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ADP BULLETIN

Title

Fiscal Year 2001-02 Drug Medi-Cal Claiming Procedures and Miscellaneous Claiming Information

Acting Assistant Deputy Director Approval

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Program Operations Division

Function:
[ ]Information Management
[ ]Quality Assurance
[ ]Service Delivery
[x]Fiscal
[ ]Administration

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PURPOSE

The purpose of this bulletin is to provide processing procedures for Fiscal Year (FY) 2001-02 Drug Medi-Cal (DMC) claims. These procedures will clarify and reiterate the DMC claiming and reporting requirements.

DISCUSSION

The following Information applies to both counties and direct contract providers.

1. General Overview

Counties and direct contract providers submit DMC Claims to the Department of Alcohol and Drug Programs (ADP). ADP in turn submits the claims to the Department of Health Services (DHS) to be processed through their automated billing system. Based on the outcome of the claims, various reports are generated. As claims are approved, reimbursements are issued.

2. Drug Medi-Cal Eligibility Worksheet (ADP 1584, Revised 7/01) (Exhibit A)

A copy of the revised Drug Medi-Cal Eligibility Worksheet (ADP 1584) (Exhibit A) is enclosed, as well as general and specific information on how to complete the ADP 1584. Hardcopy (paper) claims must be submitted on the NCR form ADP 1584 or an ADP approved facsimile. Original signatures are required on each page.

Please be sure to identify each service function code separately on hard copy ADP 1584 claims.

3. Transcribing Social Security Numbers

Do **Not** use the 10th digit from the client's eligibility swipe card. Do **Not** use dashes, hyphens, or spaces when transcribing social security numbers. Doing so will generate error reports and will delay reimbursement for client services.

4. Counselor Indicators/Identifiers

Counselor indicators/identifiers are required on DMC claims (ADP 1584) for outpatient drug free and narcotic treatment program counseling services.

DMC claims for reimbursement of outpatient drug free and narcotic treatment programs counseling services shall include either the three-alpha character initials or a provider assigned, unique five-digit numeric code of the counselor providing the individual or group counseling session. Place the counselor indicator on fields 136, 137, 138, 139 and 140 of the record layout of the electronic media claims. When using alpha characters, a minimum of three letters are required in the field: the counselor's first, middle, and last initials. For example, Jane Q. Doe would be indicated as "JQD". If the counselor has no middle initial, a dash (-) should be used : "J-D". The alpha characters should be left justified and the last two fields should be left blank. The five-digit numeric code is assigned by each provider and must be unique to the counselor. It is the provider's responsibility to keep a listing of the numeric code assigned to each counselor on the site where the services were provided. In addition, the list must be provided to ADP staff upon request.

Counties and providers have the option of including the counselor indicator on their claim form for reimbursement of Day Care Habilitative, Naltrexone, and Perinatal Residential services.

5. Submission of Automated Claims

Claims may be submitted on tapes or diskettes. ADP has also developed a Paradox Runtime Disk System for submission of DMC Claims. Refer to Exhibit B for information and instructions.

6. Information Network Project (INP)

Counties who participate in the INP process must submit invoices with original, supplemental, resubmitted, and CalWORKs Claims. This identifies the submission type of the e-mail claim.

To participate in the INP e-mail process, counties must be actively reporting CADDS through the INP/ CADDS process. ADP will contact those counties who qualify to begin the process of submitting their Drug Medi-Cal billings through INP.

A rejected claim or a resubmission of denied INP claims must be accompanied by the Drug Medi-Cal INP Rejected/Resubmission Form which may be either faxed or emailed to ADP. A resubmission must be accompanied by the denied claims report to validate the resubmission.

7. Drug Medi-Cal Monthly Summary Invoice, ADP 1592

The Drug Medi-Cal Monthly Summary Invoice (ADP 1592) (Exhibit C) is the invoice that accompanies all claims submitted. It is a summary of all providers represented in the claims submission and includes the program code, provider number, type of service provided, number of units of service provided, and the total amount. All other revenues, such as share of cost, etc., collected from clients must be reported, by provider, on the ADP 1592. If a billing error is to be adjusted from the claim, it is deducted in the adjustment column, from the appropriate provider on this form.

When completing the ADP 1592, use the first Service Function Code of the treatment service/component grouping. Example: The applicable Service Function Codes for NTP Methadone Dosing are 20 and 21; use only the number 20. (Using only the first number of each treatment service/component grouping will help speed both claims processing and reconciliation of the claims. Identify SACPA clients separately by using the specific Service Function Code.

A separate ADP 1592 must be submitted for each Program Code 20 or 25 and each submission type (original, supplemental, etc.). The complete heading area should be completed including the Contract Number. If the county/direct contract provider does not know their contract number, they can call their Fiscal Management and Accountability
Branch (FMAB) analyst for this information. Make sure all totals are correct. The appropriate persons authorized to represent the county/direct contract provider must sign this form. These signatures are required on the Grand Total page only.

Resubmission of denied claims or a rejected tape/diskette does NOT require a new ADP 1592. However, when counties/direct providers are approved to submit AOD InfoNet (electronic e-mail) claims, every submission will require an ADP 1592 whether the claim is the original monthly claim, a supplemental claim, a resubmission of denied claims, or a rejected claim which has been corrected.

8. Medi-Cal Share of Cost Information

A Medi-Cal client's share of cost (SOC) is an amount determined by the Department of Social Services (DSS) to be over the amount necessary for the client's livelihood. When a person or family's net income is in excess of their maintenance need, a share of cost must be paid or obligated toward the cost of health care services before the person or family may be certified to receive Medi-Cal benefits.

In order for a provider to determine if the client has a SOC or if the SOC has been met, the provider must query the Electronic Data System (EDS) by using the client's Point of Service (POS) swipe card, the Claim and Eligibility Real-Time System (CERTS), or the Automated Eligibility Verification System (AEVS) from a touch tone phone. EDS will return the SOC status of the client.

There are four ways for a provider to forward information to notify EDS that a Medi-Cal beneficiary has met or obligated his/her SOC:

a. Swipe Card – Swipe the plastic Medi-Cal card through the Point of Service (POS) Device and then key the beneficiary SOC information into the system. The POS device includes a small screen similar to an ATM machine.

b. Telephone - Call the Automated Eligibility Verification System (AEVS) and follow the directions to input the beneficiary SOC information into the system. The telephone number is 1-800-456-2387.

c. Computer – Input the information into the computer via the Claim and Eligibility Real-Time System (CERTS) Software (if the provider has a computer linkup and the CERTS software).

d. Eligibility Worker inputs into the Medi-Cal Eligibility Data System (MEDS) – The Medi-Cal beneficiary can take the medical bill he/she has paid or has agreed to pay into the County Welfare Office and have his/her eligibility worker input the information into the system. This method takes much longer.

After the information that the SOC has been met is in the system, the beneficiary can then use his/her Medi-Cal benefits card to receive additional services in that month i.e., physicians visit, dental procedure, etc. The beneficiary may NOT use the card to pay for his/her SOC. The SOC is to be paid or obligated by the beneficiary. The beneficiary is not eligible for any Medi-Cal services until the SOC has been met and the payment amount entered into the EDS system. If the beneficiary is eligible for one day of the month, he/she is eligible for the entire month.

If it has been determined that a client has a SOC, the provider should collect his/her cost of providing service or the whole SOC amount. Enter the amount on the ADP 1592 invoice in the SOC column and the "$ Adjustments to the Gross Claim" section and deduct it from the total claim.

The telephone number to call EDS for general questions and billing information is: 1-800-541-5555. Your provider number in the EDS system is your two digit county code followed by your four-digit provider number followed by three zeros. If they cannot find your provider number, let them know that you are part of the Short/Doyle Medi-Cal
(SD/MC) system with Other Intermediary 02.

9. Submitting a "Revised" ADP 1592

When replacing an ADP 1592 with another, please write the words **"Revised"** in large letters on the Invoice face to avoid accounting errors. The FMAB analyst normally requests a revised invoice when the claim amount is more than is reflected on the original ADP 1592 submitted by the county or direct contract provider. (Refer to Exhibit C)

10. Claim Definitions

a. Original DMC Claim Submission

The original claim is **the first claim** ADP receives for a particular month and year of service. The original claim must be submitted within 30 days of the end of the month of service. Claims received thereafter are considered late.

b. Supplemental DMC Claim Submission

A supplemental claim is any claim submitted after the original submission for that particular month and year of service.

A supplemental claim can include new clients or additional services not claimed on the original submission. A supplemental claim is not an original submission and must be clearly identified by checking the Supplemental box on the ADP 1592.

c. Late Submission

If an original or supplemental claim for the same month is not submitted within the 30-day time period, it is considered to be a late submission. A good cause code is required for late submissions and must be entered on the DMC claim form. Also required is a Good Cause Certification form (ADP 6065) (Exhibit D),

to be completed and signed by a person authorized to represent the county/direct contract provider, certifying the validity of the billing. **This form should remain at the provider site in the client file for ADP monitor review or audit.** Exception – Any Good Cause Code "D" must be submitted to ADP for approval. See Exhibit D for a list of Good Cause Reason Codes and a Good Cause Certification form.

d. Resubmission Claim

A resubmission claim is a claim that is resubmitted because the unit(s) have been denied. **A copy of the Denied Claims Report must accompany the resubmission document.** If there is no proof that the units were denied, the claim will **NOT** be processed and the resubmission will be returned to the county/direct provider.

A disk, tape, or paper resubmission does NOT require an ADP 1592 invoice. However, an ADP 1592 invoice must be submitted with an INP resubmission. The form "Drug Medi-Cal Resubmission Form" (Exhibit E) must accompany any resubmissions (non-INP) that are submitted to ADP and a form "Drug Medi-Cal Information Network Project (INP)" (Exhibit F) must accompany any INP resubmission.

If **additional units of service** (UOS) are claimed, **they must be submitted separately as a Supplemental Claim with an ADP 1592** that includes those additional units.
Do not include resubmission units with supplemental units on the same claim.(These are two different processes and **cannot** be combined.)

Please apply the following suggestions before resubmitting the claim:

Do compare the denied report to the approved report.
Do check the reason code for the denial.
Do determine if the denial reason is correctable.
Do check error messages where applicable.
Do make corrections as appropriate.
Do send in the denial report with the resubmission.
Do send in resubmissions separate from supplemental claims.
Do send in resubmissions separated by batch number (Batch Number found on Denied Report).
Do send the Drug Medi-Cal Resubmission Form or the Drug Medi-Cal INP Rejected/Resubmission Form.

In some cases the units have been previously approved.
Please apply these suggestions and save valuable time and effort.

e. Rejected Submissions

A claim may be rejected by the Short-Doyle Automated Billing System (Department of Health Services Automation System) when amount claimed does not match the records contained on the disk or tape claim. When a rejection occurs, the disk or tape is returned with a cover letter to the county/direct contract provider for corrections. The cover letter has a cut-off form on the bottom portion of the letter that explains why the disk/ tape is being returned. Once the corrections are made by the County/ Direct Contract Provider, return to ADP the cut-off portion of the cover letter with the rejected claim replacement tape or disk (Exhibit E); ADP will again submit the claim to the DHS automated billing system.

Rejected INP claims must be returned through the e-mail process with the Drug Medi-Cal INP Rejected/Resubmission Form (Exhibit F), to be submitted via mail or fax.

11. DHS Reports

The Department of Health Services (DHS) generates the following reports:

a. Edit Error Correction Report
b. Duplicate Error Correction Report
c. Detailed Report by Provider of Title XIX Approved Services and Expenditures
d. Report of Approved Title XIX Services and Expenditures by County
e. Denied Claims Report
f. Aged Suspended Claims Report
g. Minor Consent Report

12. Correcting Edit and Duplicate Error Correction Reports (ECR)

The purpose of the Error Correction Repot (ECR) is to inform providers of claim lines that were suspended due to an error in claim data submission. ECRs allow providers to make corrections to erroneous data.

A completed and appropriately corrected ECR will allow ADP to process the claims of those providers that had errors on their original claims.

Error Correction Reports must be **EXPEDITED.** All ECRs must be re-entered into the billing system within 97 days of the cut-off date (date in middle of page). If ECRs are not re-entered into the system within 97 days, they will automatically be denied. The ECRs must be corrected and received by ADP within 60 days from the cut-off date. The date the ECR is due back to ADP is included in the cover letter sent to the county or direct contract provider with the ECR.

There are two types of ECRs: 1) The Edit ECR; 2) The Duplicate ECR. Each type of report will be explained in more detail later in this section. There are general instructions, which apply to both types of reports, while each report has specific instructions. A quick checklist to help make sure your ECR is correct prior to submitting it to ADP can be found in Exhibit G, Page G-21.

- Recommendation: Make all ECR corrections in **GREEN INK.**
- **Do not use an override code and make a correction on the same record**. If inappropriate corrections or override codes are used on an ECR, the Automated Billing System will ignore them. The suspended units will remain suspended for the remainder of the 97 days and become denied.
- **Do not make an entry in the correction field when information is correct. The correction field is used only for amending incorrect information.**
- Units of Service cannot be increased on an ECR. Submit a *supplemental* claim to increase the units of service for a client.
- If a client is listed on more than one record line for correction, *each* record line must be corrected. Making a correction to one record line corrects only that line.
- It is important to read the error messages on the ECR. The error messages will tell you what needs to be done to correct the problem causing the claim to be rejected.

Override Codes

The following is a list of override codes that are allowable for correcting Edit ECRs. They are:

- The “A” through “F” override codes are late submission codes from Title 22. If the ECR is affixed with a good cause code, a ‘Good Cause Certification’ form, ADP 6065, must be prepared and held in the client file. DO NOT send the Good

Cause Certification form to ADP for Good Cause Codes A, B, C, and F. DO submit to ADP Good Cause Code "D".

- The "X" override code will delete a record from the automated billing system. The "X" requires no backup documentation.
- The "W" override code, accompanied by the two digit county code and the two digit aid code, will override an eligibility only error message. This code is used **only** when you have proof that the information on the ECR is correct. This code should only be used as a *last resort* after all other correction methods have been exhausted. If using a "W" override, *ENTER THE COUNTY CODE* and *THE AID CODE* in the first four positions of the Social Security Number field, leaving the remaining positions blank. All "W" override codes will be audited by ADP's Audit Services Section. If there is no Proof of Eligibility (POE) on file at the program, an audit exception will be taken.

13. Error Messages – Edit and Duplicate ECRs

Exhibit G is a listing of possible edit and duplicate error messages that require corrections. For each error message, a problem is identified as well as possible solutions.

14. Good Cause

Important: Use the Good Cause Certification to avoid a claim being placed on suspense due to a late submission.

The Good Cause Certification is used when a claim submission is delayed beyond 30 days of the end of the month of service. If the reason for the delay is found in Title 22, California Code of Regulations, Section 51008.5, and is within the time limitation, a Good Cause code may be affixed to the claim at submission; or may be used as an override code on an Edit Error Correction Report. Most Good Cause reasons have a time limitation of one year from the date of service to submit the claim. (See Title 22, Section 51008.5)

The Good Cause code will cause the claim to be either approved or denied. The Good Cause Certification (ADP 6065, Rev. 5/97) should be completed and signed by a person authorized to represent the county/direct contract provider certifying the validity of the billing.

The provider must determine the appropriate Good Cause reason to use. The Department of Alcohol and Drug Programs cannot advise which Good Cause reason to use.

The completed Good Cause Certification form (Exhibit D-1) must be retained on site for an ADP monitor review and/or audit. **DO NOT SUBMIT THIS FORM TO ADP, WITH THE EXCEPTION OF GOOD CAUSE CODE D.**

GOOD CAUSE REASONS
FOR LATE SUBMISSIONS OF DRUG MEDI-CAL CLAIMS
ADP 6065

Providers must meet one of the six situations, "A" through "F" below, in order to qualify for good cause exemption. All time limits and documentation requirements for a particular situation must be adhered to.

a. Reason Code A – (time limit: one year)

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

1. Providers have one year from the month in which the service was rendered to identify the client as being Medi-Cal eligible on the particular date of service.

2. Given that the identification was made within the one-year limitation, providers shall submit the delayed billing not later than 60 days from the date the client was first identified as a Medi-Cal beneficiary.

3. The Department of Alcohol and Drug Programs (ADP), Fiscal Management and Accountability Branch (FMAB) must receive the delayed billings, within one year from the month in which the service was rendered.

4. Documentation to be maintained by providers:

    a. Date of service.
    b. Date the client was identified as a Medi-Cal beneficiary.
    c. Documentation to be maintained by the providers may be any of the following for the month of service:

    1. Medi-Cal ID card
    2. Medi label.
    3. Proof of Eligibility (POE) label.

4) Any of the above indicating Kaiser, Ross-Loos or CHAMPUS coverage, when accompanied by denial of coverage by that carrier.
5) Photocopy of the Medi-Cal card or Medi/POE labels.

b. Reason Code B – (time limit: one year or 60 days)

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

1. Providers have one year *after the month of service* or 60 days from the date of notification that third party payment was denied, whichever is earlier, to bill ADP for the service rendered.
2. The delayed billing must be *received* by ADP's FMAB within the stated time limit.
3. Documentation to be maintained by the providers:

    a. Date of service.
    b. Notification of denial of payment by third party.

c. Reason Code C – (time limit: one year)

Determination by the Director of the Department of Health Services or representative that the provider was prevented from submitting bills for services within the time limitation due to circumstances beyond the provider's control, delay or error in the certification or determination of Medi-Cal eligibility of *beneficiary* by the State or county. This also applies to retroactive Medi-Cal eligibility

1. Providers have one year from the date of service to bill ADP for services rendered.
2. The delayed billings must be *received* by FMAB within the stated time limit.
3. Documentation to be maintained by the providers:

    a. Date of service.
    b. Copy of application of Medi-Cal benefits (e.g., SSI/SSP); copy of re-determination of eligibility.

d. Reason Code D – (time limit: one year)

Determination by the Director of the Department of Health Services or representative that the provider was prevented from submitting bills for services within the time limitation due to the following circumstances beyond the provider's control:

1. Damage to or destruction of the provider's business office or records by a natural disaster, including fire, flood or earthquake; or circumstances involving such disaster have substantially interfered with processing bills in a timely manner.

2. Theft, sabotage or other deliberate, willful acts by an employee.

3. Circumstances that **shall not** be considered beyond the control of the provider include, but are not limited to:

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

di. Reason Code E – (time limit – two months)

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

1. Providers have two months after the date of resolution of the circumstances to bill ADP.

2. The delayed billings must be <u>received</u> by ADP FMB within the stated time limit.

3. Documentation to be maintained by the providers:

    a. Cause of delay.
    b. Resolution of the delay, including the date of resolution.

f. Reason Code F – (time limit: one year)

Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code. The provider shall have one year in which to submit the bill after the month in which services have been rendered.

15. Multiple Billing Override

The Multiple Billing Override Certification form (Exhibit H) is used to certify that a second unit of service for the same service on the same day is necessary. The Multiple Billing Override Certification must be signed by a person authorized to represent the county/direct contract provider certifying that a review of the client's record substantiates the validity of the billing. The Multiple Billing Override Certification must be retained on site to be produced for an ADP monitor review and/or audit.

DUPLICATE\MULTIPLE BILLING

In order to detect duplicate multiple billings, it is necessary to provide exact dates of service. This means that one claim line must be used for each face to face visit. Because of the need to use exact dates of service to meet Federal requirements, a higher volume of claims data is required. To mitigate the effect of this requirement on counties/direct providers that submit hardcopy claims (ADP 1584), it is possible to use arrows on the claim form to indicate repetitive information on the same client if more than two claim lines are used.

a. Duplicate/multiple units of service (for the same service on the same day) will be suspended (duplicate error correction report) for naltrexone and residential services. The purpose of the suspense is to allow for correction of data that may have been entered into the billing system in error (e.g., date of service). If the data was correct, any units of service in excess of one will be denied. There is no capability to override this edit.

b. Duplicate/multiple units of service (for the same service on the same day) for outpatient drug free and day care habilitative services will be permitted only with a certified override code. An example of acceptable duplicate/ multiple units of service would be outpatient drug free group counseling and individual counseling on the same day. An example of unacceptable duplicate/multiple units of service would be two outpatient drug free group counseling sessions on the same day.

The certified override code for day care habilitative services will only be permitted for crisis intervention services.

A Multiple Billing Override Certification form ADP 7700 will be required to be retained on site, **in the client file**, for ADP monitor or auditor review.

c. Any combination of more than two outpatient services on the same day will not be permitted, (e.g., methadone dose and an outpatient drug free counseling session).

d. Duplicate/multiple units of service that have been affixed with the override code "Y" will require a Multiple Billing Override Certification form ADP 7700 signed by the person authorized to represent the county/direct contract provider certifying that a review of the clients record substantiates the validity of the billing. This certification form should be retained on site to be produced for an ADP monitor and/or audit. **DO NOT SUBMIT THIS FORM TO ADP**.

16. Provider Report of Drug Medi-Cal Adjustments – ADP 5035C (Exhibit I)

Adjustments can be made for any unit of service that has been billed and approved for payment. One source to determine if a unit has been billed in error is reviewing the Approved Services Report. If a county/direct contract provider discovers that the unit was billed in error or that the information provided was incorrect, the unit can be deducted or "adjusted" from the claim. This must be done within the same fiscal year as the original claim was provided. These adjustments can be made by completing an ADP 5035C, deducting the amount from the provider total and submitting it with a Monthly Summary Invoice (ADP 1592) or sending it to ADP for deduction from a future claim.

The Adjustment form ADP 5035C is often submitted with the claim and deducted from the invoice. If the adjustment is for a different fiscal year it will be held and taken at cost report settlement.

When completing the ADP 5035C, remember that the adjustment must be made from the same provider, same Service Function Code, and same Program Code. The adjustment amount should be entered in one of the two Adjustment columns and subtracted from the provider total claim and the invoice claim total claim. See Exhibit I for an example of a completed ADP 5035C form.

The Program Accountability Section (PAS) of FMAB has monitors that go to the provider sites and examine the client and provider records. If PAS monitors find errors in the billings, they will recoup the dollars by using the Adjustment form ADP 5035B, which is ADP's adjustment form.

17. CalWORKs (California Work Opportunity and Responsibility to Kids)

Please continue to submit CalWORKs claims separately from other DMC Claims (i.e., on whatever media type you normally submit your claims). A separate ADP 1592 must accompany the claim. Please check the CalWORKs box on the ADP 1592 and the media and submission type appropriate to the CalWORKs claim.

18. State General Fund Payment - Counties

Counties receive a monthly payment of 1/12 of their contract amount of State General Fund (SGF) for Drug Medi-Cal services.

19. State General Fund Payment – Direct Contract Providers

The Monthly Interim Payment Claim (MIPC) (Exhibit J) process is for direct contract providers to receive their SGF payments.

By using this process, direct contract providers can receive their SGF payments without waiting for the Approved Services Report (ASR) to generate the payment of the SGF. However, the Federal Financial Participation (FFP) will only be paid from the Approved Services Report.

Direct contract providers must submit the MIPC form (ADP 7890) to ADP within 30 days after the end of the month of service. MIPC forms received after the 30-day time limit will be returned to the direct contract provider and the SGF payment will be released after the ASR is received from DHS.

The MIPC should be a projection of the units of service that will be claimed for the service month. The Fiscal Management and Accountability Branch (FMAB) analyst will review the MIPC and approve, reduce, or deny the claim based on several factors including, but not limited to; the amount of SGF remaining in the contract and the approval percentage of prior claims. ADP retains an administrative fee for narcotic Treatment Program (NTP) units of Service. Upon approval, providers will be mailed a copy of the approved claim and the claim will be forwarded to ADP's Accounting Branch for scheduling of payment to the State Controller's Office.

20. Revised Drug Medi-Cal Rates for FY 2001-02

Please utilize the new rates (Exhibit K) when submitting DMC claims for FY 2001-2002. These rates will be published in emergency regulations in Section 51516.1 of Title 22, California Code of Regulations. These rates are effective as of July 1, 2001.

21. Follow-up to DMC Provider Training

Exhibit L identifies the various issues that were raised in the DMC Billing Provider Training that was conducted in May and June 2001.

22. Fiscal Management and Accountability Branch (FMAB) Analyst Assignments

A listing of FMAB analysts, with telephone numbers, is enclosed (Exhibit M). This listing also includes the names and telephone numbers of Contracts Management Branch analysts, and a listing of their county assignments.

REFERENCES

Title 22, California Code of Regulations, Section 51341.1, 51516.1 and 51008.
CalWORKs ADP Bulletin 98-14, dated April 2, 1998.
Counselor Indicator Required –ADP Bulletin 99-21, dated June 3, 1999.
Minor consent Report ADP Bulletin 99-07, dated February 26, 1999.

HISTORY

Drug Medi-Cal (DMC) claiming procedures are issued annually.

QUESTIONS/MAINTENANCE

If you have any questions or issues regarding the procedures, please contact the Fiscal Management and Accountability Branch (FMAB) analyst assigned to your county (Exhibit M).

EXHIBITS

Exhibit A - ADP 1584 Drug Medi-Cal Eligibility Worksheet
Exhibit B - Automated Claims Submission
Exhibit C - ADP 1592 Drug Medi-Cal Monthly Summary Invoice
Exhibit D - ADP 6065 Good Cause Certification
Exhibit E - Drug Medi-Cal Resubmission Form (Non-INP)
Exhibit F - Drug Medi-Cal INP Rejected/Resubmission Form
Exhibit G - ECR Processing Instructions, Critical Fields and Check List
Exhibit H - ADP 7700 Multiple Billing Override Certification
Exhibit I - ADP 5035C Report of Drub Medi-Cal Claims Adjustment
Exhibit J - ADP 7890 MIPC (Monthly Interim Payment Claim)
Exhibit K - DMC Rates 2001-02
Exhibit L - Drug Medi-Cal Billing Training Follow-Up Questions and Clarification Issues

Exhibit M - CMB and FMAB Analyst Assignments

DISTRIBUTION

County Alcohol and Drug Program
Administrators Wagerman Associates, Inc.
Director's Advisory Council
Drug Medi-Cal Providers