit DMC claims to ADP through the ITWS secure portal at <https://mhhitws.cahwnet.gov/default.asp>.

Trading partners submit an Approver Form to request authorization for assigning/approving users for access to their organization's area of ITWS. Information and approver forms can be found under the "Support" menu on ITWS at <https://mhhitws.cahwnet.gov/default.asp>

Trading partners must request that their authorized users enroll to obtain a username and password before logging onto ITWS to access the SDMC-ADP system. User must enter their assigned username/password to submit claims and access claim status information.

To obtain a username/password a user must:

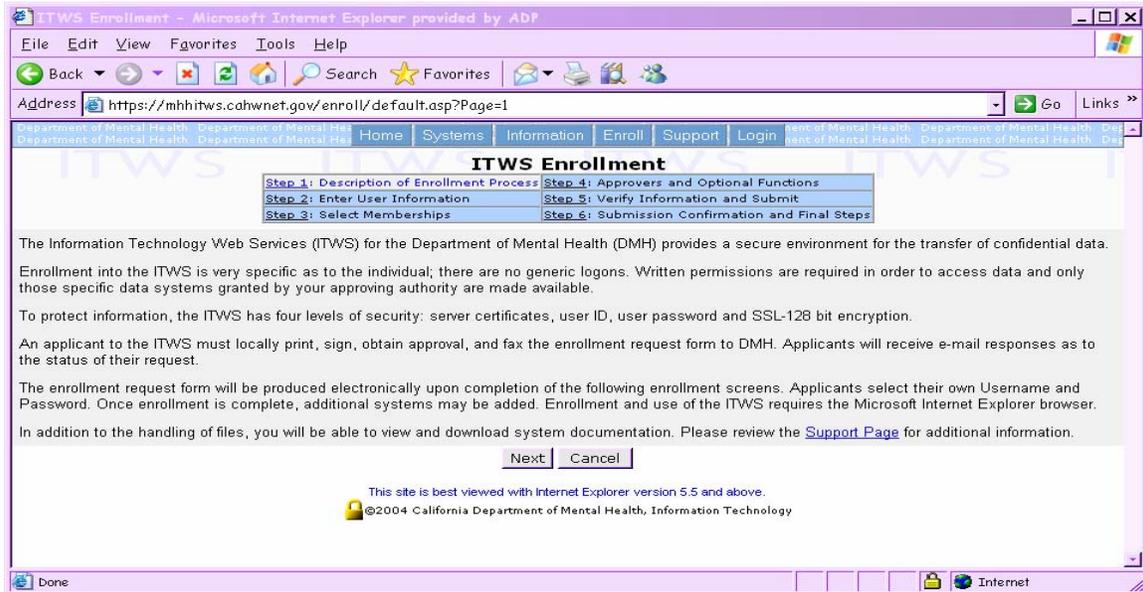
1. Access ITWS at <https://mhhitws.cahwnet.gov/default.asp>
2. Select "Enroll," either on the menu at top of the page or in the "ITWS Login" area.



DRUG MEDI-CAL BILLING MANUAL

Appendix B: ITWS Enrollment Instructions

3. ITWS Enrollment is a description of the Enrollment process and provides information and a list of the steps to follow for enrolling.
4. After reviewing the information, select the “Next” button at bottom of page to proceed to the next step of the enrollment process.



5. For the next step of the ITWS Enrollment process, complete all of the information. Click the “Help” links for assistance with select fields.

- A “User Type” must be selected from the drop-down menu.

ITWS Enrollment

Step 1: Description of Enrollment Process | Step 4: Approvers and Optional Functions
 Step 2: Enter User Information | Step 5: Verify Information and Submit
 Step 3: Select Memberships | Step 6: Submission Confirmation and Final Steps

Fields in GRAY are optional

First:

Last:

Title:

User Type: **Select a type** [Help ?](#)

Organization: **ADP Employee** [Help ?](#)

Street Address: **CONREP Field Office**

City / State / Zip: **County Employee** CA

Phone: **Direct Provider for ADP**

Fax: **DMH Employee**

Email: **Evaluator**

Username: **State Business Partners**

Password: **State Contractor**

Re-Type Password: **State Hospital**

Approver: Check this box if you are an existing ITWS approver.

User name must be 6-15 characters long and can only contain:
 A-Z, 0-9, _ (Underscore), - (Dash), or . (Period).

Password Requirements:

- Must be at least 6 characters.
- Must be re-entered exactly as typed here during login
- Password is case sensitive

Under 'User Type' select:

- 'County Employee',
- 'Direct Provider', or
- 'Vendor'

Approver box, also check if a Primary or Secondary Approver

- For submission of and access to county data by a county employee, select “County Employee” in the “User Type” box.
 - Select a county code/name; the “Organization” box must be completed;
 - For assistance see the “Help” links beside both “User Type” and “Organization.”

ITWS Enrollment

Step 1: Description of Enrollment Process | Step 4: Approvers and Optional Functions
 Step 2: Enter User Information | Step 5: Verify Information and Submit
 Step 3: Select Memberships | Step 6: Submission Confirmation and Final Steps

Fields in GRAY are optional

First:

Last:

Title:

User Type: **County Employee** [Help ?](#)

Organization: **Select an organization** [Help ?](#)

Street Address: **Select an organization**

City / State / Zip: **01 - Alameda** CA

Phone: **02 - Alpine**

Fax: **03 - Amador**

Email: **04 - Butte**

Username: **05 - Calaveras**

Password: **06 - Colusa**

Re-Type Password: **07 - Contra Costa**

Approver: Check this box if you are an existing ITWS approver.

User name must be 6-15 characters long and can only contain:
 A-Z, 0-9, _ (Underscore), - (Dash), or . (Period).

Password Requirements:

- Must be at least 6 characters.
- Must be re-entered exactly as typed here during login
- Password is case sensitive

Under 'User Type' select:

- 'County Employee',
- 'Direct Provider', or
- 'Vendor'

Approver box, also check if a Primary or Secondary Approver

- b. For submission of and access to Direct Provider data by a direct provider employee, select “Direct Provider for ADP” in the “User Type” box.
 - o The “Select an Organization” box will be disabled; the “Direct Provider” information will be selected in the ITWS Enrollment process.

Address: <https://mhhitws.cahwnet.gov/enroll/default.asp> Go Lir

Department of Mental Health | Home | Systems | Information | Enroll | Support | Login | Mental Health Department

ITWS Enrollment

Step 1: Description of Enrollment Process	Step 4: Approvers and Optional Functions
Step 2: Enter User Information	Step 5: Verify Information and Submit
Step 3: Select Memberships	Step 6: Submission Confirmation and Final Steps

Fields in GRAY are optional

First:

Last:

Title:

User Type: Help ?

Organization: Help ?

Street Address:

City / State / Zip: CA

Phone: () Ext.

Fax: ()

Email:

Username: **Username must be 6-15 characters long and can only contain:**
A-Z, 0-9, _ (Underscore), - (Dash), or . (Period).

Password: **Password Requirements:**

- Must be at least 6 characters.
- Must be re-entered exactly as typed here during login
- Password is case sensitive

Re-Type Password:

Approver: Check this box if you are an existing ITWS approver.

- c. For a Vendor which has access to ITWS on behalf of either a county or direct provider, select “Vendor” in the drop-down menu of the “User Type” box.
 - o Select the name of the Vendor from the “Select an Organization” drop-down menu in the “Organization” box.
 - o A Vendor will be listed only when a county or direct provider submitted an Approver form authorizing a Vendor, and
 - o Only when the authorized Vendor has submitted an Approver form to ADP for ITWS access.
 - o For assistance see the “Help” links beside both “User Type” and “Organization.”

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Appendix B: ITWS Enrollment Instructions

- d. **Do not** check the box for “Approver” unless the user applying for access is an existing Primary or Secondary Approver requesting User access.

- After completing the information, select “Next” to continue to the next step.
- 6. For county employee users:
 - a. To submit ADP-SDMC 837 (DMC claims) or download the adjudicated HIPAA 835, select “Short-Doyle/Medi-Cal Claims-EOB (for ADP).”
 - b. Other listed systems such as “California Outcomes Measurement System (CaIOMS)” may be selected at this time if the user is authorized to access them on behalf of the county.

- c. Leave the box “System Information and Messages access only” **(c) unchecked** if User is requesting access to submit claims and access claims data; if this box is checked, the user will only have access to ITWS system information and messages, not claims data.
- d. After selecting system(s), select the “Next” button to proceed to the next step.

- For direct provider employee users:
 - a. To submit ADP-SDMC 837 (DMC claims) or download the adjudicated HIPAA 835, select “Short-Doyle/Medi-Cal Claims-EOB (for ADP).”
 - b. Other listed systems may be selected at this time if the user is authorized to access them on behalf of the direct provider.
 - c. Select the Direct Provider number(s) for which the user is requesting access.

- d. Leave the box “System Information and Messages access only” (c) **unchecked** to request access to submit claims and access claims data; if this box is checked, the user will only have access to ITWS system information and messages, not claims data.
 - e. After selecting system(s) and direct provider number(s), select the “Next” button to move to the next step.
- For vendor users:
 - a. Select the “Direct Provider number(s)” or “County(s) Vendor is authorized to access to upload DMC claims and/or download HIPAA 835.”
 - b. To submit ADP-SDMC 837 (DMC claims) or download the adjudicated HIPAA 835, select “Short-Doyle/Medi-Cal Claims (for ADP).”

- c. Other listed systems may be selected at this time if the user is authorized to access them on behalf of the county or direct provider.

- d. Leave the box “System Information and Messages access only” **(c)** **unchecked** to request access to submit claims and access claims data; if this box is checked, the user will only have access to ITWS system information and messages, not claims data.
- e. After selecting organization(s) and system(s), select the “Next” button to move to the next step.
- Each organization (county, direct provider or vendor) must have a Primary and Secondary Approver on ITWS. If there are no Approvers, contact your organization’s fiscal or IT section for assistance.
- The user must select one of the Approvers from the list for their selected organization.
 - a. For a county user, select an “Approver” (Primary or Secondary) for the county listed under Organization; at least one (1) Approver should be listed in the drop-down menu **(a)**.

ITWS Enrollment

Step 1: Description of Enrollment Process | Step 2: Enter User Information | Step 3: Select Memberships | Step 4: Approvers and Optional Functions | Step 5: Verify Information and Submit | Step 6: Submission Confirmation and Final Steps

Approvers

Organization	System	Approver
Name of County selected by County Employee	Short-Doyle/Medi-Cal Claims - FOB (for ADP)	(a) Select Approver

Should list the County name selected by the User Type County Employee

Next Back Cancel

List under Systems identifies the system(s) and/or the resources User will have access to.

Select Primary or Secondary Approver that is listed.

- b. For a direct provider user, select an Approver (Primary or Secondary) for the Direct Provider(s) listed.

ITWS Enrollment

Step 1: Description of Enrollment Process | Step 2: Enter User Information | Step 3: Select Memberships | Step 4: Approvers and Optional Functions | Step 5: Verify Information and Submit | Step 6: Submission Confirmation and Final Steps

Approvers

Organization	System	Approver
Provider (07/01/2003 - Current)	Short-Doyle/Medi-Cal Claims - FOB (for ADP)	Select Approver
Provider (10/01/2003 - Current)	Short-Doyle/Medi-Cal Claims - FOB (for ADP)	Select Approver

Next Back Cancel

Organization list may have one or more organizations identified.

System may list more than one system and/or resources

Select a Primary or Secondary Approver for each Organization listed

- c. For a vendor user, select an Approver (Primary or Secondary) for the Vendor listed.

- After selecting an Approver, select “Next” to proceed to the next step to verify the information provided previously prior to submitting the enrollment request.

- After verifying the information on the page, and making any necessary corrections, select “Next” to submit the enrollment form to the ITWS system, and to print the enrollment form for signature and submission to the ITWS Administrator.
 - a. Have the designated Approver sign the form to authorize user access.
 - b. Fax the signed form to the ITWS Administrator at (916) 654-3007
- ITWS will notify the user by e-mail that their enrollment is approved. Contact your county or direct provider’s assigned ADP fiscal analyst with any questions.

APPENDIX C: ITWS CLAIM SUBMISSION INSTRUCTIONS

Once ITWS enrollment is approved, DMC claims can be submitted via ITWS.

1. Open a browser and type the ITWS web address: <https://mhitws.cahwnet.gov>
2. Enter the username/password requested during enrollment under "ITWS Login."
 - a. Logon can also be done using the "Login" button on the "Welcome" page.
 - b. Once logged on, the "Login" button in the top menu bar changes to "Logout." Use this button when leaving ITWS.
 - c. The first page after logging on will be the "Home" page. Later you can use the "Home" button in the top menu bar to return to this page (menu buttons display on all ITWS pages).
3. Select the "Systems" button followed by "Short-Doyle/Medi-Cal Claims" under "ADP-Alcohol and Drug Program."
4. The next page provides System Messages. Select "Transfer Files (Upload and Download)" from the "Functions" menu.
5. On the "Transfer Files" page select "SDMC-ADP Information" in the drop down menu labeled "Choose a System," if not already selected.
6. Under "UPLOAD," select the county or direct provider in the drop down menu. Select here to upload files for another county. The left side of the page lists any previously uploaded 837P files and the acknowledgement of 997 files.
7. To submit an 837P file, select the "Add..." button. Use the dialog box to select the 837P claim file to upload.
8. Once the file is located, select it and press "OK" in the dialog box.
9. The file displays in the "UPLOAD" section of the "Transfer Files" page. Click the "Upload" button below the file listing.
10. A message box displays to verify that a file is being uploaded. If the file is correct, click the "OK" button.
11. The "File Upload" page appears with the message on success of the upload and a link to the "Processing Status" page to view the tracking of the uploaded file.
12. To return to the "Transfer Files" page click the "Return to Transfer Page" button at bottom of dialog box.
13. The file that was just uploaded will be displayed on the left side.

14. E-mail acknowledgements from ITWS are generated with status messages.

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APPENDIX D: CHECKING ITWS “PROCESSING STATUS”

1. The “Processing Status” page can be checked for the status of a submitted 837P claim. Log onto ITWS and select “Processing Status” from the “Functions” menu.
2. The “Processing Status” page displays. Select “SDMC-ADP” from the “Choose a system” drop down menu. The menu options in the “Show files within list box” can be used to limit the number of files submitted to be listed in the specified time.
3. The “Processing Status” page displays tracking messages posted for each 837P file.

Two status messages are displayed in the Process Events Log for the 837 claim shown above:

- a. ITWS Received File.
- b. Received 997 File (Positive); this indicates that the 837P was accepted by SDMC as compliant with HIPAA format validation.

The 997 is an acknowledgment of receipt of a valid HIPAA file; the 997 can be downloaded from the submitter’s “Transfer Files” page, under the “DOWNLOAD” section where the 837P files are also listed.

4. Select “Transfer Files (Upload and Download)” from the “Functions” menu.

In the example below, the first file listed is the 997 acknowledgment of receipt of the 837 claim file shown directly beneath it. The 997 acknowledgment’s filename is in the same format as the corresponding 837P claim file, except 997 replaces 837.

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APPENDIX E: DOWNLOADING THE 835 REMITTANCE ADVICE

The SDMC adjudicated, approved and denied, 837P claim information will be reported in the HIPAA 835 transaction file. The 835 Healthcare Claim Remittance Advice (RA) is available for download from the ITWS “Transfer Files” page in the location where the submitted 837P and 997 acknowledgement files are posted.

The 835 RA can be used for reconciliation with 837P claim information and as a basis for Replacement or Void claims when necessary.

- Trading partners must be enrolled on ITWS to access the SDMC–ADP system to download 835 RA files.
- The 835 RA files should be downloaded, extracted, and retained in a safe and secure location to protect the contents of the file from inappropriate access.
- To download the 835 RA, go to the ITWS website at <https://mhitws.cahwnet.gov/default.asp> and logon with the appropriate ITWS username and password; use either the “Logon” menu button or the “Username” and “Password” entry boxes in the “ITWS Login” area.
- Under “Systems” menu select “ADP–Alcohol and Drug Program,” then “Short-Doyle/Medi-Cal Claims”
- Select “Transfer Files (Upload and Download)” on the option under the “Functions” menu button.
- The “Transfer Files” page lists any available electronic data interchange (EDI) HIPAA files.
- On the left side of the “Transfer Files” page under the “DOWNLOAD” is a listing of the HIPAA files which may be downloaded by trading partners; below are the file names with a brief description (please note: the samples below are from test files; files in the ITWS production environment would be named, for example, as ADP_SDM_XX_**.....ZIP, with a **P** instead of a **T**):
 - a. ADP_SDM_XX_T_835_YYYYMM.ZIP files contain adjudicated claim information for prior 837P transactions processed; approved claims will include the Warrant Number and Warrant Date.
 - 835 files may contain all denied or all approved claims, or a combination of denied and approved claims
 - 835 files are continually generated and posted once claims are processed and/or once paid claim information is received from SCO by ADP.

- b. ADP_SDM_XX_T_837_YYYYMM_XX.ZIP files are the 837P transactions submitted to SDMC via ITWS to request reimbursement of DMC services.
 - c. ADP_SDM_XX_T_997_YYYYMM_XX.ZIP is the 997 acknowledgement of 837P transactions or 276 Claim Status Request files.
 - d. ADP_STA_XX_T_276_YYYYMM_XX.ZIP is the 276 Claim Status Request sent by a trading partner for status information on an 837P claim.
 - e. ADP_STA_XX_T_277_YYYYMM_XX.ZIP is the 277 Claim Status Response to the previous 276 Claim Status Request received from the trading partner.
- To download an 835 file, highlight and select.
 - A “Download File” dialogue box will display; select the “Save” button. This will allow selection of a safe location for saving the file.
 - The “Save As” (in the browser) should display allowing you to search for a folder or create a new folder in a secure area of the organization’s system.
 - The compressed file can be opened using the county or direct provider’s password, and can be imported into the trading partner’s database, application or system in a text reader file.
 - The format for the password can be viewed at the bottom of the ITWS “System Messages” page (a user ID and password are required to view the page).

APPENDIX F: LINKS TO FREQUENTLY ASKED QUESTIONS

Drug Medi-Cal (DMC)

http://www.adp.ca.gov/dmc/dmc_FAQs.shtml¹³⁷

Narcotic Treatment Program (NTP)

<http://www.adp.ca.gov/ADPLTRS/pdf/97-46ex1.pdf>¹³⁸

HIPAA Compliance

<http://www.adp.ca.gov/hp/hipaa.shtml>¹³⁹

Licensing

<http://www.adp.ca.gov/Licensing/faqs.shtml>¹⁴⁰

¹³⁷ Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "Frequently Asked Questions," http://www.adp.ca.gov/dmc/dmc_FAQs.shtml (accessed April 29, 2009).

¹³⁸ Cal. Dept. of Alcohol and Drug Programs, "Narcotic Treatment Program (NTP) Specific Questions," <http://www.adp.ca.gov/ADPLTRS/pdf/97-46ex1.pdf> (accessed April 29, 2009).

¹³⁹ Cal. Dept. of Alcohol and Drug Programs, "HIPAA Privacy & Security," <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).

¹⁴⁰ Cal. Dept. of Alcohol and Drug Programs, Licensing, "Frequently Asked Questions," <http://www.adp.ca.gov/Licensing/faqs.shtml> (accessed April 29, 2009).

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APPENDIX G: HYPERLINKS TO MATERIALS REFERENCED IN THIS MANUAL

- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 07-04,"
http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_07-04.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 08-01,"
http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-01.pdf (accessed April 29, 2009).
- Cal. Alcohol and Drug Programs, "Bulletin 08-12,"
http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_08-12.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 98-44,"
http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_98-44.pdf. (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 99-07,"
http://www.adp.state.ca.us/ADPLTRS/PDF/ADP_Bulletin_99-07.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletin 99-39,"
http://www.adp.ca.gov/ADPLTRS/PDF/ADP_Bulletin_99-39.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Bulletins & Letters,"
http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml (accessed April 29, 2009).
- Cal. Alcohol and Drug Programs, "Calendar of Events,"
<http://www.adp.ca.gov/calendar.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "CalOMS Prevention,"
<http://www.adp.ca.gov/CalOMS/CalOMSPrevention.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "CalOMS Treatment,"
<http://www.adp.ca.gov/CalOMS/CalOMSmmain.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Confidentiality Statement for Drug Medi-Cal Patient Data," <http://www.adp.ca.gov/dmc/pdf/confidentiality.pdf> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Contact ADP,"
<http://www.adp.ca.gov/contact.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Determination of Covered Entity Status,"
http://www.adp.ca.gov/hp/pdf/covered_entity_status.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "Document Library,"
<http://www.adp.ca.gov/Library/index.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "DMC EPSDT Fact Sheet,"
http://www.adp.ca.gov/FactSheets/EPSTDT_Fact_Sheet_v4.pdf (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, "DMC Minor Consent Services Fact Sheet,"
http://www.adp.ca.gov/FactSheets/Drug_Medi-Cal_DMC_Minor_Consent_Services.pdf. (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, "DMC Provider Resource Tool-Kit," http://www.adp.ca.gov/dmc/dmc_resource_tool_kit.shtml (accessed April 29, 2009).

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Appendix G: Hyperlinks to Materials Referenced in this Manual

- Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, “DMC Provider Resource Tool-Kit Monitoring,” http://www.adp.ca.gov/dmc/dmc_drug_medical_monitoring.shtml (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Drug Medi-Cal, “Frequently Asked Questions,” http://www.adp.ca.gov/dmc/dmc_FAQs.shtml (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, “Fact Sheets,” <http://www.adp.cahwnet.gov/Library/factsheets.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, “HIPAA Privacy & Security,” <http://www.adp.ca.gov/hp/hipaa.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, “Home Page,” <http://www.adp.ca.gov> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, “Letter 97-54,” <http://www.adp.ca.gov/ADPLTRS/pdf/97-54ex1.pdf> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, “Licensing,” <http://www.adp.ca.gov/Licensing/index.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Licensing, “Counselor Certification Regulations,” <http://www.adp.ca.gov/Licensing/LCBhome.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Licensing, “Documents and Reports,” <http://www.adp.ca.gov/Licensing/reports.shtml> (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Licensing, “Drug Medi-Cal Certification,” http://www.adp.ca.gov/Licensing/Drug_MediCal.shtml (accessed April 29, 2009).
- Cal. Dept. of Alcohol and Drug Programs, Licensing, “Facility Certification,” <http://www.adp.ca.gov/Licensing/certification.shtml> (accessed April 29, 2009).
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