State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 30, 2013

ALL PLAN LETTER 13-006

TO: ALL MEDI-CAL MANAGED CARE HEATLH PLANS

SUBJECT: ENCOUNTER DATA ELEMENT FOR MEDI-CAL MANAGED CARE
             HEALTH PLANS, VERSION 2.0.

PURPOSE

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with revised instructions to use when submitting encounter data to the Department of Health Care Services (DHCS) using the "Encounter Data Format." The revised instructions titled, "Encounter Data Element Dictionary for Managed Care Plans, Version 2.0," are provided as an attachment to this APL. This data dictionary only applies to encounter data submitted in the "Encounter Data Format." It does not apply to encounter data submitted in S-35C or National Council for Prescription Drug Programs formats.

POLICY

Version 1.5 of the data dictionary was published in July 2006. The attached data dictionary is an updated version of that document. This update is intended to simplify and clarify the data format used by MCPs to submit high-quality encounter data. The changes between version 1.5 and version 2.0 are listed in Table 1 below.

Table 1: List of Changes

Data Element	Name	Nature of change
	Global Changes	Minor formatting changes throughout document.
3	FORMAT CODE	Added clarification that Long Term Care (LTC) encounters should use value 'L', not value 'H' (not a change to rules, just added clarification).
4	PROGRAM CODE	Added clarification regarding Child Health and Disability Prevention Program services reporting.
5	ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER/CLAIM CONTROL NUMBER	Added clarification regarding reporting adjustments.
13	PROVIDER NUMBER (REPORTING/BILLING)	Changed rules to permit ONLY National Provider Identifier (NPI), except in cases where the provider does not qualify for NPI according to National Plan and Provider Enumeration System (NPPES).

Data Element	Name	Nature of change
17	PROVIDER TYPE CODE	Updated the list of valid values to match most current list in use.
18	PHYSICIAN SPECIALTY CODE	Updated the list of valid values to match most current list in use.
21	REFERRING/PRESCRIBING/ ADMITTING PROVIDER	Changed rules to permit ONLY NPI, except in cases where the provider does not qualify for NPI according to NPPES.
38	PLACE OF SERVICE	Updated the list of valid values to match most current list in use.
39	PROCEDURE CODE – CURRENT PROCEDURAL TERMINOLOGY 4, HCFA COMMON PROCEDURAL CODING SYSTEM OR UNIFORM BILLING-04 CODES	Updated to state that DHCS expects to receive national standard codes, not local codes in this data element.
42	RENDERING PROVIDER NUMBER	Changed rules to permit ONLY NPI.
43	DRUGS/MEDICAL SUPPLIES	Clarified description of this data element, including clarification around valid code sets.
44	DRUG/MEDICAL SUPPLY INDICATOR CODE	Clarified description of this data element.
47	LTC ACCOMMODATION CODES	Updated to most current list of valid values.
51	PATIENT STATUS CODE	Added clarifications that the code set used for this data element depends on the type of record, and that this data element must not be blank on Hospital and LTC records.

If you have questions or concerns about the information included in this APL, please contact Aaron Toyama, Chief, Performance Measurement Unit, at: Aaron.Toyama@dhcs.ca.gov.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Attachment

ENCOUNTER
DATA ELEMENT DICTIONARY
FOR
MANAGED CARE PLANS
VERSION 2.0

April 2013
Medi-Cal Managed Care Division

TABLE OF CONTENTS

SUMMARY OF CHANGES TO VERSION 2.0

This document is an update of the *Encounter Data Element Dictionary For Managed Care Plans Version 1.5* published in July 2006. The changes made to that document are as follows:

Data Element	Name	Nature of change
	Global Changes	Minor formatting changes throughout document.
3	FORMAT CODE	Added clarification that Long Term Care encounters should use value 'L', not value 'H' (not a change to rules, just added clarification).
4	PROGRAM CODE	Added clarification regarding CHDP services reporting.
5	ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN/CCN)	Added clarification regarding reporting adjustments.
13	PROVIDER NUMBER (REPORTING/BILLING)	Changed rules to permit ONLY National Provider Identifier (NPI), except in cases where the provider does not qualify for NPI according to NPPES
17	PROVIDER TYPE CODE	Updated the list of valid values to match most current list in use.
18	PHYSICIAN SPECIALTY CODE	Updated the list of valid values to match most current list in use.
21	REFERRING/PRESCRIBING/ADMITTING PROVIDER	Changed rules to permit ONLY National Provider Identifier (NPI), except in cases where the provider does not qualify for NPI according to NPPES
38	PLACE OF SERVICE (POS)	Updated the list of valid values to match most current list in use.
39	PROCEDURE CODE (CPT 4, HCPCS OR UB-04 CODES)	Updated to state that DHCS expects to receive national standard codes, not local codes in this data element.
42	RENDERING PROVIDER NUMBER	Changed rules to permit ONLY National Provider Identifier (NPI)
43	DRUGS/MEDICAL SUPPLIES	Clarified description of this data element, including clarification around valid code sets.

Data Element	Name	Nature of change
44	DRUG/MEDICAL SUPPLY INDICATOR CODE	Clarified description of this data element.
47	LONG TERM CARE (LTC) ACCOMMODATION CODES	Updated to most current list of valid values.
51	PATIENT STATUS CODE	Added clarifications that the code set used for this data element depends on the type of record, and that this data element must not be blank on Hospital and Long Term Care records.

MEDIUM FOR SUBMISSION OF DATA

All encounter data must be submitted through Medi-Cal Web Site telecommunication. The data must be in ASCII or EBCDIC format and in the appropriate "encounter data submission record layout". The web site is a communications infrastructure that supports the secure exchange of electronic information among the many organizations accessing the web site. Paper submissions for encounter data are not acceptable.

When using the Medi-Cal Web Site for faster uploads, compress files using PKZIP or WINZIP. Upload file size is limited to 2 Mb during peak business hours (8:00 AM to 6:00 PM, Pacific Standard Time) and 6 Mb during off-peak business hours. If your input file exceeds this size, it will not be accepted by Medi-Cal.

The naming convention used when setting up the file is at the discretion of the submitter.

Before every submission, the plan must send e-mail notification to their assigned Fiscal Intermediary analyst.

TRANSMISSION

Telecommunication: Medi-Cal Web Site

ACCESSING THE MEDI-CAL WEB SITE

To sign up for a Medi-Cal Web site User ID and Password you must fill out the Medi-Cal Web Site Managed Care Plan Agreement Form. Please contact the POS Help Desk for the Medi-Cal Web Site Managed Care Plan Agreement Form.

POS/Internet Help Desk
820 Stillwater Rd
West Sacramento, CA 95605
1-800-541-5555

(See sample document at end of this section). *This form is not currently available on the web site.*

SYSTEM REQUIREMENTS

Basic requirements are as follows:

- Printer (if you intend to print downloaded publications)
- Latest version of an Internet browser (older versions may work but they may not support certain technologies used on the Medi-Cal Web site)

- Specific software applications for viewing documents online and performing Medi-Cal transactions

HARDWARE

Computer: Windows 98 operating system or higher; Pentium I processor (1.33 MHz) or higher; minimum 32 MB RAM
Modem Speed: Minimum 28 kilobits per second (KBps)
Monitor: Any monitor will work, but for best viewing results a 17-inch monitor or larger with a resolution set to 1024 x 768 is recommended.
Printer: A PostScript printer is recommended for printing publications downloaded from the Medi-Cal Web site. Most printers sold today support PostScript, but older printers may not.
Internet Connection: Any type of Internet connection will work, but a broadband connection, such as DSL or cable, is recommended for fastest page viewing and document downloading.

SOFTWARE
Browser: Microsoft® Internet Explorer (IE) version 5.0 or higher, Mozilla Firefox or Netscape Navigator version 6.2 or higher. Older browser versions may work but they may not support certain technologies used on the Medi-Cal Web site. For best results, we recommend using the most current browser version, which can be downloaded either via the Medi-Cal website's Web Toolbox (http://www.medi-cal.ca.gov/toolbox.asp) or through the individual companies' websites.

> **Note:** Your browser may need to be configured to interpret JavaScript and accept cookies. This process is different for IE, Firefox, and Netscape® Navigator. Please refer to the Microsoft, Mozilla or Netscape website for instructions.
>
> Microsoft: http://support.microsoft.com/
>
> Mozilla: http://support.mozilla.com/en-US/kb/
>
> Netscape: http://browser.netscape.com/
>
> To access the Medi-Cal Web site, type in the following address in the address box of your browser: www.medi-cal.ca.gov. The Medi-Cal homepage displays. Clicking on the links on the homepage enables you to use the products and services available on the Web site.

SAMPLE MEDI-CAL WEB SITE MANAGED CARE PLAN AGREEMENT FORM

<u>This agreement is required of all Medi-Cal Managed Care Plans (Plan) intending to utilize the Medi-Cal Web Site applications at www.medi-cal.ca.gov.</u>

I (a). The California Department of Health Services (DHCS) will permit the use of the California Medi-Cal Web Site by the following Managed Care Plan:

Plan Name: _____ subject to the terms and conditions of this agreement.

I (b). Plan requests access to the Medi-Cal Web Site for the following service(s) and are subject to the terms and conditions of this agreement:

_____ 1). Encounter Data

_____ 2). Eligibility File (FAME)

II. Plan agrees to limit the usage of the Medi-Cal Web Site to the following Medi-Cal eligibility and claims-related transactions on the Medi-Cal Web Site:

A. Submission of other transactions as may be subsequently permitted by DHCS and as documented in one or more of the user manuals identified above or in the Publications area of the Medi-Cal Web Site.

B. Browsing of Medi-Cal Web Site.

C. Submission and retrieval of Encounter Data files and/or reports.

D. Retrieval of the Eligibility file (FAME)

III. Plan agrees to report all malfunctions of the Medi-Cal Web Site to the POS/Internet Help Desk at 1-800-541-5555.

IV. Plan acknowledges that failure to limit the usage of the Medi-Cal Web Site to the transactions and or processes described above may, at a minimum, result in DHCS revoking the privilege to use the Medi-Cal Web Site. Abuse of transactions and processes available on the Medi-Cal Web Site may result in DHCS revoking Plan access to the Medi-Cal Internet.

V. Plan acknowledges that neither DHCS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHCS.

VI. For POS Help-Desk validation, Plan contact validation data:

Primary Name:_____Phone:_____Email:_____

Back-up Name:_____Phone:_____Email:_____

Plan Validation Password:

VII. Plan Signature:

> I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement. Phone number is provided in the event neither the Primary nor Back-up is the caller requesting help from the POS Help Desk. The Authorized Signatory will be contacted to confirm caller's identification.

_____   _____

Printed Name of Signatory   Authorized Signature

_____   _____   _____

Title   Phone   Date

For assistance or inquiries please call the POS/Internet Help Desk at 1-800-541-5555 between the hours of 6:00 AM and 12:00 AM Pacific Standard Time, Sunday through Saturday.

Return the completed and signed agreement to:

POS/Internet Help Desk
820 Stillwater Rd
West Sacramento, CA 95605

ACCESSING THE SYSTEM

1. Medi-Cal Home Page – www.medi-cal.ca.gov

The user will view the following screen when logging into the Medi-Cal Web site.

Action: Click on Transactions.
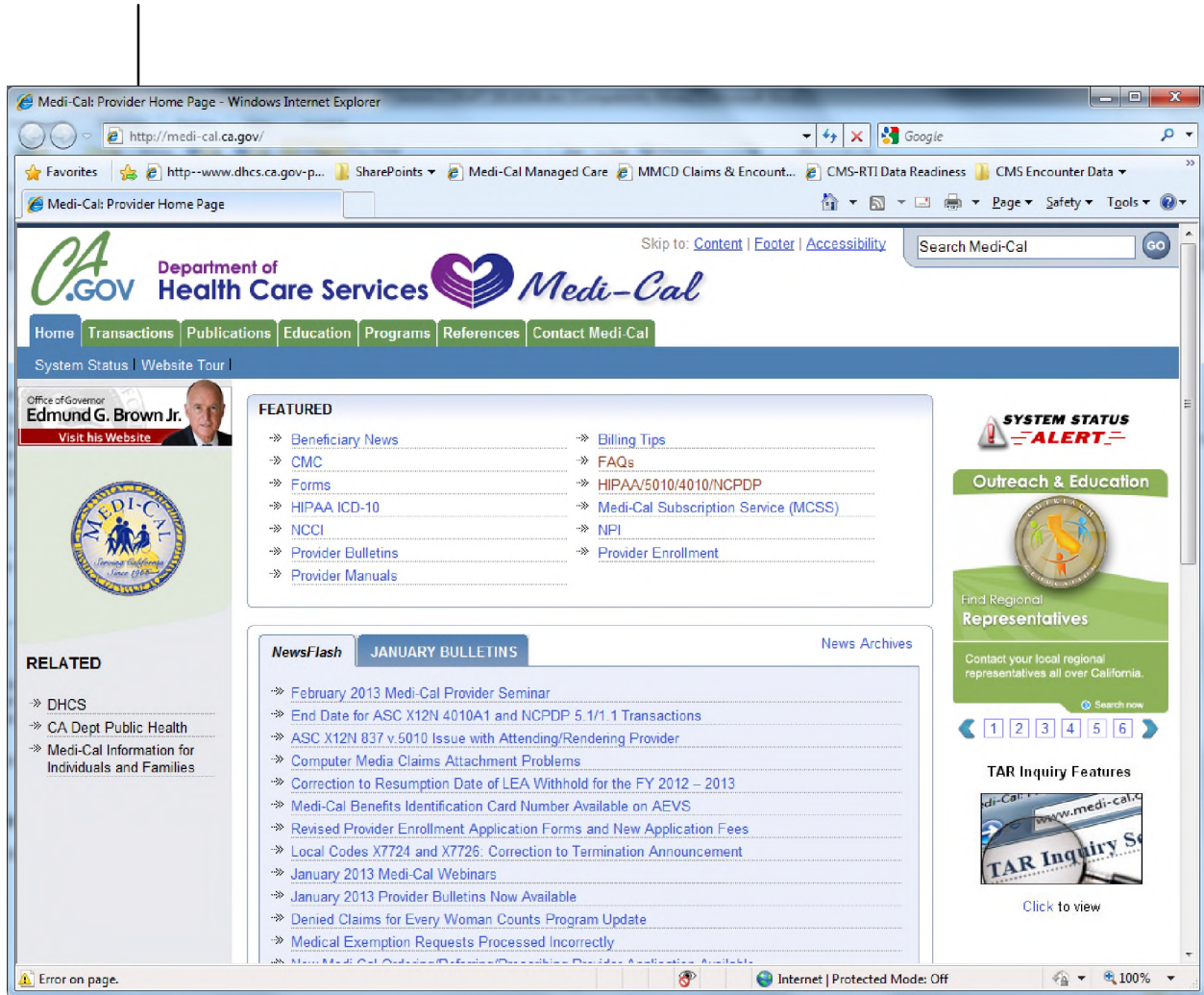
2. User Validation-login

Logon Page

Logon instructions:

1. Enter your user ID.
2. Enter your password.
3. Click **Submit**.

Once your user ID and password are authenticated, the Transaction Services page displays, listing services and transactions available to you based on your user ID and password. Below is an example of the Transaction Services page for Managed Care Plans.

3.   Provider Services Main Menu

Action: To submit a data file click on Uploads.
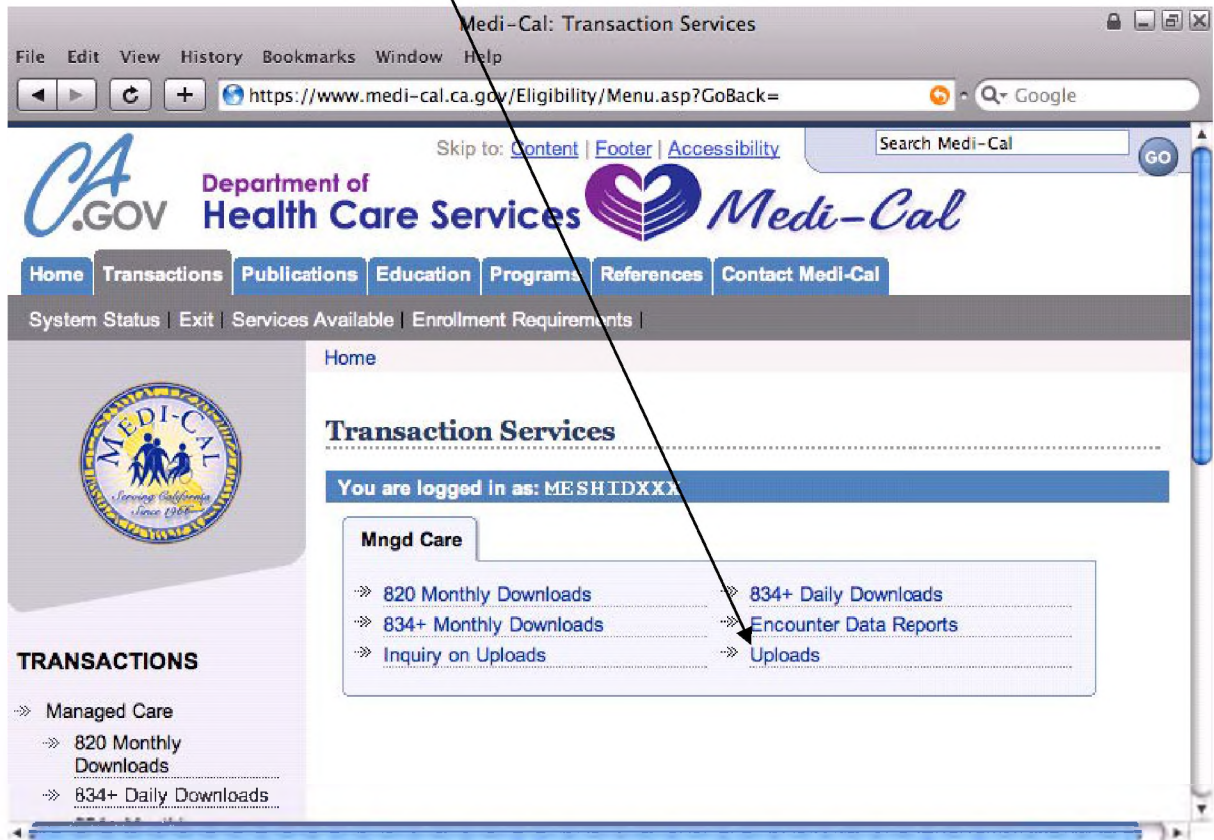
4. Managed Care Uploads

Action: Hit Browse, select a file and press Upload File.

5.   Managed Care Upload Response

Action: User writes down Volser number for future reference
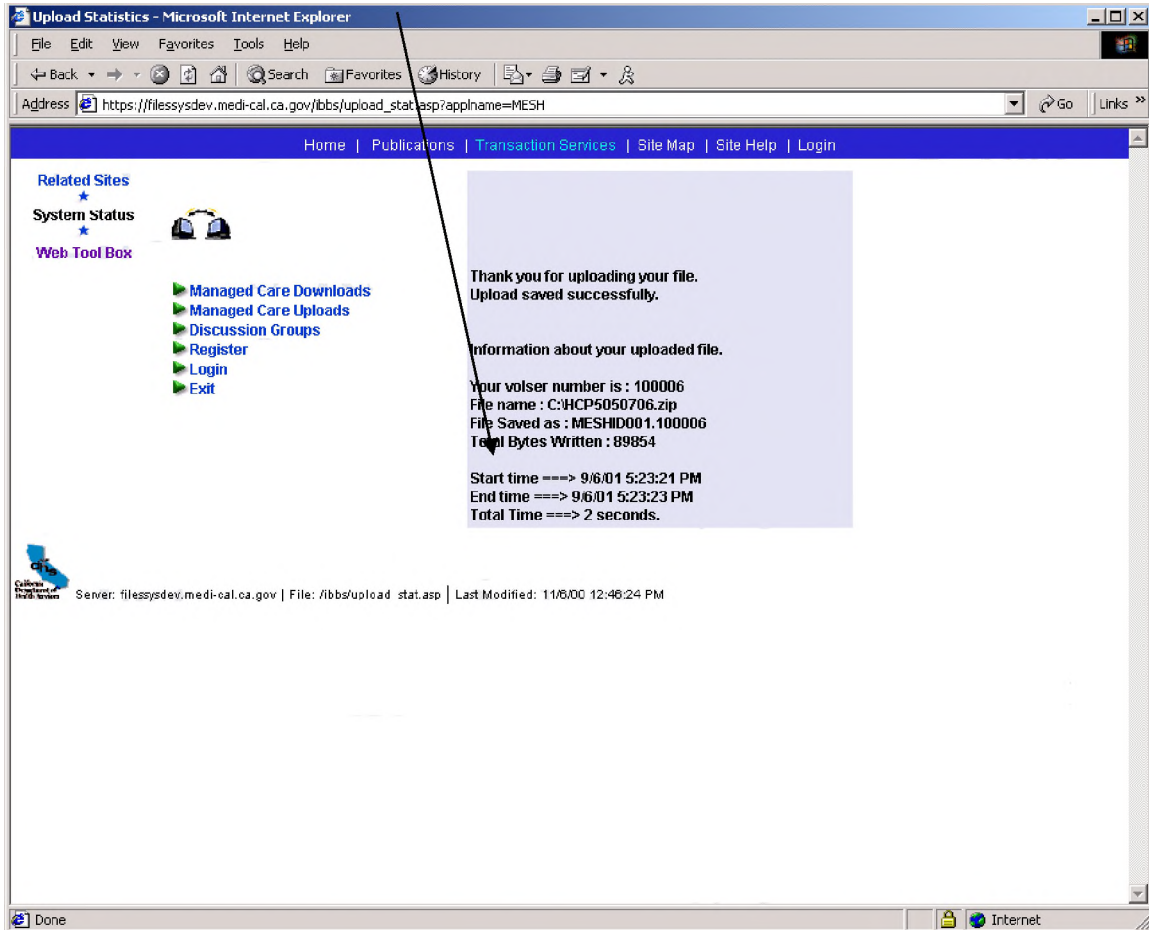
6.   Inquiry on Managed Care Downloads

Action: To confirm that the files were uploaded, from the above screen click on the link 'Inquiry on Upload'. This is a listing of all files successfully uploaded and the assigned Volser # for each file.

User ID	Date/Time of Upload	Filename	Volser #	File Size
MESHID***	6/30/2009 7:25:12 PM	MESHID***.211478	211478	2368918
MESHID***	6/30/2009 7:00:11 PM	MESHID***.211477	211477	1649475
MESHID***	6/30/2009 6:59:18 PM	MESHID***.211476	211476	1457486
MESHID***	6/30/2009 6:55:12 PM	MESHID***.211475	211475	1593521

For uploads, you must compress all files using PKZIP OR WINZIP.
To download PKZIP, go to http://www.pkware.com/.
To download WINZIP, go to http://www.winzip.com/index.htm.

You may download free versions of MS Word, Excel, PowerPoint and Adobe Reader Document viewers directly from the Medi-Cal website. With these you can read, copy, or print documents you received but you cannot alter then. These tools are located at http://www.dhcs.ca.gov/pages/freewebtools.aspx or at http://www.medi-cal.ca.gov/toolbox.asp
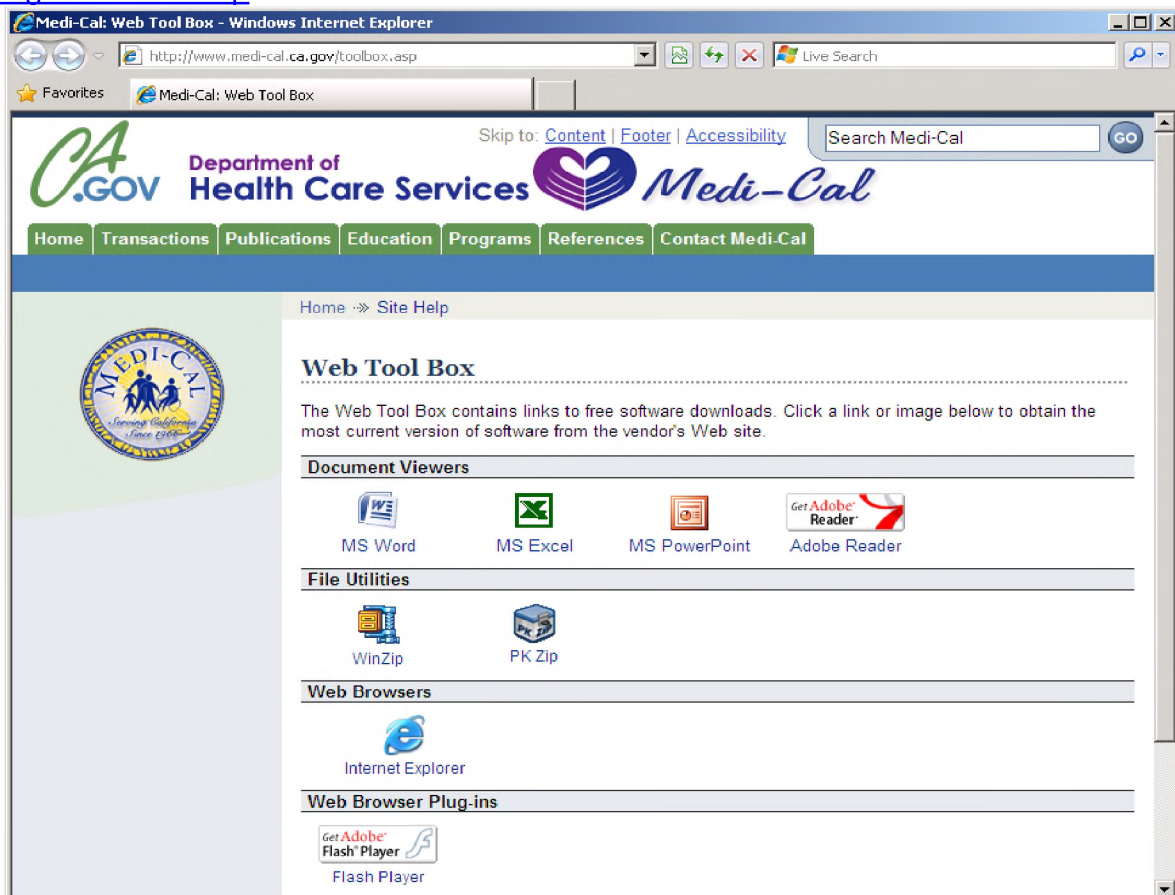
EDIT PROCESS

Test Condition Description
DE 01: **Claim Reference Number** 1. CRN/CCN is a duplicate of another record within same file. 2. CRN/CCN date is greater or less than the run date. 3. CRN/CCN contains less than 13 numeric characters, contains invalid characters or is in an invalid format.
DE 02: **Plan Code** 1. File contains a plan code in the header record that does not match the code in the body of the record. 2. Record contains invalid characters or is in an invalid format.
DE 03: **Format Code** 1. Format code on record is not an M, P, L or H or is left blank.
DE 04: **Program Code** 1. Program code on record is not a C, S or P or is left blank.
DE 05: **Adjustment Code** 1. Record is left blank and an adjustment CRN/CCN, DE #6 is present. 2. Record contains a code and no adjustment CRN/CCN is present
DE 06: **Adjustment CRN/CCN** 1. CRN/CCN contains less than 13 numeric characters, contains invalid characters or is in an invalid format.
DE 07: **Beneficiary ID** 1. Record contains an invalid County code or Aid Code. Aid code must be one used in MCP. 2. Record contains a BID number that is less than 14 alphanumeric characters.
DE 08: SSN – (#1-4 informational only) 1. Record contains a Medi-Cal BID, CIN (Client index number) or SSN (Social Security number) that are not found on the Eligibility file. 2. Record contains an ID with invalid characters (spaces or special character). 3. Record contains a SSN that has alphanumeric characters in bytes 2 through 8. 4. Recipient not eligible for month of service
DE 09: **Beneficiary Name** 1. Record contains spaces for the beneficiary name.
DE 10: Date of Birth 1. Record contains a DOB that is not numeric or is not in a valid format. 2. Record contains DOB that is greater than the run date. 3. Record contains a DOB with the year less than 1850 or greater than 2050 4. Date of birth does not match FAME record **(informational only)**
DE 11: **Sex Code** 1. Record contains a blank or is not 'M' or 'F' 2. Sex does not match FAME record **(informational only)**

Test Condition Description
DE 13: Provider Number 1. Record contains spaces or a non-alphanumeric value 2. Record contains a Billing Provider number that does not exist on the Billing Provider file (MR-F-177) **(informational only).**
DE 14: Provider Name 1. Record contains spaces for the provider name
DE 15: Zip Code 1. Record contains a nonnumeric zip code or '00000'.
DE 16: Provider County 1. Record contains a nonnumeric character or is left blank. 2. Record contains a County Code for Provider (Rendering) and the record does not exist on MMIS table 0211
DE 17: Provider Type 1. Record contains invalid characters (not alphanumeric) for the provider type. 2. Record contains an invalid provider type (not found on Encounter table).
DE 18: Provider Specialty 1. Field was left blank. Physician Specialty is required for Provider Types 022, 026 or DN. 2. Field contains a code or is invalid when PT not 022,026 or DN. Field must be blank or filled with spaces **(informational only)**
DE 19: Beginning Date of Service 1. Record contains a date that was not numeric or in the correct format 20040925. 2. Record contains a beginning DOS that is less than the Encounter Data start (Before January 1, 1994). 3. Record contains a beginning DOS that is greater than the run date.
DE 20: Ending Date of Service 1. Record contains a date that was not numeric or in the correct format 20040925. 2. Record contains an ending DOS that is greater than the run date. 3. Record contains an ending DOS that is less than the Encounter Data start (Before January 1, 1994). 4. Record contains an ending DOS that is less than beginning DOS.
DE 21: Refer/Pres/Admit Provider # 1. Record is a pharmacy or Inpatient record and the Referring Provider number contains spaces – This is required on all records 2. Record contains a Referring Provider number that does not exist in the Referring Provider file (MR-F-178). 3. Record contains a Referring Provider number that is not alphanumeric **(informational only).**
DE 22: Prior Authorization No critical errors for this data element

Test Condition Description
DE 23, 24 & 25: Primary/Secondary/Tertiary Diagnosis Code: Primary Dx required on all LTC & Hospital and for Provider Type (DE #17) 5,6,7,10,22,26,27,31,32,34,35,40,41,43,44,46 or 49 in Medical Records. 1. Diagnosis is not 5 alphanumeric characters 2. Record contains a code that does not exist on the Diagnosis file and the Encounter Data Table 3. Record is blank or contains spaces and file type requires reporting. **This pertains only to DE #23**
DE 26: Family Planning Indicator No critical errors for this data element.
DE 27: Adjudication Status 1. Record does not contain a C (Capitated), D (Denied) or P (Paid)
DE 28: Adjudication Date 1. Record contains a date that was not numeric or in the correct format (20040925). 2. Record contains a date that is greater than the run date. 3. Adjudication date is out of range (1994-2050)
DE 29 – Date of Payment 1. Record contains a date that is not numeric or in the correct format (20040925) 2. Date of Payment is out of range (1994-2050) 3. Record contains a date that is greater than the run date. 4. Date of pay by plan/check date must be 0 when adjudication status is 'C'
DE 30: Billed Amount (required for Paid services only) 1. Amount is not 9 numeric characters.
DE 31: – Reimbursement Amount (required for Paid services only) 1. Amount is not 9 numeric characters
DE 32: – Patient Liability (required only if recipient has Share of cost) 1. Amount is not 9 numeric characters
DE 33: – Medicare Deductible Amount (required only if recipient has Share of cost) 1. Amount is not 9 numeric characters
DE 34: – Medicare Co-ins (this field must be zero field) 1. Field does not contain zeros
DE 38: Place of Service 1. POS is not 2 alphanumeric characters, contains spaces or invalid characters. 2. Record contains a POS that does not exist
DE 39: Procedure Code 1. Code is not 5 alphanumeric characters or contains invalid characters. 2. Record contains a code that does not exist on the Procedure code extract or the Encounter 1500 table.

Test Condition Description
DE 40: Procedure Modifier 1. Code is not 2 alphanumeric characters or contains invalid characters. 2. Record contains a code that does not exist on the MMIS 0384 table or the Encounter 1200 table.
DE 41: Quantity 1. Code is not 5 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.
DE 42: Rendering Provider Number - required for Provider type (DE #17) 05, 07, 10, 22 & 26 1. Record contains spaces. 2. Field is not 12 alphanumeric characters or contains invalid characters.
DE 43: NDC/UPC code 1. Record is not 11 numeric characters 2. Record contains a UPC/NDC code that does not exist on the Formulary file.
DE 44: Drug/Medical Supply indicator (1 byte) 1. Record contains a non-alphanumeric character. 2. Drug/medical supply indicator does not match MMIS file
DE 45: Drug Quantity 1. Code is not 5 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.
DE 46: Days Supply 1. Code is not 3 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Quantity must be greater than zero.
DE 47: LTC Accommodation Code 1. Code is not 2 alpha numeric characters or contains invalid characters. 2. Record contains an LTC accommodation code that is not found on MMIS table
DE 48: Days Stay 1. Code is not 3 numeric characters or contains invalid characters. 2. Field contained zeros '00000' Days Stay must be greater than zero.
DE 49: Admission Date 1. Record contains a date that was not numeric or in the correct format (20040925). 2. Admission date is out of range (1994-2050)"
DE 50: Discharge Date 1. Record contains a date that was not 8 numeric characters or in the correct format (20040925). 2. Discharge date is out of range (1994-2050) 3. Discharge date is before admission date (DE #49) 4. Discharge date is not valid for patient status

Test Condition Description
DE 51: Discharge/Patient Status (required on LTC & Hospital or Provider type 05, 06, 10, 22 & 26 in Medical   1. Record contains spaces/blanks and met above requirements.   2. Status is not 2 numeric characters on LTC or Hospital record   3. Status is not 2 alpha characters on Medical record
DE 52: Admission Necessity – Hospital files   1. Record does not contain a 1 (Emergency), 2 (Elective) or 3 (Newborn) or contains spaces or invalid characters.
DE 53: 1st Surgical Code – Hospital files   1. Code is not 5 alphanumeric characters   2. Code does not exist on the Procedure extract file.
DE 54: 2nd Surgical Code – Hospital Files   1. Code is not 5 alphanumeric characters   2. Code that does not exist on the Procedure extract file.
DE 56: # of Claim Lines – required on Hospital Files. Can submit up to 22 detail lines   1. Code is not 2 alphanumeric characters   2. Record contains zeros or a number greater than 22.
DE 57: Accommodation/Ancillary codes   1. Code is not 3 alphanumeric characters   2. Code not found on Encounter Table.
Header Record: Error in header record will reject the 'entire' file.   1. Header record count not numeric or in an invalid format   2. Header record count not equal to actual record count in file.   3. Header record without any submitter records   4. Encounter file contains no header record.   5. Header create date not numeric   6. Invalid header submitter ID

ENCOUNTER DATA HEADER RECORD FORMAT

HEADER RECORD: SUBMITTER ID

Purpose:
Unique number to identify each plan submitter.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTESS :	3
FORMAT:	XXX
RECORD LOCATION:	Columns 1 through 3
REQUIRED ON:	Header record of each submission

COMMENTS:
DHCS currently assigns each health plan a unique submitter ID that corresponds to the last three bytes of their Plan Code. Health plans must enter their unique submitter ID on the encounter header for each submission.

HEADER RECORD: VOLUME ID

Purpose:
Used by DHCS to uniquely identify each submission. Leave blank.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTESS :	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 4 through 9
REQUIRED ON:	Header record of each submission

COMMENTS:
DHCS USE ONLY; Leave blank.

HEADER RECORD: MEDIA TYPE

Purpose:
Identifies the media type (diskette, tape, or telecommunications) of each submission.

CHARACTER TYPE:	Alpha/Numeric

NUMBER OF BYTESS :	1
FORMAT:	X
RECORD LOCATION:	Columns 10
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the code corresponding to the type of media for the submission.

D = Diskette
T = Tape
E = Telecommunications

HEADER RECORD: HEADER INDICATOR

Purpose:
To identify to the processing system that this is the encounter header record.

CHARACTER TYPE:	Alpha
NUMBER OF BYTESS:	3
FORMAT:	XXX
RECORD LOCATION:	Columns 11 through 13
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the value of 'HDR' in this field.

HEADER RECORD: SUBMISSION DATE

Purpose:
Identifies the date the submission was sent to DHCS in year and Julian date format.

CHARACTER TYPE:	Numeric
NUMBER OF BYTESS:	4
FORMAT:	YJJJ
RECORD LOCATION:	Columns 15 through 18
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the last digit of the year in column 15 and the Julian date in columns 16 through 18. For example: If the submission is sent on December 15, 2005, the date in this field will be entered as '5349'.

HEADER RECORD: SUBMITTER NAME

Purpose:
Identifies the name of the health plan submitting data.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTESS:	33
FORMAT:	X(33)
RECORD LOCATION:	Columns 24 through 56
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the full name of the health plan in all UPPERCASE letters (CAPs).
Left justify, space fill.

HEADER RECORD: RECORD COUNT

Purpose:
Delineates the number of records within the submission. This count should only include the number of actual data or encounter service records and should not include the header record as part of the count.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	6
FORMAT:	XXXXXX
RECORD LOCATION:	Columns 57 through 62
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the total number of encounter records (not including the header record).
Right justify, zero fill. Please do not use special characters such as commas, periods, etc.

HEADER RECORD: CREATION DATE

Purpose:
Identifies the date the encounter submission media was produced by the health plan.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	6

FORMAT:	MMDDYY
RECORD LOCATION:	Columns 75 through 80
REQUIRED ON:	Header record of each submission

COMMENTS:
Enter the date the submission was created in month, day, year format. Do not use special characters such as dashes or slashes.

PLEASE NOTE: The encounter header record must be 200 bytes in length. All columns not indicated in this section with specific header data elements are filler.

RECORD LAYOUT

AGE: 1 OF 3
ATE: 07/19/2000
EVISION: _____
EVIEWER: _____

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

R E C O R D   L A Y O U T

FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT: _____
SOURCE: MANAGED CARE PLANS

CLAIM REFERENCE NUMBER (CRN)						ADJUSTMENT CRN			BENEFICIARY ID			
JULIAN DATE (YDDD)	CLAIM NUMBER	PLAN CODE	FORMAT CODE	PC PROGRAM	ACCO ADJUSTMENT	JULIAN DATE (YDDD)	CLAIM NUMBER	COUNTY	AID CODE 9/H	CASE NUMBER SSN	FBU PERSON	RECIP SSN

RECIPIENT SSN (CONT)	RECIPIENT NAME (LAST, FIRST)	BIRTHDATE				SEX	ETHNIC/RACE	PROVIDER NUMBER, LICENSE NUMBER, OR FACILITY NUMBER	PROVIDER NAME (LAST, FIRST)
		CC	YY	MM	DD				

PROVIDER NAME (CONT)	PROVIDER ZIP	PROVIDER COUNTY	PROVIDER TYPE	PHYSICIAN SPECIALTY	BEGINNING DATE OF SERVICE				ENDING DATE OF SERVICE				REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER
					CC	YY	MM	DD	CC	YY	MM	DD	

REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER (CGNT)	PRE PRIOR IN AD AUTH/	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS	FP ALMA INLN VING	FILLER	ATDI JO UN DIS CTAA -T UE	ADJUDICATION DATE				DATE OF PAYMENT				BILLED AMOUNT	
								CC	YY	MM	DD	CC	YY	MM	DD	0000000	00

MODE: BINARY - B   LABELS: STANDARD [X]   RECORD FORMAT: FIXED - F [ ]   RECORD LENGTH: 335   PROGRAMS THAT USE THIS AS:
      PACKED - P   NON-STANDARD [ ]   VARIABLE-V [X]   RECORDS PER BLOCK: D= , T=   INPUT _____
(HD.PAIDCLM.RECORD.LAYOUT(MCNONIP))   BLOCK SIZE: D= , T=   OUTPUT MANAGED CARE PLANS

DATE: 07/19/2000
REVISION:
REVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
R E C O R D   L A Y O U T

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:

FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA

SOURCE: MANAGED CARE PLANS

REIMBURSEMENT AMOUNT	PATIENT LIABILITY AMOUNT	MEDICARE DEDUCTIBLE AMOUNT	MEDICARE COINSURANCE AMT	OTHER HEALTH COVERAGE AMT	PROVIDER TYPE (NEW IN JULY 2000)	FILLER
******* ¢¢	******* ¢¢	******* ¢¢	******* ¢¢	******* ¢¢		

FILLER	TOOTH SURFACE	FILLER	FILLER RESERVED FOR STATE USE

OUTPATIENT, MEDICAL, VISION OR DENTAL CLAIM DATA

PLACE OF SERVICE	PROCEDURE CODE	PROCEDURE MODIFIER	OR TOOTH	PROCEDURE QUANTITY	RENDERING PROVIDER NUMBER	PATIENT STATUS	FILLER	FOR RECORDS WITH FORMAT CODE "M" (OUTPATIENT, MEDICAL, VISION) OR "D" (DENTAL), POSITIONS 301-350 ARE DEFINED AS SHOWN TO THE LEFT.

DRUG CLAIM DATA

NATIONAL DRUG CODE (NDC) OR UNIVERSAL PRODUCT CODE (UPC)	DRUG SUPP GRP USED	QUANTITY	DAYS SUPPLY	PLACE OF SERVICE	FILLER	FOR RECORDS WITH FORMAT CODE "P" (PHARMACY), POSITIONS 301-350 ARE DEFINED AS SHOWN TO THE LEFT.

MODE: BINARY - B
PACKED - P

LABELS: STANDARD [X]
NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [ ]
VARIABLE-V [X]

RECORD LENGTH: 339
RECORDS PER BLOCK: D= , T=
BLOCK SIZE: D= , T=

PROGRAMS THAT USE THIS AS:
INPUT
OUTPUT MANAGED CARE PLANS

PAGE: 3 OF 3

DATE: 07/19/2000

REVISION: _____

REVIEWER: _____

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

RECORD LAYOUT

FILE NAME: MANAGED CARE NON-INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN

SYSTEM/PROJECT: _____

SOURCE: MANAGED CARE PLANS

LONG TERM CARE CLAIM DATA

ACCT COMMAND	DAYS STAY	PT STATUT	ADMISSION DATE				DISCHARGE DATE				FILLER
			CC	YY	MM	DD	CC	YY	MM	DD	

FOR RECORDS WITH FORMAT CODE "L" (LTC), POSITIONS 301-505 ARE DEFINED AS SHOWN TO THE LEFT.

MODE: BINARY - I   PACKED - P

LABELS: STANDARD [M]   NON-STANDARD [ ]

RECORD FORMAT: FIXED - F [ ]   VARIABLE-V [X]

RECORD LENGTH: 555

RECORDS PER BLOCK: O= ___ , T= ___

BLOCK SIZE: O= ___ , T= ___

PROGRAMS THAT USE THIS AS:

INPUT _____

OUTPUT MANAGED CARE PLANS

Row 1 (positions 001–050)

CLAIM REFERENCE NUMBER (CRN)			FORMAT CODE	PROGRAM	ADJUE STMENT	ADJUSTMENT CRN		COUNTY	BENEFICIARY ID				RECIP SSN
JULIAN DATE (YDDD)	CLAIM NUMBER	PLAN CODE				JULIAN DATE (YDDD)	CLAIM NUMBER		AID CODE	CASE NUMBER / SSN	S/ M	PER SON	F BU	

Row 2 (positions 051–100)

RECIPIENT SSN (CONT)	RECIPIENT NAME (LAST, FIRST)	BIRTHDATE				SEX	ETHNICITY/RACE	PROVIDER NUMBER, LICENSE NUMBER, OR FACILITY NUMBER	PROVIDER NAME (LAST, FIRST)
		CC	YY	MM	DD				

Row 3 (positions 101–150)

PROVIDER NAME (CONT)	PROVIDER ZIP	PROVIDER COUNTY	PROVIDER TYPE	PHYSICIAN SPECIALITY	BEGINNING DATE OF SERVICE				ENDING DATE OF SERVICE				REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER
					CC	YY	MM	DD	CC	YY	MM	DD	

Row 4 (positions 151–200)

REFERRING/ PRESCRIBING/ ADMITTING PROVIDER NUMBER OR LICENSE NUMBER (CONT)	PRE IF OR N AD U TH /	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS	FP AL MA IN LN YI N G	FI LL ER	AT DI JG UN D IS CT AA T US	ADJUDICATION DATE				DATE OF PAYMENT				BILLED AMOUNT	
								CC	YY	MM	DD	CC	YY	MM	DD	########	cc

PAGE: 2 OF 5
DATE: 07/19/2000
REVISION:
REVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH

RECORD LAYOUT

FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:
SOURCE: MANAGED CARE PLANS

REIMBURSEMENT AMOUNT		PATIENT LIABILITY AMOUNT		MEDICARE DEDUCTIBLE AMOUNT		MEDICARE COINSURANCE AMT		OTHER HEALTH COVERAGE AMT		PROVIDER TYPE (NEW IN JULY 2000)	FILLER

FILLER	TOOTH SURFACE	FILLER	FILLER RESERVED FOR STATE USE

ANDE MC REGS SESTON QTON	PATIENT STATUS	PRIMARY SURGICAL PROCEDURE CODE	SECONDARY SURGICAL PROCEDURE CODE	ADMISSION DATE				DISCHARGE DATE				FILLER	NUMBER OF CLAIM LINES
				CC	YY	MM	DD	CC	YY	MM	DD		

CLAIM LINE 1 / CLAIM LINE 2

ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	

MODE: BINARY - B   LABELS: STANDARD [X]   RECORD FORMAT- FIXED - F [ ]   RECORD LENGTH: LRL.VAR   PROGRAMS THAT USE THIS AS:
      PACKED - P   NON-STANDARD [ ]   VARIABLE-V [X]   RECORDS PER BLOCK: D= , T=   INPUT
                                                                                 BLOCK SIZE: D= , T=   OUTPUT MANAGED CARE PLANS

AGE: 3 OF 5
ATE: 07/19/2000
EVISION: _____
EVIEWER: _____

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
R E C O R D   L A Y O U T

FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

ORIGINATOR: KELLEY KLEHIH
SYSTEM/PROJECT: _____
SOURCE: MANAGED CARE PLANS

| 4 0 1 | 4 0 2 | 4 0 3 | 4 0 4 | 4 0 5 | 4 0 6 | 4 0 7 | 4 0 8 | 4 0 9 | 4 1 0 | 4 1 1 | 4 1 2 | 4 1 3 | 4 1 4 | 4 1 5 | 4 1 6 | 4 1 7 | 4 1 8 | 4 1 9 | 4 2 0 | 4 2 1 | 4 2 2 | 4 2 3 | 4 2 4 | 4 2 5 | 4 2 7 | 4 2 8 | 4 2 9 | 4 3 0 | 4 3 1 | 4 3 2 | 4 3 3 | 4 3 4 | 4 3 5 | 4 3 6 | 4 3 7 | 4 3 8 | 4 3 9 | 4 4 0 | 4 4 1 | 4 4 2 | 4 4 3 | 4 4 4 | 4 4 5 | 4 4 6 | 4 4 7 | 4 4 8 | 4 4 9 |

CLAIM LINE 3 / CLAIM LINE 4

ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	cc	#######	cc				#######	cc	#######	cc

| 4 5 1 | 4 5 2 | 4 5 3 | 4 5 4 | 4 5 5 | 4 5 6 | 4 5 7 | 4 5 8 | 4 5 9 | 4 6 0 | 4 6 1 | 4 6 2 | 4 6 3 | 4 6 4 | 4 6 5 | 4 6 6 | 4 6 7 | 4 6 9 | 4 7 0 | 4 7 1 | 4 7 2 | 4 7 3 | 4 7 4 | 4 7 5 | 4 7 6 | 4 7 7 | 4 7 8 | 4 7 9 | 4 8 0 | 4 8 1 | 4 8 2 | 4 8 3 | 4 8 4 | 4 8 5 | 4 8 6 | 4 8 7 | 4 8 8 | 4 8 9 | 4 9 0 | 4 9 1 | 4 9 2 | 4 9 3 | 4 9 4 | 4 9 5 | 4 9 6 | 4 9 7 | 4 9 8 | 4 9 9 | 5 0 0 |

CLAIM LINE 5 / CLAIM LINE 6

ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	cc	#######	cc				#######	cc	#######	cc

| 5 0 1 | 5 0 2 | 5 0 3 | 5 0 4 | 5 0 5 | 5 0 6 | 5 0 7 | 5 0 8 | 5 0 9 | 5 1 0 | 5 1 1 | 5 1 2 | 5 1 3 | 5 1 4 | 5 1 5 | 5 1 6 | 5 1 7 | 5 1 8 | 5 1 9 | 5 2 0 | 5 2 1 | 5 2 2 | 5 2 3 | 5 2 4 | 5 2 5 | 5 2 7 | 5 2 8 | 5 2 9 | 5 3 0 | 5 3 1 | 5 3 2 | 5 3 3 | 5 3 4 | 5 3 5 | 5 3 6 | 5 3 7 | 5 3 8 | 5 3 9 | 5 4 0 | 5 4 1 | 5 4 2 | 5 4 3 | 5 4 4 | 5 4 5 | 5 4 6 | 5 4 7 | 5 4 8 | 5 4 9 | 5 5 0 |

CLAIM LINE 7 / CLAIM LINE 8

ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	cc	#######	cc				#######	cc	#######	cc

| 5 5 1 | 5 5 2 | 5 5 3 | 5 5 4 | 5 5 5 | 5 5 6 | 5 5 7 | 5 5 8 | 5 5 9 | 5 6 0 | 5 6 1 | 5 6 2 | 5 6 3 | 5 6 4 | 5 6 5 | 5 6 6 | 5 6 7 | 5 6 8 | 5 6 9 | 5 7 0 | 5 7 1 | 5 7 2 | 5 7 3 | 5 7 4 | 5 7 5 | 5 7 6 | 5 7 7 | 5 7 8 | 5 7 9 | 5 8 0 | 5 8 1 | 5 8 2 | 5 8 3 | 5 8 4 | 5 8 5 | 5 8 6 | 5 8 7 | 5 8 8 | 5 8 9 | 5 9 0 | 5 9 1 | 5 9 2 | 5 9 3 | 5 9 4 | 5 9 5 | 5 9 6 | 5 9 7 | 5 9 8 | 5 9 9 | 6 0 0 |

CLAIM LINE 9 / CLAIM LINE 10

ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMODATION CODE OR ANCILLARY CODE	DAYS STAY	FILLER	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	cc	#######	cc				#######	cc	#######	cc

MODE: BINARY - B   LABELS: STANDARD [X]   RECORD FORMAT: FIXED = F [ ]   RECORD LENGTH: 390-900   PROGRAMS THAT USE THIS AS:
PACKED - P   NON-STANDARD [ ]   VARIABLE-V [X]   RECORDS PER BLOCK: D= , T=   INPUT
BLOCK SIZE: D= , T=   OUTPUT MANAGED CARE PLANS

DATE: 07/19/2000
REVISION:
REVIEWER:

DEPARTMENT OF HEALTH SERVICES - DATA SYSTEMS BRANCH
R E C O R D   L A Y O U T

ORIGINATOR: KELLEY KLEMIN
SYSTEM/PROJECT:

FILE NAME: MANAGED CARE INPATIENT ENCOUNTER DATA

SOURCE: MANAGED CARE PLANS

| 8 0 1 | 8 0 2 | 8 0 3 | 8 0 4 | 8 0 5 | 8 0 6 | 8 0 7 | 8 0 8 | 8 0 9 | 8 1 0 | 8 1 1 | 8 1 2 | 8 1 3 | 8 1 4 | 8 1 5 | 8 1 6 | 8 1 7 | 8 1 8 | 8 1 9 | 8 2 0 | 8 2 1 | 8 2 2 | 8 2 3 | 8 2 4 | 8 2 5 | 8 2 6 | 8 2 7 | 8 2 8 | 8 2 9 | 8 3 0 | 8 3 1 | 8 3 2 | 8 3 3 | 8 3 4 | 8 3 5 | 8 3 6 | 8 3 7 | 8 3 8 | 8 3 9 | 8 4 0 | 8 4 1 | 8 4 2 | 8 4 3 | 8 4 4 | 8 4 5 | 8 4 6 | 8 4 7 | 8 4 8 | 8 4 9 | 8 5 0 |

| | CLAIM LINE 19 | | | | | CLAIM LINE 20 | | | |

ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	F I L L E R	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	F I L L E R	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	##	#######	##				#######	##	#######	##

| 8 5 1 | 8 5 2 | 8 5 3 | 8 5 4 | 8 5 5 | 8 5 6 | 8 5 7 | 8 5 8 | 8 5 9 | 8 6 0 | 8 6 1 | 8 6 2 | 8 6 3 | 8 6 4 | 8 6 5 | 8 6 6 | 8 6 7 | 8 6 8 | 8 6 9 | 8 7 0 | 8 7 1 | 8 7 2 | 8 7 3 | 8 7 4 | 8 7 5 | 8 7 6 | 8 7 7 | 8 7 8 | 8 7 9 | 8 8 0 | 8 8 1 | 8 8 2 | 8 8 3 | 8 8 4 | 8 8 5 | 8 8 6 | 8 8 7 | 8 8 8 | 8 8 9 | 8 9 0 | 8 9 1 | 8 9 2 | 8 9 3 | 8 9 4 | 8 9 5 | 8 9 6 | 8 9 7 | 8 9 8 | 8 9 9 | 9 0 0 |

| | CLAIM LINE 21 | | | | | CLAIM LINE 22 | | | |

ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	F I L L E R	BILLED AMOUNT		REIMBURSEMENT AMOUNT		ACCOMMO-DATION CODE OR ANCIL-LARY CODE	DAYS STAY	F I L L E R	BILLED AMOUNT		REIMBURSEMENT AMOUNT	
			#######	##	#######	##				#######	##	#######	##

MODE: BINARY - B   LABELS: STANDARD [X]   RECORD FORMAT: FIXED - F [ ]   RECORD LENGTH: 550-900   PROGRAMS THAT USE THIS AS:
      PACKED - P   NON-STANDARD [ ]   VARIABLE-V [X]   RECORDS PER BLOCK: D=   , T=   INPUT
                                                                                          BLOCK SIZE: D=   , T=   OUTPUT MANAGED CARE PLANS

DATA ELEMENTS

1. CLAIM REFERENCE NUMBER (CRN) / CLAIM CONTROL NUMBER (CCN)

PURPOSE:
The CRN/CCN serves to uniquely identify any record, documenting an encounter, in order to locate and retrieve the record. The CRN/CCN also provides a way to calculate the length of time between the date of service to the date the record was received by the health plan and the date the record was sent to the State.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	13
FORMAT:	YDDDXXXXXXXXX
RECORD LOCATION:	Columns 1 through 13
REQUIRED ON:	All records

COMMENTS:
The first four characters indicate the Julian date, including a single digit year indicator, on which the health plan received the record. The last nine characters are assigned by the health plan.

Example: (5123123456789). The first four digits '5123' represent May 3, 2005 in the Julian date format. The first digit '5' represents the year 2005 and '123' is the 123rd day of the year, or May 3. The nine numeric characters following the Julian date identify the record number and are in a format assigned by the health plan. For leap year, (i.e., 2006) one day must be added to the number of days after February 28, 2006. For example, March 1, 2006 becomes 6061 unlike March 1, 2005 which was 5060.

A single encounter, defined as a "face-to-face" delivery of a medical service by a health care provider on a given date of service, can generate one or more records for the same recipient on the same day depending on the number of procedures performed by the provider. Each service or procedure rendered by a provider must be assigned a unique CRN/CCN by the health plan, except for hospital inpatient encounter records where up to 22 accommodation or ancillary codes can be entered on a single record (see data element 57).

2. PLAN CODE

PURPOSE:
To identify each health plan relative to each record.

CHARACTER TYPE:	Numeric

NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 14 through 18
REQUIRED ON:	All records

COMMENTS:
DHCS currently assigns each health plan a unique plan code. Health plans must enter their assigned plan code in this field, including two leading zeroes, (i.e., 00160) for each encounter record. The plan code entered on each record must match the submitter identifier in the header record.

3. FORMAT CODE

PURPOSE:
Identifies the record format code on each record for one of five general types of encounters including medical outpatient, pharmaceutical, long term care, hospital inpatient acute care services.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 19
REQUIRED ON:	All records

COMMENTS:
Record Layout Format Codes = M, P, L, H

M = Medical Outpatient Services
Includes but is not limited to the following types of services: physician and nursing visits, surgical procedures, anesthesia services, laboratory tests, X-rays, physical therapy procedures, durable medical equipment, prosthetic and orthotic devices, transportation (i.e., ambulance), outpatient hospital services, dialysis, home health agency and vision services. Medical services must be reported in data element 39 (procedure codes) with HCPCS, Outpatient and Home Health Services using UB-04 or CPT- 4 codes.

P = Pharmacy Services
Includes drug or medical supply items provided by a pharmacy. Use National Drug Codes (NDC). http://www.deadiversion.usdoj.gov/arcos/ndc/ndcfile.txt or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

L = Long Term Care Facility Charges.
For reporting LTC accommodations for admitted patients only.

Outpatient services provided by a Long Term Care Facility, such as Community Based Adult Services (CBAS), must be reported using the Medical Outpatient Services format above.

H = Hospital Inpatient Acute Care Charges.
Applies to each inpatient acute care hospital admission. Use UB-04 hospital accommodation and hospital ancillary codes for data element 57, hospital accommodation/ancillary codes. **Long Term Care facility stays should NOT use this value – use value 'L' above.**

4. PROGRAM CODE

PURPOSE:
To identify specific DHCS program services rendered and included in the capitation.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 20
REQUIRED ON:	Not Required

COMMENTS:
This field can be left blank or filled with spaces.

Program Codes:

C = CHDP is also reported on the PM 160 sent to Child Health and Disability Prevention program. **All CHDP services must be reported on PM 160 Informational Only and as Encounter Data to receive credit.**

S = For managed care plans contracted through California Children Services reporting encounter data

P = For managed care plans contracted through California Department of Mental Health reporting Encounter Data.

5. ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN/CCN)

PURPOSE:
Indicates whether a previously submitted record is voided or replaced.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTESS :	1

FORMAT:	X
RECORD LOCATION:	Column 21
REQUIRED ON:	Only when a previously submitted record is voided or replaced

COMMENTS:

Enter an adjustment code only if the submitted record voids or replaces a previously accepted record. The following two codes indicate the disposition of a previously reported record:

Adjustment Codes
Blank = Not an adjustment
1 = Void
2 = Replacement

When an issue has been found with a previously accepted record, the steps to correct it are:

1) Submit a Void for the record. The Void must have the following characteristics:
   a. The contents of the Void must be identical to the contents of the original record EXCEPT:
      i. **Data element 1, CLAIM REFERENCE NUMBER (CRN/CCN)** shall be a new, unique number to identify the voiding record.
      ii. **Data element 5, ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN/CCN)** must = 1
      iii. **Data element 6, ADJUSTMENT CLAIM REFERENCE NUMBER (CRN)** of the void must be identical to the **CLAIM REFERENCE NUMBER (CRN/CCN) / CLAIM CONTROL NUMBER (CCN)** of the original record.
2) After the void has been submitted and accepted by DHCS, a new record with the correct information (the Replacement) must be submitted. The Replacement must have the following characteristics:
   a. The contents of the Replacement must be identical to the contents of the original record EXCEPT:
      i. **Data element 1, CLAIM REFERENCE NUMBER (CRN/CCN)** shall be a new, unique number to identify the replacement record.
      ii. **Data element 5, ADJUSTMENT CODE FOR CLAIM REFERENCE NUMBER (CRN/CCN)** must = 2
      iii. **Data element 6, ADJUSTMENT CLAIM REFERENCE NUMBER (CRN/CCN)** of the Replacement must be identical to the **CLAIM REFERENCE NUMBER (CRN/CCN) / CLAIM CONTROL NUMBER (CCN)** of the original record
      iv. **The data elements that were found to be at issue are populated with the correct information.**

Note: when correcting an erroneous submission, the Void record MUST be submitted prior to the Replacement record.

6. ADJUSTMENT CLAIM REFERENCE NUMBER (CRN/CCN)

PURPOSE:
Identifies the CRN/CCN of a previously submitted record that is voided or replaced.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	13
FORMAT:	YDDDXXXXXXXXX
RECORD LOCATION:	Columns 22 Through 34
REQUIRED ON:	Only when an adjustment code is entered in data element 5

COMMENTS:
The Adjustment CRN/CCN identifies the original Claim Reference Number in data element 1 of the encounter record being voided or replaced. This field provides an audit trail of voided or replaced records. Data element 6 must contain a CRN/CCN if an adjustment code is entered in data element 5, Adjustment Code. Conversely, if there is no adjustment code in data element 5, there must not be an adjustment CRN/CCN in data element 6.

If a previously submitted record does not need to be voided or replaced, this field is to be left blank or filled with spaces.

Cross reference with Adjustment Code for Claim Reference Number in data element 5.

7. MEDI-CAL BENEFICIARY IDENTIFICATION (BID)

PURPOSE:
Identifies a Medi-Cal recipient's eligibility for month of service. This data element includes the beneficiary's county of residence code and aid code plus a State or county assigned number.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	14
FORMAT:	CCAAXXXXXXXXXX
RECORD LOCATION:	Columns 35 Through 48
REQUIRED ON:	All records

COMMENTS:

The BID is supplied by the State to health plans each month and is not to be altered by the health plan when submitted back to the State on an encounter record. This data element must have the exact Medi-Cal number denoting eligibility for the month of service as supplied by the State or the county. The 14-character identification number may either be: (1) a county code, aid code, "9" and SSN assigned by DHCS MEDS system for Social Security Administration's Supplemental Security Income/Supplemental Security Payment (SSI/SSP) eligible; or (2) a county code, aid code, case number, family budget unit and person number assigned by county welfare departments (for AFDC cash assistance and various medical assistance only programs.) The following box shows how to read the beneficiary ID:

C	C	A	A	X	X	X	X	X	X	X	X	X	X
3	4	1	0	9	1	2	3	4	5	6	7	8	9
3	4	3	0	1	2	3	4	5	6	7	8	9	0

CC = County Code
AA = Aid Code
X = '9' plus the SSN or Case number, Family Budget Unit, Person number assigned

Reporting Newborns
If submitting encounter data for a newborn for the month of birth and/or the following month, enter the mother's BID in this field.

8. SOCIAL SECURITY (SSN) OR CLIENT INDEX NUMBER (CIN)

PURPOSE:
Identifies the same recipient as indicated in data element 7 (Medi-Cal BID) and data element 9 (Medi-Cal recipient's name) by their SSN or DHCS assigned Client Index Number (CIN).

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	Columns 49 Through 57
REQUIRED ON:	All records

COMMENTS:
The beneficiary's SSN is supplied by the State to the health plans. The recipient's SSN must not be altered when submitted back to the State on the encounter record. The first nine characters of the CIN or SSN from the Beneficiary Identification Card (BIC) are to

be entered in the SSN field. The SSN or CIN appear as ten digits on the BIC. The last digit is a check digit. Only the first nine characters of the BIC are entered in the SSN field, NOT the final check digit.

This field may contain a pseudo SSN where the first byte is an '8' or '9' and the last byte is the letter 'P'. (Example: '8xxxxxxxP' or '9xxxxxxxP'.)

The CIN format is as follows: 9NNNNNNNA. It always starts with a 9, has 7 numbers and ends with one of the following alpha characters: A, C, D, E, F, G, H, M, N, S, T, U, V, W, X or Y. The CIN never ends with a P so that it cannot be confused with Pseudo SSNs.

<u>Reporting newborns</u>
If submitting encounter data for a newborn for the month of birth and/or the following month of birth, enter the mother's SSN in this field.

DO NOT USE ANY SPACES OR SPECIAL CHARACTERS SUCH AS HYPHENS. USE LOW VALUES OR BLANKS ONLY

9. NAME OF MEDI-CAL RECIPIENT

PURPOSE:
Identifies the Medi-Cal recipient by full or partial name.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	10
FORMAT:	Free format-Last name First name
RECORD LOCATION:	Columns 58 Through 67
REQUIRED ON:	All records

COMMENTS:
Use UPPER CASE (CAPs) only. The last name is entered first beginning in column 58 followed by the first name, space permitting. When included as part of a name, use of embedded hyphens is acceptable. If the last name is less than nine characters long, insert one space before the first character of the first name. If the last name is nine or 10 characters long, no part of the first name can be entered in this field. This field is left justified with trailing blanks.

If submitting data for a newborn, using the mother's identification number in data element 7, (BID), enter the infant's name in this field. If the infant has not yet been named, enter the mother's last name and, space permitting, the following 2 or 3 byte identifiers: BB (baby boy) or BG (baby girl). For multiple births, enter BB1 (baby boy #1), BG1 (baby girl #1), etc.

Examples of entering full and partial names:

M	A	Y	A		R	I	O		
W	A	L	L	O	O	N		B	I
R	O	D	R	I	G	U	E	Z	

DO NOT USE COMMAS OR APOSTROPHES.

10. BIRTH DATE OF MEDI-CAL RECIPIENT

PURPOSE:
Identifies the Medi-Cal recipient's date of birth (DOB)

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 68 Through 75
REQUIRED ON:	All records

COMMENTS:
Example: July 31, 2005 or 31 July 2005 or 7/31/95 would be entered in this field only as 20050731.

If reporting data for a newborn using the mother's ID, enter the infant's date of birth in this field.

Do not use special characters such as slashes, commas or hyphens

The date entered into the date field must be a valid date.

11. SEX CODE OF MEDI-CAL RECIPIENT

PURPOSE:
Identifies the sex of the Medi-Cal recipient.

CHARACTER TYPE:	Alpha (UPPER CASE)
NUMBER OF BYTES:	1
FORMAT:	X

RECORD LOCATION:	Column 76
REQUIRED ON:	All records

COMMENTS:
USE UPPER CASE ONLY WHEN ENTERING ONE OF THE FOLLOWING CODES.

Acceptable codes are: M = MALE
                          F = FEMALE

12. ETHNIC/RACE CODE OF MEDI-CAL RECIPIENT

(Leave this field blank. FOR STATE USE ONLY)

PURPOSE:
Identifies ethnicity of Medi-Cal recipient.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 77
REQUIRED ON:	Not required

COMMENTS:
Entries in this field are only made by the State. Health plans are to leave this field blank.

Race/Ethnicity Codes

0 - Unknown
1 - White
2 - Hispanic
3 - Black
4 - Other Asian or Pacific Islander
5 - American Native or American Indian
7 - Filipino
8 - No Valid Data Reported (MEDS generated)
A - Amerasian
C - Chinese
H - Cambodian
J - Japanese
K - Korean
M - Samoan
N - Asian Indian
P - Hawaiian
R - Guamanian

T - Laotian
V - Vietnamese

13. PROVIDER NUMBER (REPORTING/BILLING)

PURPOSE:
Identifies the National Provider Identifier (NPI) of an individual, group, clinic, or facility that has billed a health plan for, or reported a capitated encounter service.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	12
FORMAT:	X XXXXXXXXXX
RECORD LOCATION:	Columns 78 through 89
REQUIRED ON:	All records

COMMENTS:
This is one of three data elements, including data elements 21 and 42, identifying providers' National Provider Identifiers (NPI). Data element 13 must always contain a provider number for each record in order to identify the provider billing the health plan or reporting the delivery of a capitated service.

This field should only be populated with NPI values, unless the provider is ineligible for NPI. In those cases, use Medi-Cal Provider Number or the plan provider identifier.

Providers ineligible for NPI would be those providing certain services that are not normally considered health care services, but which may be covered by some health plans. These services would include, but not be limited to: physical alterations to living quarters for the purpose of accommodating disabilities and case management.

Do NOT send Social Security Numbers in this data element.

This field is left justified with trailing blanks.

Cross-reference this field with data element 14, provider name.

14. PROVIDER NAME (REPORTING/BILLING)

PURPOSE:
Identifies the name of the provider billing for, or reporting a capitated service.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	28

FORMAT:	X (28)
RECORD LOCATION:	Columns 90 through 117
REQUIRED ON:	All Records

COMMENTS:
This field contains the name of the physician, facility, clinic, Ambulance Company, or whoever is billing for or reporting the delivery of an encounter service as indicated in data element 13, provider number.

If reporting an individual's name, the last name must precede the first name with one space separating the two as in the following example:

ZIMMERMAN ROBERT

If reporting the name of a clinic, hospital, health plan or anything other than an individual provider's name, enter the facility or company's name as it normally appears, i.e., Memorial Hospital.

This field must be left justified.

Cross-reference with data element 13, provider number.

15. ZIP CODE OF PROVIDER (RENDERING)

PURPOSE:
Identifies the zip code where the reported encounter service was rendered.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 118 through 122
REQUIRED ON:	All records

COMMENTS:
Enter the zip code where the reported service was rendered.

Cross-reference with data element 16, County Code.

Cross-reference with data element 42, rendering provider, when field is filled.

16. COUNTY CODE OF PROVIDER (RENDERING)

PURPOSE:
Identifies the county where the reported encounter service was rendered.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 123 through 124
REQUIRED ON:	All records

COMMENTS:
Enter the county code where the service was rendered. Cross reference with data element 15, zip code.

CODE	COUNTY	CODE	COUNTY	CODE	COUNTY
01	Alameda	21	Marin	41	San Mateo
02	Alpine	22	Mariposa	42	Santa Barbara
03	Amador	23	Mendocino	43	Santa Clara
04	Butte	24	Merced	44	Santa Cruz
05	Calaveras	25	Modoc	45	Shasta
06	Colusa	26	Mono	46	Sierra
07	Contra Costa	27	Monterey	47	Siskiyou
08	Del Norte	28	Napa	48	Solano
09	El Dorado	29	Nevada	49	Sonoma
10	Fresno	30	Orange	50	Stanislaus
11	Glenn	31	Placer	51	Sutter
12	Humboldt	32	Plumas	52	Tehama
13	Imperial	33	Riverside	53	Trinity
14	Inyo	34	Sacramento	54	Tulare
15	Kern	35	San Benito	55	Tuolumne
16	Kings	36	San Bernardino	56	Ventura
17	Lake	37	San Diego	57	Yolo
18	Lassen	38	San Francisco	58	Yuba
19	Los Angeles	39	San Joaquin	99	Out of State
20	Madera	40	San Luis Obispo		

17. PROVIDER TYPE CODE

PURPOSE:
Identifies the type of provider that rendered the reported service or procedure.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 125 through 126
REQUIRED ON:	All records

COMMENTS:
The provider type indicated in this field can be, but is not necessarily, the same as the billing or reporting provider indicated in data elements 13 and 14, provider number and provider name. The provider type refers to the provider who rendered the service. The provider type must be consistent with the type of license held by the provider and the type of service reported on the encounter record.

If provider type codes 22 (physician group) or 26 (physician) are entered in this field, then a physician specialty code must be entered in data element 18. Physicians or physician groups must be coded either a 22 or 26.

See the following pages for a list of current provider type codes, updated April, 2013.

Use of code 99 Miscellaneous Medical should only be used when unable to place the rendering provider type into one of the listed provider types.

(DE 17 continued) PROVIDER TYPE CODES			
CODE	DESCRIPTION	CODE	DESCRIPTION
DN	Dentist	43	Multispecialty Clinics
01	Adult Day Care Center	44	Surgical Clinics
02	Assistive Device & Sick Room Supplies, Durable Medical Equipment	45	Exempt from Licensure Clinics
03	Audiologist	46	Rehabilitation Clinics
04	Blood Bank	47	Employer/Employee Clinics
05	Certified Nurse Midwife	48	County clinics not associated with hospital
06	Chiropractor	49	Birthing centers-Primary Care Clinic
07	Certified Pediatric Nurse & Certified Nurse Practitioner	50	Clinic - otherwise undesignated

(DE 17 continued) PROVIDER TYPE CODES

CODE	DESCRIPTION	CODE	DESCRIPTION
08	Christian Science Practitioners	51	Outpatient heroin detoxification center
09	Clinical Laboratories	52	Alternative Birth Centers-Specialty Clinics
10	Group Certified Pediatric NP & Certified Family NP	53	Breast Cancer Early Detection Program
11	Fabricating Optical Laboratory	54	Expanded Access to Primary Care
12	Dispensing Opticians	55	Local Education Agency
13	Hearing Aide Dispensers	56	Respiratory Care Practitioner
14	Home Health Agencies(HHA)	57	EPSDT Supplement Services Provider
15	Community hospital outpatient departments	58	Health Access Program
16	Community hospital inpatient	59	HCBS Congregate Living Health Facilities, Type A Licensure
17	Certified Long Term Care Facility (LTC)	60	County Hospital Inpatient
18	Certified Nurse Anesthetists	61	County Hospital Outpatient
19	Occupational Therapists	62	Group Respiratory Care Practitioner
20	Optometrists	63	Licensed Building Contractors
21	Orthotists	64	Employment Agency
22	Physicians Group	65	Pediatric Subacute Care/LTC
23	Optometric Group	66	Personal Care Agency
24	Pharmacies/pharmacist	67	Individual Nurse Providers (Waivers)
25	Physical Therapists	68	HCBS Benefit Provide
26	Physicians	69	Professional Corporation
27	Podiatrists	70	Acute Psych Hospital
28	Portable X-ray Laboratory	72	Mental Health Inpatient
29	Prosthetists	73	AIDS Waiver Provider
30	Ground Medical Transportation	74	Multi-Purpose Senior Services Pgm
31	Psychologists	75	Tribal Health Plan/Indian Health Services
32	Certified Acupuncture	80	CCS/GHPP Non-Institutional
33	Genetic Disease Testing	81	CCS/GHPP - Institutional
34	Medicare Crossover Provider Only	82	Licensed Midwife Program

(DE 17 continued) PROVIDER TYPE CODES

CODE	DESCRIPTION	CODE	DESCRIPTION
35	P.L. 95-210 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)	84	Independent DX Testing Facility (Crossover)
36	HCB - Cert Home Health Agency	85	CNS Crossover Provider Only
37	Speech Therapist	90	Out-Of-State Provider
38	Air Ambulance Transportation Service	92	Residential Care Facility For the Elderly (RCFE)
39	Certified Hospice Service	93	Care Coordinator (CCA)
40	Free Clinics	95	Private Non-Profit Proprietary Agency
41	Community Clinics	98	Miscellaneous
42	Chronic Dialysis Clinics	99	Dentists

18. PHYSICIAN SPECIALTY CODE

PURPOSE:
Identifies the area of specialization for a physician who rendered the reported service.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 127 through 128
REQUIRED ON:	Medical records only

COMMENTS:
If data element 17, provider type, is coded 22 (physician group) or coded 26 (physician) enter the appropriate physician specialty code for data element 18.
If the provider type is not a physician (22 or 26) as indicated in data element 17, then leave this field blank or fill with spaces.

See the following page for a list of physician specialty codes.
Cross-reference with data element 17, provider type.

(DE 18 Continued) PHYSICIAN SPECIALTY CODES

DESCRIPTION	CODE	DESCRIPTION	CODE
Allergy	03	Oncology	78
Anesthesiology	05	Ophthalmology	18

(DE 18 Continued) PHYSICIAN SPECIALTY CODES

DESCRIPTION	CODE	DESCRIPTION	CODE
Aviation (MD Only)	11	Orthopedic Surgery	20
Cardiovascular Disease (MD Only)	06	Otology, Laryngology, Rhinology (ENT)	04
Clinics – Mixed Specialty	70	Pathology (MD Only)	22
Dentists	19	Pathology – Forensic	90
Dermatology	07	Pediatric Allergy	43
Emergency Medicine (Urgent Care)	66	Pediatric Cardiology (MD Only)	35
Endocrinology	67	Pediatrics	40
Family Practice	08	Pharmacology – Clinical	91
Gastroenterology (MD Only)	10	Physical Medicine & Rehabilitation	25
General Practice (General Medicine)	01	Plastic Surgery	24
General Surgery	02	Preventive (MD Only)	39
Geriatrics	38	Proctology (Colon & Rectal)	28
Hand Surgery	46	Psychiatry	36
Hematology	68	Psychiatry – Child	26
Infectious Disease	77	Public Health	44
Internal Medicine	41	Pulmonary Diseases (MD Only)	29
Miscellaneous	47	Radiology	30
Neoplastic Diseases	78	Rheumatology	83
Nephrology (Renal-Kidney)	45	Surgery – Head & Neck	84
Neurological Surgery	14	Surgery – Pediatric	85
Neurology (MD Only)	13	Surgery – Traumatic	89
Neurology – Child	79	Thoracic Surgery	33
Nuclear Medicine	42	Unknown	99
Obstetrics	15	Urology, Urological Surgery	34
Obstetrics-Gynecology (MD Only) Neonatal	16		
Osteopaths Only			
Gynecology	09	Peripheral Vascular Disease or Surgery	23
Manipulative Therapy	12	Psychiatry Neurology	27
Ophthalmology, Otolaryngology, Rhinology	17	Radiation Therapy	32
Pathologic Anatomy; Clinical Pathology	21	Roentgenology, Radiology	31

19. BEGINNING DATE OF SERVICE

PURPOSE:
Identifies the beginning date of service reported for each record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 129 through 136
REQUIRED ON:	All Records

COMMENTS:
The first two bytes represent the century, followed by two bytes indicating the year of the century, two bytes for the month of the year and two bytes for the day of the month. For example, the date of October 19, 2005 would be entered as 20051019.

The beginning date of service shall be the first date of service regardless of payment date and always be equal to or earlier than the ending date of service.

This field must be numeric and greater than zero.

Do not use special characters such as slashes, commas or hyphens.

20. ENDING DATE OF SERVICE

PURPOSE:
Identifies the ending date of service reported for each record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 137 through 144
REQUIRED ON:	All Records

COMMENTS:
The first two bytes represent the century, followed by two bytes indicating the year of the century, two bytes for the month of the year and two bytes for the day of the month. For example, the date of November 16, 2005 would be entered as 20051116.

The ending date of service shall be the last date of service pertaining to the reported record. When the reported service begins and ends on the same day, the beginning and ending dates of service shall be the same. The date entered in this field must never be earlier than the date entered in data element 19, beginning date of service.

This field must be numeric and greater than zero.

Do not use special characters such as slashes, commas or hyphens.

21. REFERRING/PRESCRIBING/ADMITTING PROVIDER

PURPOSE:
Identifies an individual provider who has: referred, prescribed medication, or admitted a patient into a hospital.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 145 through 156
REQUIRED ON:	Medical Outpatient records resulting from referrals, All pharmacy records, All hospital inpatient records, and All long term care records.

COMMENTS:
This field should only be populated with NPI (National Provider Identifier) values.
Do NOT send Social Security Numbers in this data element.

Referring Physician: the referring physician must never be the same as the billing/reporting or rendering provider as indicated in data elements 13 or 42. If no referral was linked with this reported service, leave this field blank or fill it with spaces.

Prescribing Physician: For all pharmacy records, enter the NPI of the physician who prescribed the medication or authorized the medical supply.

Admitting Physician: For all inpatient hospital records enter the NPI of the physician who admitted the patient into the hospital.

Left justify this field with trailing blanks.

22. PRIOR AUTHORIZATION OR PRIMARY CARE PHYSICIAN (PCP) REFERRAL INDICATOR

PURPOSE:
Identifies whether the service rendered required a referral or prior authorization from the PCP or health plan.

CHARACTER TYPE:	Alpha
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 157
REQUIRED ON:	Medical, Hospital and Long Term Care records resulting from referrals or prior authorizations

COMMENTS:
If the service reported on this record was the result of a referral or required prior authorization from the PCP or health plan, enter the appropriate indicator code listed below. If no referral or prior authorization preceded this reported service, leave this field blank or fill with spaces.

INDICATOR CODES:

R - Referral from a PCP was required prior to this service being rendered.

P - Prior Authorization was required from the PCP or health plan prior to this service being rendered.

B - Both a PCP referral and prior authorization was required prior to this service being rendered.

Entries in this field must be in CAPS.

23. PRIMARY DIAGNOSIS (ICD 9 CM)

PURPOSE:
Identifies the diagnosis code for the principle condition of the patient.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Column 158 through 162
REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider and procedure codes (see below).

COMMENTS:
Enter all letters and/or numbers of the International Classification of Diseases - Clinical Modifications, Revision 9 (ICD-9-CM). The ICD-9 code can be 3 to 5 characters. The three digit code is the most general description of the patient's condition. The 4th and

5th digits provide a more detailed description. Do not enter a decimal point when entering the code.

For all hospital and long term care records; enter the patient's diagnosis upon admission to the facility.

For Outpatient Medical records, the primary diagnosis must be entered if the service was rendered by any one of the following types of providers:

05-Certified Nurse Midwife	34-Rural Health Clinic
06-Chiropractor	35-PL-95-210 Rural Health Clinic and Federally Qualified Health Center
07-Certified Pediatric or Family Nurse Practitioner	40-Free Clinic
10-Group Certified Pediatric or Family Nurse Practitioner	41-Community Clinic
22-Physician Group	43-Multispecialty Clinic
26-Physician	44-Surgical Clinic
27-Podiatrist	46-Rehab Clinic
31-Psychologist	49-Alternative Birthing Center-Primary Care Clinic
32-Acupuncturist	

The ICD-9 diagnosis codes are required on the encounter/claims for laboratory/pathology. These will be identified by the use of the CPT 80000 series codes on reported services.

For all other provider types, entries in this field are optional. Cross-reference this field with data Element 17, provider type.

24. SECONDARY DIAGNOSIS (ICD 9 CM)

PURPOSE:
Identifies the diagnosis code for the secondary condition, if any, of the patient.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Column 163 through 167

REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:
Enter all letters and/or numbers of the ICD-9-CM code for the secondary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a secondary diagnosis, this field can be blank or filled with spaces.

See DE #23

25. TERTIARY DIAGNOSIS (ICD 9 CM)

PURPOSE:
Identifies the diagnosis code for the tertiary condition of the patient.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Column 168 through 172
REQUIRED ON:	Hospital, Long Term Care and Medical Outpatient records depending on type of provider (see data element 23, primary diagnosis).

COMMENTS:
Enter all letters and/or numbers of the ICD-9-CM code for the tertiary diagnosis including fourth and fifth digits, if applicable. Do not enter a decimal point when entering the code.

Left justify this field with trailing blanks.

If the patient does not have a tertiary diagnosis, this field can be blank or filled with spaces.

See DE #23

26. FAMILY PLANNING INDICATOR

PURPOSE:
Identifies the provision of family planning services.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 173
REQUIRED ON:	Medical outpatient records reporting family planning services.

COMMENTS:
If family planning services were provided and reported on this record, enter the appropriate code (1 or 2) in this field.

If no family planning services were provided, leave this field blank or fill with spaces.

FAMILY PLANNING INDICATOR CODES:

1 - Family Planning/Sterilization

2 - Family Planning/Other

27. ADJUDICATION STATUS CODE

PURPOSE:
To identify whether the service rendered was provided on a capitated or non-capitated basis. If non-capitated, this field also indicates whether the health plan paid, or denied payment for a service, procedure or supply.

CHARACTER TYPE:	Alpha
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 175
REQUIRED ON:	All Records

COMMENTS:
If the service was provided by a provider having a capitated or negotiated rate arrangement with the health plan then enter code C in this field.

If the service was provided by a provider not having a capitated or negotiated rate arrangement with the health plan, and the health plan paid the provider for the specific service rendered, enter code P.

Enter the codes in CAPS.

ADJUDICATION STATUS CODES FOR ALL CLAIM TYPES IDENTIFIED AS DATA ELEMENT #3 FORMAT CODE:

C – Capitated   Service provided on a capitated or negotiated rate arrangement basis.

P – Paid   Plan paid provider for specific service, procedure or supply.

28. ADJUDICATION DATE

PURPOSE:
Identifies the date this record was adjudicated.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 176 through 183
REQUIRED ON:	All Records

COMMENTS:
Entries in this field must be numeric and greater than zero.

The first two bytes are the century, followed by two bytes for the year, two bytes for the month and two bytes for the day of the month. For example, October 31, 2005 would be entered as 20051031.

If the record resulted from a capitated service (i.e., adjudication status, code C) enter the date the record was processed by the health plan.

If the record resulted from a service provided as non-capitated, fee for service arrangement, (i.e., adjudication status, code "P") enter the date when the health plan determined (adjudicated) to pay for the reported service or supply.

Cross-reference with data element 27, adjudication status.

Data element 29, Date of Payment, must be equal to or later than the adjudicated date.

29. DATE OF PAYMENT BY PLAN (CHECK DATE)

PURPOSE:
Identifies the date payment was issued to the billing provider by the health plan for the service provided on a non-capitated, fee for service basis.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Columns 184 through 191
REQUIRED ON:	Records with adjudication status P in data element 27

COMMENTS:
The first two bytes are the century, followed by two bytes for the year, two bytes for the month and two bytes for the day of the month. For example, November 1, 2005 would be entered as 20051101.

If data element 27, adjudication status is code P, enter the date of payment.
The date of payment must be equal to or later than the adjudication date.

If the adjudication status is code C, zero-fill this field.

Cross-reference this field with data element 27, adjudication status.

30. BILLED AMOUNT

PURPOSE:
Identifies the amount the provider billed the health plan for this service(s) reported on this record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	All Records: Columns 192 through 200 Hospital Inpatient records (detail): Segment 1: columns 358 through 366 Segment 2: columns 383 through 391 Refer to the hospital record layout for the location of additional billed amount fields for the remaining 20 detail segments.
REQUIRED ON:	All Records with adjudication status P in data element 27

COMMENTS:

If the adjudication status (data element 27) is C, capitated, enter an appropriate amount (optional) or zero fill this field. When the adjudication status is P (paid), the billed amount is entered in this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $25,450.13 would be entered as 002545013

For hospital records, the total billed amount is also entered in this field in columns 192 - 200 and represents the sum of the billed amounts for all hospital charges.

Enter the billed amount for each type of hospital accommodation and ancillary service (data element 57). The billed amount for the first claim line is entered in column 358 - 366. Enter the billed amount for any additional reported accommodation/ancillary codes in the appropriate columns. Sum the billed amount from all claim line segments (i.e., accommodation and ancillary services) and enter the total billed amount in columns 192 - 200.

Cross-reference this field with data element 27, adjudication status.

31. REIMBURSEMENT AMOUNT

PURPOSE:

Identifies amount paid to the provider by the health plan for the service(s) reported on this record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	All Records: Columns 201 through 209 Hospital Inpatient records (detail): Segment 1: columns 367 through 375 Segment 2: columns 392 through 400 Refer to the hospital record layout for the location of additional reimbursement amount fields for the remaining 20 segments.
REQUIRED ON:	All Records with adjudication status P in data element 27

COMMENTS:

If the adjudication status (data element 27) is C, capitated, enter an appropriate paid amount (optional) or zero fill this field. When the adjudication status is P (paid), the paid amount is entered in this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $25,450.13 would be entered as 002545013

For hospital records, the total paid amount is also entered in this field in columns 201 - 209 and represents the sum of the paid amounts for all hospital charges reported on the record.

Enter the paid amount for each type of hospital accommodation and ancillary service (data element 57). The paid amount for the first segment is entered in column 367 - 375. Enter the paid amount for any additional reported accommodation/ancillary codes in the appropriate columns. Sum the paid amount from all claim line segments (i.e., accommodation and ancillary services) and enter the total paid amount in columns 201 - 209.

Cross-reference this field with data element 27, adjudication status.

32. PATIENT LIABILITY AMOUNT (Share of Cost)

PURPOSE:
Amount owed by the recipient to the provider for services or supplies provided and reported on this record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	Columns 210 through 218
REQUIRED ON:	Records with recipients having share of cost

COMMENTS:
This field is right justified with leading zeroes. The last two bytes are considered cents.

Example: $731.48 would be entered as 000073148

If the recipient has no share cost obligation for the service reported on this record, fill this field with zeroes.

33. MEDICARE DEDUCTIBLE AMOUNT

PURPOSE:
Indicates the amount of the Medicare deductible for the service reported on this record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	Columns 219 through 227
REQUIRED ON:	Records having a Medicare deductible

COMMENTS:
If there is no Medicare deductible for this record, or if the adjudication status in data element 27 is code C, zero fill this field.

If the recipient is Medicare eligible and the encounter service is allowed by Medicare, enter the deductible amount, if any.

This field is right justified with leading zeroes. Last two digits are considered cents.

For example, $1,223.47 would be entered as 000122347

34. MEDICARE CO-INSURANCE AMOUNT

PURPOSE:
Identifies co-insurance amount for Medicare services.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	Columns 228 through 236
REQUIRED ON:	Not Required

COMMENTS:
Zero fill this field.

35. OTHER HEALTH COVERAGE AMOUNT

PURPOSE:
Identifies the amount paid by insurance carrier or third party for the service reported on this record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	9
FORMAT:	XXXXXXXXX
RECORD LOCATION:	Columns 237 through 245
REQUIRED ON:	Records having other insurance payments associated with the reported service

COMMENTS:
If a third party or insurance carrier provided a payment on behalf of the recipient for this service, enter the amount paid.

If there was no payment by an insurance carrier or third party for the service reported on this record, or the adjudication status was code C, (capitated), zero fill this field.

This field is right justified with leading zeroes. The last two bytes are considered cents.

For example, $1.49 would be entered as 000000149

Cross reference with data element 27, adjudication status.

36. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPTITATED PROGRAMS

37. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPTITATED PROGRAMS

38. PLACE OF SERVICE (POS)

PURPOSE:
Identifies where the service was rendered.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 301 through 302 for medical records. Columns 321 through 322 for pharmacy records
REQUIRED ON:	Medical Outpatient and Pharmacy Records

COMMENTS:

Place of Service Codes are maintained for outpatient services by the Centers for Medicare & Medicaid Services and for hospitals, skilled nursing facilities and other providers utilizing UB 92 codes by NUBC.

For pharmacy records, if the POS is a long-term care facility, enter code 31, 32, 54, 92 or 93. For all other pharmacy records enter code 01, Pharmacy.

To obtain current listing of POS codes published by CMS use the following URL: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

For outpatient medical and vision records, enter one of the following appropriate CMS Place of Services Codes: (The 90 series was developed by DHCS). The table below is current as of 07/20/2009. Updates to this table can and will occur. To ensure you are using the correct code, refer to the website listed above.

Code	Place of Service (POS)
01	Pharmacy
03	School/Inpatient Hospital
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility (Outpatient hospital)
06	Indian Health Provider-Based Facility (Indian laboratory)
07	Tribal 638 Free-Standing Facility (Other)
08	Tribal 638 Provider-Based Facility (Independent kidney treatment center)
09	Prison-Correctional Facility
11	Office
12	Home (Patient's home)
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical
25	Birthing (Birthing center)
26	Military Treatment Ctr.
31	Skilled Nursing Facility
32	Nursing Facility (Nursing home/nursing facility)
33	Custodial Care Facility
34	Hospice
41	Ambulance (land)

Code	Place of Service (POS)
42	Ambulance (air or water)
50	Federally Qualified Health Center (FQHC)
51	Inpatient Psychiatric Facility
52	Psych. Facility-Partial Hospitalization (Day care facility/psych facility(Not valid for Medi-Cal billing)
53	Community Mental Health Center
54	Intermediate Care Facility/MR (Specialized treatment center/intermediate care)
55	Residential Treatment Ctr/Substance Abuse
56	Psychiatric Residential Treatment Ctr
57	Non-Residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehab Facility
62	Comprehensive Outpatient Rehab Facility
65	Independent Kidney Disease Treatment Ctr
71	State or Local Public Health Clinic
72	Rural Health Clinic (RHC)
81	Independent Laboratory
91	Nursing Facility Level B (Adult Subacute)
92	Intermed Care Facility (DD, ICF-DD)
93	Intermed Care Facility Nursing (DD, ICF-DD) (Developmentally Disabled habilitative)
94	Non-Home
95	Mobile Van
96	Pediatric Subacute
97	Transitional Inpatient Care
99	Other place of service not identified

UB92 TYPE OF FACILITY CODE used for encounters submitted by hospitals, long term care facilities, home health agencies, hospital clinics, hospice, and others as noted on the listing:

UB92 FACILITY CODES
CODE   **TYPE OF FACILITY DESCRIPTION**
11   Hospital-Inpatient, Medical assistance facilities, LTC with ALOS greater than 25 days, Rehab hosp. or distinct part unit, Pediatric hospitals, Psychiatric hosp. or distinct part, Critical access hospitals
12   Hospital – inpatient (Part B)
13   Hospital – outpatient
14   Hospital- other Part B
18   Hospital – swing bed

UB92 FACILITY CODES

CODE	TYPE OF FACILITY DESCRIPTION
21	SNF – inpatient
22	SNF – inpatient Part B
23	SNF – outpatient
28	SNF – swing bed
32	Home Health
33	Home Health
34	Home Health (Part B only)
41	Religious nonmedical health care institutions – hospital inpatient
43	Religious nonmedical health care institutions – home health services
71	Clinic – rural health
72	Clinic - ESRD
73	Clinic – FQHC
74	Clinic – OPT
75	Clinic – CORF
76	Clinic – CMHC
81	Non-hospital based hospice
82	Hospital based hospice
83	Ambulatory surgery center (ASC)
85	Critical access hospital outpatient

39. PROCEDURE CODE (CPT-4, HCPCS OR UB-04 CODES)

PURPOSE:

Identifies specific medical services and procedures that were performed and medical supplies or materials provided.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 303 through 307
REQUIRED ON:	Medical Outpatient records

COMMENTS:

As outlined in the MMCD All Plan Letter 02005, the HCFA Common Procedure Coding System (HCPCS) Levels II, Uniform Billing Codes (UB-04) and Current Procedural Terminology (CPT- 4) codes identify and describe types of services and procedures rendered by health care professionals. Most codes appear in the Medi-Cal Provider Manuals or the Physicians' Current Procedural Terminology manual updated and published yearly by the American Medical Association. CPT codes also include condition codes to be used in conjunction with the appropriate CPT code describing procedure done. HCPCS Levels II is used to bill for supplies, equipment, pharmaceuticals and services/procedures performed by allied medical professionals

such as Dentists and optometrists. HCPCS are also used to for certain services and procedures not defined in CPT. UB –92 codes are available from the National Uniform Billing Committee. CPT codes are used for reporting medical, surgical and diagnostic services performed by physicians. UB92 codes are used for accommodation revenue codes, and ancillary revenue codes.

DHCS encourages the use of standard (i.e. non-local) codes in this data element.

Procedure code formats are as following:

> HCPCS - 1 Alpha character and 4 numeric characters

> CPT-4 - 5 Numeric characters

> UB-04 - 4 Numeric characters left justified with a trailing blank.

In codes that have leading zeroes, include the leading zero (for example, for a code "0123" do NOT send "123", send "0123".

There should be no entries in this field for hospital, pharmacy or long term care records. CPT 4 or ICD-9 Surgical procedure codes for hospital inpatient records are entered in data elements 53 and 54, primary and secondary surgical procedures.

40. PROCEDURE MODIFIER CODE

PURPOSE:
For Medical records - To determine any special external circumstances connected to the procedure or service reported in data element 39, procedure code.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 308 through 309
REQUIRED ON:	Medical Outpatient Records

COMMENTS:
For medical records reporting no special circumstances associated with the procedure, this field can be left blank or filled with spaces.

 All current CPT - 4 and HCPC procedure modifier codes are allowable in addition to Medi-Cal designated modifier codes

Cross-reference this field with data element 39, procedure code.

41. MEDICAL OUTPATIENT PROCEDURE QUANTITY

PURPOSE:
Identifies the quantity or number of units of services, procedures or supplies provided.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 310 through 314
REQUIRED ON:	Medical Outpatient Records

COMMENTS:
This numeric field describes the quantity related to the procedure code reported in data element 39. The reported quantity may be the number of medical "visits", surgical "lesions", number of "items" or "units" of service, some which are defined in units of "time". For example, physicians may report the number of visits, surgeries, anesthesia units, injections, lab procedures, X-rays, etc. Units of "time" may be reported as day, hour or minute increments. For example, the delivery of one hour of anesthesia services, in 15 minute increments, would be reported as 00004 units. The contents of this field must be compatible with type of service rendered. This field should never contain a "0".

Cross-reference this field with data element 39, procedure code.

This field is right justified with leading zeroes

42. RENDERING PROVIDER NUMBER

PURPOSE:
Identifies the individual provider who directly rendered the service reported on the record.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	12
FORMAT:	XXXXXXXXXXXX
RECORD LOCATION:	Columns 315 through 326
REQUIRED ON:	Medical Records when the service was provided by one of the following types of providers: • Physician or • Physician Assistant • Certified Pediatric or

	• Family Nurse Practitioner • Certified Nurse Midwife or • Certified Physician's Assistant

COMMENTS:

Entries in this field are for specific types of individually identified providers only. Do not enter a group provider number or facility license number in this field.

This field should only be populated with NPI values.

Do NOT send Social Security Numbers in this data element.

Left justify this field with trailing blanks.

If the reported service or procedure was provided by any type of provider not listed above, leave this field blank or fill with spaces.

43. DRUGS/MEDICAL SUPPLIES

PURPOSE:
Identifies the drug or whether a medical supply was dispensed.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	11
FORMAT:	XXXXXXXXXX or 4 spaces/blanksXXXXXXX
RECORD LOCATION:	Columns 301 through 311
REQUIRED ON:	Pharmacy Records Only

COMMENTS:
This data element should only be populated by either NDC or 11-digit UPC codes.

When reporting the provision of a drug, enter the national drug code (NDC) assigned by the Federal Drug Administration (FDA).

If data element 44, Drug/Medical Supply Indicator is coded '2', indicating a medical supply was provided, this field can be filled with UPC or the following code:
9999MZZ
This seven byte alpha/numeric string must be preceded by four spaces or blanks and can be used to identify all medical supplies provided.

If a compound drug was provided, enter ten 9s and one 6 as in the following example:
99999999996

Embedded spaces are not allowed in this field.

The 11-digit Universal Product Codes (UPC) can be used in this data element.

Cross-reference this field with data element 44, Drug/Medical Supply Indicator.

44. DRUG/MEDICAL SUPPLY INDICATOR CODE

PURPOSE:
Identifies whether a prescription drug or medical supply was provided.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Columns 312
REQUIRED ON:	Pharmacy Records Only

COMMENTS:
Drug or Medical Supply Indicator Codes:

 1 = Prescription Drug

 2 = Medical Supply or over the counter drugs not requiring a prescription but supplied by the pharmacy.

If code 1 is entered in this field, then data element 43, Drugs/medical supplies, must have an eleven digit NDC number.

If code 2 is entered in this field, then data element 43, Drugs/Medical Supplies must have four spaces or blanks preceding 9999MZZ or an appropriate NDC number or 11-digit UPC number.

Cross-reference this field with data element 43, Drugs/Medical Supplies.

45. DRUG/MEDICAL SUPPLY QUANTITY

PURPOSE:
Identifies the quantity of drugs or medical supplies dispensed.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	5

FORMAT:	XXXXX
RECORD LOCATION:	Columns 313 through 317
REQUIRED ON:	Pharmacy Records Only

COMMENTS:
When reporting the quantity of drugs or medical supplies, the following guidelines are to be used:

Tablets, capsules, ampoules, diapers, injections, and most medical supplies - Report the total number of each item contained in the container. For example, when cases of diapers are provided, report the total number of diapers not the number of cases. Or if a single bottle of 25 diabetic test strips was provided, report as 25, not 1. For injections sold as dry powders and reconstituted with water, report the number of injections the bottle will yield.

If the drug/supply is measured by weight (i.e., ointments, powders) report the number of grams rounding off to the nearest whole number.

For liquids, report the number of milliliters (ml). An exception here is for nutritional supplements which would be reported as the number of cans.

The value of this numeric field must be greater than zero and always a whole number. Do not use decimals.

This field is right justified with leading zeroes.

Cross-reference this field with data element 43, Drugs/Medical Supplies.

46. DAYS SUPPLY

PURPOSE:
Identifies the number of days covered by the prescription or medical supply.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	3
FORMAT:	XXX
RECORD LOCATION:	Columns 318 through 320
REQUIRED ON:	Pharmacy Records Only

COMMENTS:
The number entered for days supply must be greater than zero.

This field is right justified with leading zeroes.
Cross-reference with data element 43, Drugs/Medical Supplies

47. LONG TERM CARE (LTC) ACCOMMODATION CODES

PURPOSE:
Identifies type of accommodation for stays in long term care facilities.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	LTC Records: Columns 301 through 302
REQUIRED ON:	Long Term Care Records Only

COMMENTS:
If the patient has been admitted to a nursing or intermediate care facility, enter the appropriate LTC accommodation code in this field.

See following pages for Long Term Care Accommodation codes as updated February 2013.

The following is a list of acronyms used for the LTC Accommodation Codes:
DD - Developmentally Disabled
DD-CN - Developmentally Disabled/Continuous Nursing
DD-H - Developmentally Disabled/Habilitative
DD-N - Developmentally Disabled/Nursing
DP - Distinct Part
ICF - Intermediate Care Facility
NF - Nursing Facility
NF A - Nursing Facility Level A (meets the criteria of 22 CCR 51334)
NF B - Nursing Facility Level B (meets the criteria of 22 CCR 51335)

LONG TERM CARE (LTC) ACCOMMODATION CODES

Description	Regular Services	Leave Days Non-DD Patient	Leave Days DD Patient
NF-B Regular	01	02	03
NF-B Rural Swing Bed Program	04	05	N/A
NF-B Special Treatment Program-Mentally Disordered	11	12	N/A

NF-A Regular	21	22	23
Rehabilitation Program-Mentally Disordered	31	32	N/A
ICF Developmental Disability Program	41	N/A	43
ICF/DD-H 4-6 Beds	61	N/A	63
ICF/DD-H 7-15 Beds	65	N/A	68
ICF/DD-N 4-6 Beds	62	N/A	64
ICF/DD-N 7-15 Beds	66	N/A	69
ICF/DD-CN Pilot Program			
Description	Regular Services	N/A	N/A
ICF/DD-CN Ventilator Dependent	55	----	----
ICF/DD-CN Non-Ventilator Dependent	56	----	----
NF-B Adult Subacute			
Description	**Regular Services**	**Bed Hold**	**Leave of Absence**
Hospital DP/NF-B – Ventilator Dependent	71	73	79
Hospital DP/NF-B – Non-ventilator Dependent	72	74	80
Free-standing NF-B – Ventilator Dependent	75	77	81
Free-standing NF-B – Non-ventilator Dependent	76	78	82
NF-B Pediatric Subacute			
Description	**Regular Services**	**Bed Hold**	**Leave of Absence**
Hospital DP/NF-B – Supplemental Rehabilitation Therapy Services	83	N/A	N/A
Hospital DP/NF-B – Ventilator Weaning Services	84	N/A	N/A
Hospital DP/NF-B – Ventilator Dependent	85	87	89

Hospital DP/NF-B – Non-ventilator Dependent	86	88	90
Free-standing NF-B – Ventilator Dependent	91	93	95
Free-standing NF-B – Non-ventilator Dependent	92	94	96
Free-standing DP/NF-B – Supplemental Rehabilitation Therapy Services	97	N/A	N/A
Free-standing DP/NF-B – Ventilator Weaning Services	98	N/A	N/A

48. DAYS STAY

PURPOSE:
Indicates the patient's number of days stay in a hospital or long-term care (LTC) facility.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	3
FORMAT:	XXX
RECORD LOCATION:	Hospital Records: Columns 354 through 356 LTC Records: Columns 303 through 305
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:
This field captures the patient's length of stay in a hospital or long-term care facility. The discharge day is not counted unless the patient was admitted and discharged on the same day. The discharge day is counted if the patient expired in the hospital. For example, if a patient was admitted on October 23, 2005 and was discharged alive on October 31, 2005, the day's stay for this record would be entered as 008. If the same patient dies instead of being discharged alive on October 31, the day's stay would be entered as 009.

If a patient was still in the hospital when submitting the record to the state, indicate the number of days stay between the patient's admit date and the last date of service as reported on the record. Instead of entering a discharge date in data element 50, zero fill the discharge date field. Indicate on the record all relevant header information including the beginning and ending dates of service, data elements 19 and 20. Also, enter the patient's status as still admitted (code 30 or 31) in data element 51, patient status.

This field is right justified with leading zeroes and must be greater than zero.

49. ADMISSION DATE

PURPOSE:
Identifies the patient's date of admission to an acute care hospital or long-term care facility.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Hospital Records: Columns 314 through 321 Long Term Care Records: Columns 308 through 315
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:
Enter the date the patient was admitted to either a hospital or LTC facility (i.e., nursing or intermediate care facility). The admission date must always be the same as or earlier than the date of discharge.

Example: If the patient's admission date was October 24, 2005, it would be entered as 20051024.

Do not use special characters such as slashes, commas or hyphens.

Cross reference with data element 50, Discharge Date.

50. DISCHARGE DATE

PURPOSE:
Identifies the patient's date of discharge from a hospital or long-term care facility.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	8
FORMAT:	CCYYMMDD
RECORD LOCATION:	Hospital Records: Columns 322 through 329 LTC Records: Columns 316 through 323
REQUIRED ON:	Hospital Records Long Term Care Records

COMMENTS:

Enter the date the patient was discharged from either a hospital or LTC facility (i.e., nursing or intermediate care facility). The discharge date must always be the same as or later than the date of admission.

If the patient has not been discharged at the time the record is reported to the state, zero fill this field. If the patient is on a leave status or bed hold enter the date this change took place and the date the patient returned or was discharged. For patient status codes (DE 51) 06, 07, 08 and 09 the date range must be used.
The day of discharge is excluded from the days stay (Data Element 46) calculation except when it is the same date as the date of admission or the patient expires in the hospital, in which case the discharge day would be counted.

Do not enter any future or expected dates of discharge.

Do not use special characters such as slashes, commas or hyphens.

   Example: November 22, 2005 would be entered as 20051122.

Cross-reference with data element 49, Admission Date.

51. PATIENT STATUS CODE

PURPOSE:
Indicates patient's inpatient or outpatient status as of the ending date of service reported on this record.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Medical Records: Columns 327 through 328 Hospital Records: Columns 302 through 303 LTC Records: Columns 306 through 307
REQUIRED ON:	Hospital Records Long Term Care Records Medical Outpatient Records when applicable (see next page)

COMMENTS:
Valid values differ by record type. See the instructions and charts below for appropriate valid values for each record type.

This data element must not be blank on Hospital and Long Term Care records.

Each hospital inpatient record must indicate the patient's status by entering one of the numeric UB92 valid values listed below. .

HOSPITAL INPATIENT DISCHARGE/STATUS CODES:
01 = Discharged to home or self care
02 = Discharged/transferred to another acute care hospital
03 = Discharged/transferred to a SNF
04 = Discharged/transferred to an ICF
05 = Discharged/ transferred to another type of facility not defined in code list
06 = Discharged/transferred to home under HHA before Admit to SNF
07 = Left against medical advice or discontinued care
20 = Expired
30 = Still patient or expected to return
31 = Admitted (First Interim Bill)

For Hospice records enter one of the following UB-04 codes:

40 = Expired at home
41 = Expired in a hospital, SNF, ICF or freestanding hospice
42 = Expired, place unknown

For long term care records, enter one of the following numeric discharge/patient status codes:

LONG TERM CARE DISCHARGE/PATIENT STATUS CODES
00 = Still under care
01 = Admitted (interim bill)
02 = Expired (Deceased)
03 = Discharged to acute hospital
04 = Discharged to home
05 = Discharged to another Long Term Care facility
06 = Leave of absence to acute hospital (bed hold)
07 = Leave of absence to home
08 = Leave of absence to acute hospital/discharged
09 = Leave of absence to home/discharged
10 = Admit/expired
11 = Admitted/discharged to acute hospital
12 = Admitted/discharged to home
13 = Admitted/discharged to another long term care facility
32 = Transferred to TC status in same facility

Codes to be used by hospitals, SNFs, HHAs, and

43 = Discharge/transferred to a federal health care facility
50 = Discharge to hospice-home

51 = Discharge to hospice-medical facility
61 = Discharge/transferred w/in facility to swing bed
62 = Discharge/transferred to inpatient rehab facility or rehab distinct part unit
63 = Discharged/transferred to Medicare long term care hospital
64 = Discharged/transferred to Medicaid long term care facility
65 = Discharged/transferred to a psych hospital or distinct part of a hospital

For medical outpatient records (code M in data element 3), enter one of the applicable alphabetic codes listed below. If none of the medical outpatient codes are applicable to this record, leave this field blank or fill with spaces.

MEDICAL OUTPATIENT STATUS CODES
AA - Referred to Another Physician
AB - Return to Referring Physician
AC - Return if Needed – PRN
AD - Telephone Follow Up
BA - Referred to CHDP
BB - Referred to CCS
BC - Referred for CPSP Services
BD - Referred for WIC Services

52. ADMISSION NECESSITY CODE

PURPOSE:
Identifies the type or reason for the patient's admission into an acute care hospital.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	1
FORMAT:	X
RECORD LOCATION:	Column 301
REQUIRED ON:	Hospital Records

COMMENTS:
For service date on and subsequent to January 1, 2006 enter one of the following numeric codes indicating the necessity or reason for admitting the patient into the hospital. "4" is to be used for delivery. If the newborn remains an inpatient when mother is discharged "3" is to be used to identify the newborns' inpatient stay.

HOSPITAL ADMISSION NECESSITY CODES:

1 = Emergency
2 = Urgent

3 = Elective
4 = Newborn
5 = Trauma Center
9 = Information Not Available

53. PRIMARY SURGICAL PROCEDURE CODE

PURPOSE:
Identifies primary surgical procedure performed during hospital inpatient stay.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 304 through 308
REQUIRED ON:	Hospital Records

COMMENTS:
Enter appropriate CPT- 4 or ICD-9 surgical code identifying the primary surgical procedure. If no surgery has been performed, leave this field blank or fill with spaces.

The code should be left justified with trailing blanks. Trailing zeros will result in an error.

54. SECONDARY SURGICAL PROCEDURE CODE

PURPOSE:
Identifies secondary surgical procedure performed during hospital inpatient stay.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	5
FORMAT:	XXXXX
RECORD LOCATION:	Columns 309 through 313
REQUIRED ON:	Hospital Records

COMMENTS:
Enter appropriate CPT- 4 or ICD-9 surgical code identifying the primary surgical procedure. If no surgery has been performed, leave this field blank or fill with spaces.

The code should be left justified with trailing blanks. Trailing zeros will result in error.

55. DATA ELEMENT

FILLER – NOT USED AT THIS TIME IN CAPITATED PROGRAMS

56. NUMBER OF CLAIM LINES

PURPOSE:
Identifies the number of completed hospital claim line (detail segments) appended to the header segment of each hospital inpatient record.

CHARACTER TYPE:	Numeric
NUMBER OF BYTES:	2
FORMAT:	XX
RECORD LOCATION:	Columns 349 through 350
REQUIRED ON:	Hospital Records

COMMENTS:
For each hospital record, there can be up to 22 claim lines or detail segments. Each segment contains several fields, described elsewhere in this manual, including the accommodation/ancillary codes, indicating the type of hospital room or accommodation (i.e., room & board, semi-private, 2 bed pediatric) and types of services and supplies provided and charged directly by the hospital. Each segment also includes the number of days stay, amount billed and reimbursed amount.

For each hospital record, there must be at least one detail and no more than 22 detail segments completed. The number of segments completed for each hospital record must correspond with the number (01 - 22) entered in this data element, number of claim lines.

If more than 22 detail segments need to be entered, start a new record including a new, unique Claim Reference Number in Data Element 1.

57. ACCOMMODATION and ANCILLARY CODES

PURPOSE:
Identifies the type of accommodation and/or ancillary service(s) provided by the hospital.

CHARACTER TYPE:	Alpha/Numeric
NUMBER OF BYTES:	3
FORMAT:	XXX
RECORD LOCATION:	Columns 351 through 353

REQUIRED ON:	Hospital Records

COMMENTS:
Enter UB92 accommodation and/or UB92 ancillary codes in this field. A minimum of one accommodation or ancillary code is required to be entered in this field for each hospital record. A maximum of 22 accommodation/ancillary codes can be entered for each record. If the number of detail segments is insufficient for the record, (i.e., greater than 22), start a new record beginning with a unique claim reference number in Data Element 1.

If less than 22 detail segments are filled, leave the remaining detail segments blank. Do not space fill the remaining, unused detail segments.

Cross-reference with data element 56, number of claim lines.

APPENDIX A - STANDARD CODE SETS USED

PROCEDURE & RELATED MODIFIER CODES

The combination of CPT-4 and HCPCS are the code sets used for physician services and other health care services:

CPT-4

Common Procedure Coding Service (HCPCS) Level I, is the same as the Current Procedural Terminology (CPT) 4th edition, used to code physician services (including maxillofacial surgery). The American Medical Association owns and maintains CPT-4 except for anesthesia codes. The use of the specific data elements, including codes and modifiers, is enumerated in the HIPAA implementation specifications.

HCPCS Level II

Procedure and modifier codes are used to report other health related services (ancillary services, radiology and laboratory, other medical diagnostic procedures, physical and occupational therapy, hearing and vision services and medical transportation), other substances, equipment, supplies, or other items used in health care services includes medical supplies, orthotic and prosthetic devices, and durable medical equipment. Level II HCPCS is maintained and distributed by the U.S. Department of Health and Human Services.

HCPCS Level III

Are procedure codes that have been developed by individual states for their own programs. With the implementation of HIPAA, use of HCPC Level III codes will no longer be allowed, on a routine basis. There have been a limited number of modifiers identified for specific use and designation by individual states.

National Drug Codes (NDC)

For pharmaceuticals (drugs and biologics). The NDC codes are maintained and distributed by the U.S. Department of Health and Human Services, in collaboration with drug manufacturers. The specific data elements for which the NDC is a required code set are enumerated in the HIPAA implementation specifications.

The NDC database is here: http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

UB-04

Also called the CMS-1450, was developed and approved for use in 2002. Hospitals, skilled nursing facilities (SNF) and other providers such as home health practitioners utilize the UB-04 to bill Medicare. Other major third party payers (Medicaid, Blue

Cross/Blue Shield, commercial insurers and managed care plans) have substantially adopted Medicare UB-04 guidelines. The UB-04 is not used for billing the professional component.

DIAGNOSIS CODES

ICD-9-CM

International Classification of Diseases, Ninth Edition Volumes 1 and 2, are used for the descriptor of diseases, injuries, impairments, other health related problems, their manifestations, and causes of injury, disease, impairment, or other health related problems. This code set is maintained and distributed by the U.S. Department of Health and Human Services.

DISCHARGE/PATIENT STATUS CODES

Discharge status/patient status codes are used by hospitals, long term care facilities, hospice, and home health agencies. Patient status codes are found in the UB-04 coding manuals.

PLACE OF SERVICE CODES

MEDICAL AND PROFESSIONAL CLAIMS

Maintained by the Department of Health & Human Services/Centers for Medicare &Medicaid Services (CMS), Place of Service Codes are listed in Chapter 26 in the Medicare/Medicaid manual.

INPATIENT AND LONG TERM CARE

First two digits of the Facility Type coding found in the UB-04 coding manuals is used as the place of service code.

APPENDIX B - LIST OF ABBREVIATIONS

This is a list of abbreviations referenced in this document.

ASCII	American Standard Code for Information Interchange (7-bit +parity)
BID	Medi-Cal Beneficiary Identification Number
CMC	Computer Media Claim
CRN/CCN	Claim Reference Number/Claim Control Number
DD	Developmentally Disabled
DD-CN	Developmentally Disabled/Continuous Nursing
DD-H	Developmentally Disabled/Habilitative
DD-N	Developmentally Disabled/Nursing
DP	Distinct Part
DSB	DHCS Data Systems Branch
EBCDIC	Extended Binary Coded Decimal Interchange Code (8 bit)
EDF	Encounter Data Format
GMC	Geographic Managed Care
HWDC	Health and Welfare Data Center
ICF	Intermediate Care Facility
LTC	Long Term Care
MCP	Managed Care Plan
MMCD	Medi-Cal Managed Care Division
NDC	National Drug Code
NF	Nursing Facility
NF A	Nursing Facility Level A (meets the criteria of 22 CCR 51334)
NF B	Nursing Facility Level B (meets the criteria of 22 CCR 51335)
PCP	Primary Care Physician
SSN	Social Security Number
UPC	Universal Product Code