PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE

DATA ELEMENT DICTIONARY, VERSION 1.5

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1.1 PREFACE

1.2 INTRODUCTION

Medi-Cal is the main source of health care coverage for millions of Californians, aiding the poor, elderly, disabled, and other populations access needed health services. A broad range of health care services are covered under Medi-Cal, including hospitalization and out-patient primary care, mental health, long-term care, nursing home, and dental services. Thousands of health care services and medical supplies providers prepare millions of claims and encounters records per month. Medi-Cal reimbursement to the health care providers is accomplished in one of three basic modes: either

- "fee-for-service" based on a claim, claims adjudication, and the resulting paid or denied claim record; or
- a fixed rate per member per month, or capitation, for Medi-Cal beneficiaries enrolled in a Managed Care plan, reporting an "encounter" record defining the health services provided; or
- funding reimbursement to another health program such as for Short-Doyle mental health services or for waivers such as for in-home community-based services, resulting in a "paid claim" record for each service covered.

The Department of Health Services (DHS) manages California's Medi-Cal program and the program's eligibility, scope of benefits, reimbursement, and related components. DHS contracts with Fiscal Intermediaries (FIs) to process fee-for-service claims and requires the Managed Care contractors to provide encounter records. To obtain Medi-Cal funding, the waiver programs and Departments of Mental Health and Alcohol and Drug must submit claim records. DHS collects and processes all of these records for the various purposes outlined later. The current DHS FIs are Electronic Data Systems (EDS) and Delta Dental.

Records for the services paid for in part with federal financial participation funds (FFP) are collected. This includes claims processed by Electronic Data Systems (EDS), Delta Dental Services, the Departments of Mental Health (DMH) and Alcohol and Drugs, services provided under such managed care (capitation) models as County Organized Health Systems (COHS), geographic managed care (GMC), and two-plan counties.

The following list indicates uses of Paid Claim/Encounter data:

- Research
- Public Health Analysis & Policy Setting
- Program Management and Control
- Budgeting (Local Assistance and Admin Support)
- Rate Setting
- Fraud and Abuse (Surveillance, Restricted Services, Case Finding, Case Building, Court Documents, etc.)
- Audits
- Third Party Collections (Auto accidents, Estates, etc.)
- Medicaid funding for other Departments/Programs
  - Mental Health/ADP - Short Doyle
  - Waivers for DDS, AIDS etc.
- State and Federal Reporting
- Drug Rebate - Volume purchase information
- Comparing Health Models (FFS vs. Managed Care)
- Data Warehousing, Data Mining and drill down

1.2.1 Purpose And Uses Of The Data Element Dictionary

This Data Element Dictionary (DED) is provided to define and describe the Paid Claims/Encounter DataStream Standard 35-File. The DED is organized to reflect the order in which the data elements occur on the individual records of the file. Accordingly, the schematic of the record is shown first, followed by each data element in order. For each data element, it's name, definition, location on the file and allowed values are described. The reader may use the Table of Contents to select the page number of a data element and immediately transfer to the page in the DED where that data element's data definition begins.

The same basic document can assist researchers and other users of the Paid Claims/Encounters records, several appendices provide code values and historical information about the data elements. For ease of use, "links" have been established to quickly refer to the associated 'history' information previously found to be helpful for analysts considering the PC/E data across past time periods.

1.2.2 Description Of The 35-File Structure

The Paid Claims/Encounters (PC/E) DataStream Standard 35-file contains variable length records. Each record consists of a header section that is 400 characters in length followed by (0-99) detail segments that are each 250 characters long. The detail segments exist in two types: Main type and Compound Drug type.

Each Main type segment in a claim record contains information for a specific service (claim line) reported by the provider on a claim document or electronic claim record.

Each Compound Drug type segment in a claim record contains information for a specific ingredient in the compound drug, as well as information on the compound as a whole. There is one Compound Drug type segment for each ingredient in the compound. A compound drug claim record can contain information for only one compound drug prescription. A compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is thus normally one more than the compound drug number of ingredients. A compound drug claim record can have a segment count of zero, with no detail segments.

Typically, claim records with a segment count of zero are Adjustment Claims.

Attached is the file layout diagram. For a hardcopy, this record layout needs to be printed separate from the document and attached after the Preface.

S35-Record Layout

Click on link to display.

1.2.3 Data Element Descriptions

This document contains a definition for each data element used in the PC/E DataStream Standard 35-file. The data element definitions are arranged in sequential order as they appear on the record layout.

The DED is designed to provide quick, easy access to the appropriate reference material. From the data element in the dictionary the reader can link to appropriate appendices for more detailed reference material. The reader can also link to historical data, if it exists, for each particular data element.

The Appendices provide a Glossary of terms used, explanation of codes used by data elements, historical and other relevant information.

The following information is generally available for each data element:

General Name
COBOL Name
Location on the record
Definition
Format description
Allowed values
Comments and special considerations
Revisions and History

The DED contains the following appendices:

Appendix A.	Glossary
Appendix B.	Beneficiary Aid Codes
Appendix C.	Compound drug segment
Appendix F.	Claim counts by plan codes
Appendix G.	Provider type codes
Appendix H.	EDS category of service (COS)
Appendix I.	Comparison of provider type and category of service codes
Appendix J.	Physician specialty codes
Appendix K.	Vendor codes
Appendix L.	Routines prenatal care codes
Appendix M.	Provider naming/number system
Appendix N.	Inpatient accommodation codes
Appendix O.	LA. waiver codes – inpatient/outpatient
Appendix P.	Delta dental codes
Appendix Q.	Short-Doyle/Medi-Cal codes
Appendix R.	Long-Term Care (LTC) accommodation codes
Appendix S.	Mio 2-digit accommodation and ancillary codes
Appendix T.	Developmental center accommodation codes (plan code 6)
Appendix U.	Rural health billing procedure codes
Appendix W.	Comparison of paid claims fields for various plan codes
Appendix Y.	Comparison of EDS's type of service codes to DHS' fields
Appendix Z.	Data Element History contains anecdotal information prior to 10/01/2001 about the data elements.
Appendix Y	Background information regarding CCS and GHPP
Appendix AA.	Information related to FI is specific data unique to each fiscal intermediary (FI).
Appendix AB.	35-File edits

1.2.4 Document Maintenance and Revisions

As new or revised data elements are defined, the DED will be expanded to include them. Each time a change to the DED occurs, the revision date on each of the eight footers needs to be updated. In addition, there is a Revision Log at the end of the document that contains the Version number, Date, Requestor and Description of Change.

Please send all corrections and updates or requests for more copies of this manual to:

Department of Health Services
Information Technology Services Division
Help Desk
1615 Capitol Ave., 73-2
P.O. Box 942732
Sacramento, CA 942732

1.2.5 Procedures To Create An Index

1) Create a 'Concordance.doc' Word document consisting of one Word table with two columns. The left column is the text item to be indexed. The right column is the index entry label under which the item will be shown. Please note that these entries are case-sensitive.

2) Go into the document to be indexed.

3) Under Tools > Options > View-Tab, ensure that:
- Field Codes are unchecked
- Hidden Text is checked
- All is unchecked

4) Go to the location in the document where the index is to be displayed.

5) Go to Insert > Index and Tables > Index-tab > AutoMark. Find and select the appropriate Concordance file. Now you should see which items in the text are marked for indexing.

6) Go to Tools > Options > View-Tab, and change All back to unchecked (to eliminate display of paragraph marks).

7) Go to Insert > Index and Tables > Index-Tab > Modify, and select Apply, followed by OK. The index should now be displayed in the document.

8) Go to Tools > Options > View-Tab, and change Hidden-Text to unchecked (to eliminate display of text markings).

1.2.5.1 Procedures To Update the Index When the Concordance File Has Been Modified.

1) Modify the contents of the Concordance file as needed. (The left column is the text item to be indexed. The right column is the index entry label under which the item will be shown. Please note that these entries are case-sensitive.)

2) Go into the document being indexed.

3) Go to Insert > Index and Tables > Index-tab > AutoMark. Find and select the appropriate Concordance file. You should now see updates to Concordance entries reflected in the marking of text items.

4) Go to Tools > Options > View-Tab, and change All back to unchecked (to eliminate display of paragraph marks).

5) Go to where the index is displayed and place your cursor within the displayed index. Press F9 to update. New Concordance entries should now be reflected in the displayed index.

6) If Concordance modifications included change to the labels under which text items are indexed (Concordance right-hand column), previous versions of these labels may still be in effect within the document and index due to old text markings still being present. You must manually delete old unwanted text markings. Then repeat step #5.

7) Go to Tools > Options > View-Tab, and change Hidden-Text to unchecked (to eliminate display of text markings).

1.2.6 Procedures To Update Table Of Contents And The Index

<u>Note: Use this procedure after this file has been changed</u>

1) Go to Table of Contents (TOC) right click, click on update field, select update entire field and then click ok.

2) Go to the index and pace your cursor in front of the first entry. Right click the click on update field.

1.2.7 Procedures For Maintaining An Embedded Record Layout

1) The record layout document (an embedded Word document), is hyperlinked to this document. To keep the source document in synch with a revised record layout document, delete the embedded record layout link/object from this document above, and then embed a new (modified) record layout link/object into this document.

2) To change the way an embedded object appears, go to Edit > Worksheet-Object > Convert, and adjust the Display-As-Icon and/or Float-Over-text settings.

1.2.8 Reference Sources For Other Related Information:

The following organizations have other data files, publications and reports that relate to the Medi-Cal program or health field in general.

STATE OF CALIFORNIA
Internet http://www.ca.gov/state/portal/myca_homepage.jsp

Department of Finance
Demographic Research Unit
915 L St.
(916) **322-465**1
Internet: http://www.dof.ca.gov/html/Demograp/druhpar.htm
Information available: Population Estimates for California State and Counties.

Department of Health Services
Internet: http://www.dhs.ca.gov/

Medi-Cal Policy Institute
Internet: http://www.medi-cal.org/

FEDERAL GOVERNMENT
Department of Health and Human Services
Internet: http://www.os.dhhs.gov/

Centers for Disease Control and Prevention
Atlanta, Georgia
(202) **690-686**7
Internet: http://www.cdc.gov/

National Institutes of Health
(301) **496-400**0
Internet: http://www.nih.gov/

2.0 SEGMENT COUNT

COBOL Name:	F35C-SEGMENT-CNT	
Location on Record:	**003-004**	
Definition:	Segment Count identifies the number of fixed length detail segments appended to header segment of the record.	
Format Description:	Data Type:	Binary
	Display Length:	Up to 4
	Storage Length:	2
	Picture Clause:	S9(04) BINARY
Allowed Values:	00-99 Non-Adjustment claims must have at least one detail.	
Comments and Special Considerations:	There should be one main type detail segment for each service reported by the provider on a claim document or electronic claim record. Compound drug claims can be submitted in either of two methods: 1) Report all ingredients: This is the method that will be used for fee for service claims processed by EDS. In this method a compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is normally one more than the compound drug number of ingredients. In this method only one compound drug can be reported per claim record. A compound drug claim record can have a segment count of zero with no detail segments. Typically, claim records with a segment count of zero are adjustment claims.2) Report the most expensive element: This is the method that will be used for claims other than those in 1) above. In this method a compound drug claim will have one main segment for each compound drug and that segment will report only the most expensive ingredient used in the compound drug. Using this method as many as 99 compound drugs could be reported on a single claim. If there is no detail, the claim is an adjustment claim. See "DATA ELEMENT:ADJUSTMENT INDICATOR for more information. For claims other than 1) above, the number of main type details (if greater than zero) on a pharmacy claim corresponds to the number of prescriptions. Encounter claims can have up to 22 details. Each hospital claim must have at least one detail. If there are more than 22 detail segments, a new Encounter claims record must be started with a new ICN/CCN. Go to Appendix F35C-SEGMENT-CNT AB to see edits.	
Revisions and History:	**Date**	**Description**

3.0 PLAN CODE

COBOL Name:	F35C-PLAN-CODE	
Location on Record:	**005-006**	
Definition:	Plan Code identifies the specific fiscal intermediary that processed the claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	00 Delta Dental Services (DELTA) 01 %Department of Developmental Services Waiver Program 01 %Department of Social Services Personal Care Services 02 Encounter Data 01,02,04 Medi-Cal Intermediary Operations (MIO) (through November 1980) 03 Formerly used by Redwood Health Foundations (RHF) (Their contract to create Long Paid Claims ended 6/89.) 04 County Operated Health Systems (COSH) (*Santa Barbara Health Initiative (SBHI), Marin County, *Santa Cruz County Health Options (SCCHO), *+Napa County County, *+Solano County, *CalOptima (Orange county), *Health Plan of San Mateo (HPSM), Yolo County, Monterey County) 05 &Early Periodic Screening, Diagnosis and Treatment (EPSDT) 06 !State Hospitals/State Developmental Centers (DDS is their claims processor.) (also called Department of Mental Hygiene(DMH)) 08 Short-Doyle/Medi-Cal (SD/MC) (Also called Medi-Cal Short/Doyle) (Department of Mental Health and Department of Alcohol and Drugs create the data the MSD system uses to create these claims.) 09 Electronic Data Systems (EDS) 09 @Electronic Data Systems (EDS) Mental Health Inpatient 29 EDS: As of Dec,06 Aid code 8H (FPACT) has been assigned “29”. NOTE: % To determine which department is which, use Vendor Code '89' for the Department of Social Services Personal Care Services Program. Use Vendor Code '76' for the Department of Developmental Services Waiver Services. NOTE: * To determine which county health initiative (plan code 4) is which, use the county code to make the determination or use the recipient HCP code (a.k.a. PHP Code). NOTE: + See Note in History Appendix Z : Plan Code NOTE: & EPSDT is the Federal program name. In California it is known as Child Health and Disability Prevention Program (CHDP), which is maintained and processed by EDS. These are created claims just like the SD/MC claims. NOTE: * See Note in History Appendix Z : Plan Code NOTE: ! See Note in History Appendix Z : Plan Code NOTE: @ The EDS Mental Health inpatient claims can be determined by using	

	the first three characters of the Provider Number. It always starts with HSM for hospital Mental health. Vendor Code 63 also identifies these claims.
Comments and Special Considerations:	See "Appendix W. COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES" for an overview of various plan codes fields interrelationships. GO TO APPENDIX AB F35C-PLAN-CODE TO SEE EDITS.
Revisions and History:	**Date** / **Description** History can be found in Appendix Z

4.0 DHS CLAIM TYPE

COBOL Name:	F35C-CLAIM-TYPE	
Location on Record:	**007-007**	
Definition:	DHS Claim Type identifies the general type of service that was rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	DHS Claim Type 1 = Outpatient 2 = Inpatient 3 = Pharmacy 4 = Medical/Physician 5 = Dental 6 = EPSDT/CHDP	
Comments and Special Considerations:	Only Delta Dental creates claim type 5. Claim type 6 is used only on claims reformatted from the EPSDT claim files. For our purposes to determine if the claim is a crossover, you must check the Medicare Indicator. See "DATA ELEMENT:MEDICARE INDICATOR". Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units of Service are not inpatient days. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included. See "Appendix W. COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES" for an overview of various plan codes' fields interrelationships. Information related to FI (Fiscal Intermediary) can be found in Appendix AA. Go to Appendix AB F35C-CLAIM-TYPE to see edits	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z.	

5.0 CLAIM CONTROL NUMBER (CCN)

COBOL Name:	F35C-CCN	
Location on Record:	**008-014**	
Definition:	Claim Control Number (CCN), also known as Internal Control Number (ICN) uniquely identifies any processed claims within a specific plan code.	
Format Description:	Data Type:	Packed
	Display Length:	13
	Storage Length:	7
	Picture Clause:	S9(13) COMP-3
Allowed Values:	Plan Code Source Format 00 DELTA YYYYJJJSSSSSS 01,02 MIO AAYYJJJBBBSSS 01 DDS Waiver YYJJJNNNNNNNN (Sequential starts w/000000001) 01 DSS PCSP YYJJJ00000000 02 Encounter YYJJJNNNNNNNN 04 Monterey YYJJJNNNNNNNN 04 Napa 28YYJJJBBBSSS 04 Orange YJJJRRFFSSSLL (non pharmacy claims – claim type not equal 3) 04 Orange 30YYJJJBBBSSS (pharmacy claims – claim type equal 3) 04 San Mateo 41YYJJJBBBSSS 04 Santa Barbara YYJJJNNNNNNNN 04 Santa Cruz YYJJJNNNNNNNN 04 Solano 48YYJJJBBBSSS 04 Yolo 57YYJJJBBBSSS 05 EPSDT YYJJJSSSS0000 06 DDS HHCCCCCCCYYMM 08 S/D YYJJJ00000000 09 EDS YJJJRRFFSSSLL Format Values Code Value A COUNTY/AREA/REGION B BATCH NUMBER C CASE NUMBER F MICROFILM ROLL SEQUENCE NUMBER H DDS PROVIDER NUMBER J JULIAN DATE L LINE NUMBER M MONTH N NUMBER R EDS' MICROFILM ROLL NUMBER S SERIAL NUMBER Y YEAR 0 ZERO	

Comments and Special Considerations:	The purpose of the ICN is for a data source to be able to locate that particular claim in their system. If the originating claim is needed, that number should make it easy to identify it. Also, within the ICN, the Julian date that the data source received the claim is needed. It can be used to calculate length of time from service to claim received for processing or from received to processed. This field is also referred to as CCN because it is called Claim Control Number (CCN) by EDS. The format of the ICN is dependent on the data source and contains the year and Julian date. See "DATA ELEMENT:PLAN CODE". Information concerning roll numbers related to the FI (EDS) can be found in Appendix AA Go to Appendix AB F35C-CCN to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

6.0 BENEFICIARY ID NUMBER

COBOL Name:	F35C-BENE-ID	
Location on Record:	**015-028**	
Definition:	Beneficiary Identification identifies a specific individual.	
Format Description:	Data Type:	Character
	Display Length:	14
	Storage Length:	14
	Picture Clause:	X(14)
Allowed Values:	Alphanumeric CO = County AC = Aid Code 9 = MEDS ID or SSN follows C = CIN follows M = MEDS ID or SSN follows A = Alphabetic (or numeric) J = CTP's pre-imprinted number from paper claim form K = CTP's pre-imprinted number from paper claim form N = Numeric F = Family budget unit (FBU) P# =Person Number CO AC 9 NNNNNNNNN SSI/SSP with aid code of 10,20 or 60 CO AC 9 NNNNNNNNN non-SSI/SSP without aid code of 10,20 0r 60 CO ACM NNNNNNNNN M with SSN used CO ACM 8NNNNNNNP M with MEDS ID with pseudo MEDS ID starts with 8 CO ACM 9NNNNNNNP M with MEDS ID with pseudo MEDS ID starts with 9 CO AC C 9NNNNNNNA C and then CIN CO AC NNNNNN F P# County defined Bene ID 19 AC AAAAAA F P# LA county defined Bene ID can have alphas 19 AC 9AAAAA F P# LA county series number can start with a 9 59 00 NNNNNN CCS CO is always 59 and IDS end with letter CCS CO 9H 9 9NNNNNNNA SD/MC Healthy Families with 9 and then CIN CO 94 M NNNNNNNNJ Children's Treatment Program with # from form CO 94 M NNNNNNNNK Children's Treatment Program with # from form	
Comments and Special Considerations:	The identification number may either be assigned by the MEDS for Social Security Administration's Supplemental Security Income/Supplemental Security Payment (SSI/SSP) eligible or county welfare departments (for AFDC cash assistance and various medical assistance only programs). There are five different types of Beneficiary Identification (BID)/Bene ID numbers, with various components. The number assigned by MEDS for Social Security Administration (SSA) consists of the 2 digit county code, 2 digit aid code, a '9' in the fifth digit, and the person's Social Security Number. If the person moves, MEDS will only need to update the county. The only valid aid codes are the SSI/SSP aid codes 10, 20 and 60. It should be noted that providers will bill using a '9' in the 5th digit and the aid code is not 10, 20, or 60. Frequently you can see the aid codes starting with 1, 2, or 6 since these persons were dropped from SSI/SSP but retain no-cost Medi-Cal eligibility until the responsible county can determine if they are eligible under a Medi-Cal only program.	

On the other hand, county assigned numbers are county specific. That is, if a person moves to another county he/she transfers eligibility and receives a new BID number. The number consists of the 2 digit county code, 2 digit aid code, 7 digit county defined case number, 1 digit Family Budget Unit (FBU), and a 2 digit Person Number. Sometimes the Family Budget Unit is alphabetic.

With the implementation of LA county's Los Angeles Eligibility Automated Determination Evaluation Report (LEADER) system, the serial number can contain many alphabetic letters. Their meaning is only known to the LEADER system. The person number will be numeric though.

Within a given county a person may change eligibility status (aid code) while retaining the same basic BID number. That is, the person might go from AFDC-cash grant (aid code 30) to AFDC-medically needy share of cost (aid code 37) with the BID reflecting only the aid code change. In addition to the above two formats, some fiscal intermediaries and providers who bill Medi-Cal are using another format consisting of the 2 digit county code, 2 digit aid code, an 'M' + SSN number or pseudo SSN number. A pseudo SSN is a MEDS assigned number that starts with an '8' or a '9' and ends with a 'P'. Note when working with Medicare Crossover Claims: This may OR may not be the Medicare number for that individual. Medicare numbers CAN be different from regularly assigned SSA numbers.

Also note, some providers bill using a '9' or 'M' almost what appears to be interchangeable so if you see a '9' do not assume it is a Crossover Medi-Care claim. Check the aid code for 10, 20 or 60 to make that determination.

Starting March 1994, California started using plastic State of California Benefits Identification Cards (BICs) for beneficiaries throughout the state. Note: Recipient card ownership does not guarantee eligibility. That must be verified though the Point of Service (POS) device, Claims and Eligibility Real-Time System (CERTS) PC software, AEVS or Third Party software that has been written to allow provided is similar to the pseudo BID number and consisting of the 2 digit county code, 2 digit aid code, an 'C' + Client Index Number (CIN). The CIN is defined as 9NNNNNNNA. It always starts with a '9', has 7 numeric digits and ends with an alpha character of: A, C through H, M, N, and S through Y. These characters are invalid endings for CINs: B, J, K, L, O, P, Q, R, Z, or I. Note that CINs never end with a 'P' and therefore cannot be confused with Pseudo SSNs. CINs are cross-referenced to MEDS IDs in the MEDS system.

Starting with the May 20th, 1999 cut off, California's Healthy Families Program was implemented in the Medi-Cal Health. Since SSNs are not required for billing, a new ID had to be developed. It was decided to use another pseudo BID number and it consists of the 2 digit county code, 9H (the HFP aid code) or 7X (the HFP Bridge code), an '9' + Client Index Number (CIN). EDS claims do not have this requirement, so this format will never be seen on the claims they process.

Go to Appendix AB F35C-BENE-ID to see edits.

Refer to "DATA ELEMENT:BENEFICIARY SERIAL NUMBER/MEDS ID/CIN" for MEDS and County assigned numbers.

Revisions and History:	**Date**	**Description**

7.0 SSN OR MEDS ID

COBOL Name:	F35C-SSN-OR-MEDS-ID	
Location on Record:	**029-037**	
Definition:	This field contains the client's SSN or a MEDS-assigned pseudo-id	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(01)
Allowed Values:	'8' '9'	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

8.0 BENE CLIENT INDEX NUMBER

COBOL Name:	F35C-BENE-CLIENT-INDEX-NUMBER	
Location on Record:	**038-046**	
Definition:	Client Index Number identifies a beneficiary using a unique assigned number.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(09)
Allowed Values:	CIN is defined as 9NNNNNNNA. It always starts with a '9', has 7 numeric digits and ends with an alpha character of: A, C through H, M, N, and S through Y. These characters are invalid endings for CINS: B, I, J, K, L, O, P, Q, R, or Z. Note that CINS never end with a 'P' and therefore cannot be confused with pseudo SSNS.	
Comments and Special Considerations:	CINs are cross-referenced to MEDS IDs in the MEDS system using the CIN cross-reference file. This field is spaces. Go to appendix AB F35C-BENE-CIN to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z	

9.0 BENEFICIARY NAME

COBOL Name:	F35C-BENE-NAME	
Location on Record:	**047-061**	
Definition:	Beneficiary Name identifies Medi-Cal recipient by name.	
Format Description:	Data Type:	Character
	Display Length:	15
	Storage Length:	15
	Picture Clause:	X(15)
Allowed Values:	Alpha numeric	
Comments and Special Considerations:	Left justify field with the following format: LLLLLLLLLLLLFFF Information related to FI can be found in Appendix AA Go to appendix AB F35C-BENE-NAME to see edits.	
Revisions and History:	**Date**	**Description**

10.0 SEX (GENDER)

COBOL Name:	F35C-BENE-SEX	
Location on Record:	**062-062**	
Definition:	Sex identifies the Sex of the Beneficiary (also referred to as Gender).	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 or M – Male 2 or F – Female Space – Not Reported	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-BENE-SEX to see edits.	
Revisions and History:	**Date**	**Description**

11.0 ETHNICITY (RACE)

COBOL Name:	F35C-BENE-RACE	
Location on Record:	**063-063**	
Definition:	Ethnicity identifies ethnicity of beneficiary. This coding scheme is used on MEDS.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Codes used by Meds Space Unknown (This code is not on MEDS) 0 Unknown 1 White 2 Hispanic 3 Black 4 Other Asian or Pacific Islander 5 Alaskan Native or American Indian 7 Filipino 8 No Valid Data Reported (MEDS generated) 9 No response, client declined to state A Amerasian (Children of Southeast Asian mothers and American citizen fathers. This is a subset of Vietnamese.) C Chinese H Cambodian J Japanese K Korean M Samoan N Asian Indian P Hawaiian R Guamanian T Laotian V Vietnamese Z Other	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-BENE-RACE to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

12.0 BENEFICIARY HIC

COBOL Name:	F35C-BENE-HIC	
Location on Record:	**064-075**	
Definition:	Beneficiary HIC (Health Insurance Claim) number identifies Medi-Cal recipient's Medicare coverage identification number.	
Format Description:	Data Type:	Character
	Display Length:	12
	Storage Length:	12
	Picture Clause:	X(12)
Allowed Values:	Alphanumeric, or space	
Comments and Special Considerations:	The HIC can contain two kinds of numbers. One is the Railroad Retirement Board Claim Number. Individuals whose primary employment has been with the railroad use it. It is either a six or nine digit number with an alphabetic prefix. The SSA computer system changes it so that it looks like a pseudo SSN number. Please see the State Data Exchange documentation for more information. The other kind of HIC number is the SSN with suffix that describes how that person is related to the SSN. If the suffix is an 'A', then it is the wage holder's SSN. If the suffix is a 'B' the person is a wife. If the suffix is a 'C' the person is a child. Numbers are assigned after the suffix to describe which wife or child. There are also other suffixes too numerous to describe here. Please refer to the BENDEX (Beneficiary Data Exchange) documentation for more information.	
Revisions and History:	**Date**	**Description**

13.0 PROVIDER ZIP CODE

COBOL Name:	F35C-PROVIDER-ZIP-CODE	
Location on Record:	**076-084**	
Definition:	Provider Zip Code identifies the geographical location of the provider.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	9
	Picture Clause:	X(09)
Allowed Values:	Alphanumeric or space.	
Comments and Special Considerations:	This is about the only way to identify out-of-state providers. For all practical purposes EDS will process out-of-state provider claims. For the United states ZIP codes, the main 5 characters are left justified and the next 4 characters are zero of the real assigned zip code value. For the Canadian Postal Codes, the 6 character codes are not kept in the EDSNET provider file's zip code field. They are kept in the city field and the zip code is all zeros. EDSNET lists the state code as CN. For the Mexican Postal Codes, the 6 character codes are left justified and zero filled at the end if the code is known. Otherwise the postal code is all zero filled. EDSNET list the state code as MX. Some providers have more than one zip code. This happens especially for hospitals. The hospital itself has its own, but the billing department may be in another zip code. The hospital may have satellite offices also for their outpatient clinics like radiology, mental health, OB/GYN, etc. If the satellite location bills, they may have a different zip code than the main facility. It also happens that the provider zip code is their billing location's zip code, not the physical location where the provider renders services to the beneficiaries. Not present on DDS, SD/MC or EPSDT claims. Information related to FI can be found in Appendix AA Go to appendix AB F35C-PROVIDER-ZIP-CODE to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z.	

14.0 PROVIDER NUMBER

COBOL Name:	PROVIDER-NUMBER	
Location on Record:	**085-094**	
Definition:	The provider number of the billing provider	
Format Description:	Data Type:	Character
	Display Length:	
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

15.0 BILLING PROVIDER TAXONOMY

COBOL Name:	F35C-BILLING-PROVIDER-TAXONOMY	
Location on Record:	**095-104**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

16.0 BILLING PROVIDER OWNER NUMBER

COBOL Name:	F35C-BILL-PROVIDER-OWNER-NUM	
Location on Record:	**105-106**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	3
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

17.0 BILLING PROVIDER LOCATION NUMBER

COBOL Name:	F35C-BILL-PROVIDER-LOCATN-NUM	
Location on Record:	**107-109**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	
	Storage Length:	2
	Picture Clause:	X(03)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

18.0 PROVIDER COUNTY

COBOL Name:	F35C-PROVIDER-COUNTY	
Location on Record:	**110-111**	
Definition:	Provider County identifies the location of the provider's practice.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric Values '01' through '09' '10' through '19' '20' through '29' '30' through '39' '40' through '49' '50' through '58'. Out of state provider value '99' Please refer to "DATA ELEMENT:BENEFICIARY COUNTY" for the list of county codes.	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-PROVIDER-CNTY to see edits.	
Revisions and History:	**Date**	**Description**

19.0 PROVIDER SPECIALTY

COBOL Name:	F35C-PROVIDER-SPECIALTY	
Location on Record:	**112-113**	
Definition:	Physician Specialty identifies the reported area of specialization for Physician/Medical and Outpatient claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	0-9, or space. Please refer to "Appendix J. PHYSICIAN SPECIALTY CODES" for a list of Physician Specialty codes.	
Comments and Special Consideration:	It is on EDS, SBHI, HPSM, DELTA and Encounter claims. It is not on DDS, DSS, or SD/MC. This item is as declared by the physician when obtaining a provider number. Applies only to Vendor Codes 20 and 22 and FI Provider Type Codes 22 and 26. Information related to FI can be found in Appendix AA. Go to appendix AB F35C-PROVIDER-SPECIALTY to see edits.	
Revisions and History:	**Date**	**Description**

20.0 REIMBURSEMENT RATE

COBOL Name:	F35C-REIMBURSEMENT-RATE	
Location on Record:	**114-116**	
Definition:	Reimbursement Rate identifies the percentage rate in which allowed charges will be adjusted to reflect the variance between charges and actual cost for out-of-state and non-contract hospitals.	
Format Description:	Data Type:	Numeric
	Display Length:	3
	Storage Length:	3
	Picture Clause:	9(03)
Allowed Values:	Numeric	
Comments and Special Considerations:	EDS files have 100 in this field for in-state claims. Monterey files have 100 in this field for all of claim types they bill for (1, 2, 3, and 4). DDS, DSS, and Encounter files all contain Zeros in this field. Applies to out-of-state and non-contract hospital inpatient claims. If the hospital is contracted with the state of California, the percentage rate is 100.	
Revisions and History:	**Date**	**Description**

21.0 SPECIAL PROCESSING TYPE

COBOL Name:	F35C-SPECIAL-PROCESSING-TYPE	
Location on Record:	**117-117**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric	
Comments and Special Considerations:	**Special Processing Type Codes** A Rural Health Adult Day Health Care B Bypass Rate Update C CCS Medical Therapy Unit D Exclude from Automated Deactivation F Federally Qualified Health Clinic M Medically Indigent L LA Waiver - Outpatient Only S Licensed Clinical Social Worker R Rural Health Clinic T TAR Exempt	
Revisions and History:	**Date**	**Description**

22.0 SPECIAL PROGRAM TYPE

COBOL Name:	F35C-SPECIAL-PROGRAM-TYPE	
Location on Record:	**118-118**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric	
Comments and Special Considerations:	**Special Program Type Codes** W 1115 Waiver L LA Waiver - Inpatient Only	
Revisions and History:	**Date**	**Description**

23.0 COBA ID

COBOL Name:	F35C-COBA-ID	
Location on Record:	**119-123**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	Numeric	
Comments and Special Considerations:	A crossover carrier code field which identifies which Medicare contractor paid.	
Revisions and History:	**Date**	**Description**

24.0 PAYER SEQUENCE CODE

COBOL Name:	F35C-PAYER-SEQUENCE-CODE	
Location on Record:	**124-124**	
Definition:	Payer sequence code also known as payer responsibility code.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

25.0 VENDOR CODE

COBOL Name:	F35C-VENDOR-CODE	
Location on Record:	**125-126**	
Definition:	Vendor Code identifies the general type of provider.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:	Valid vendor code values 01 through 99.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

26.0 DISCHARGE CODE

COBOL Name:	F35C-DISCHARGE-CODE	
Location on Record:	**128-128**	
Definition:	DHS Discharge/Patient Status Code Indicates status of patient on last day of service on inpatient claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	DHS Discharge /Patient Status: 1. Transfer to another hospital 2. Transfer to long term care (prior to 4/1/96). Transfer to Transitional Inpatient Care(effective 4/1/96) 3. Transfer to long term care 4. Discharge-deceased 5. Discharge to home 6. Still a patient 7. Transfer to long term care (obsolete) 8. Leave of absence 9. Transfer to board (obsolete) The DDS Patient Status Coding for Plan Code 6 claims is entirely different: 0. Still a patient 1. Still a patient 2. Still a patient 3. Still a patient 4. Still a patient 5. Still a patient 6. Still a patient 7. Transferred 8. Discharged 9. Discharge Deceased	
Comments and Special Considerations:	See "DATA ELEMENT:DISCHARGE DATE" because these two fields are related and "DATA ELEMENT:FI DISCHARGE/PATIENT STATUS CODE" for EDS' discharge codes. Information related to FI can be found in Appendix AA Go to appendix AB F35C-DISCHARGE-CODE to see edits.	
Revisions and History:	**Date**	**Description**

27.0 SURGERY CODE

COBOL Name:	F35C-SURGERY-CODE	
Location on Record:	**130-130**	
Definition:	Surgery code identifies whether or not surgery was performed.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	**S** Surgery was performed. Space No Surgery was performed.	
Comments and Special Considerations:	See "DATA ELEMENT:INPATIENT PRIMARY SURGERY CODE" and "DATA ELEMENT: INPATIENT SECONDARY SURGERY CODE for more information. For medical/physician, outpatient, vision, and crossover claim types, the procedure code is checked to determine if the surgery code should be set to an "S". This field is not used by SD/MC, DDS, DSS, EPSDT, and DELTA. This field was set to "S" on 3 of the 3 Encounter inpatient claims from the March 2000 file, even though they had no segments. The primary and secondary surgery codes were also not found on EDSNET, so the Encounter files must have their own unique coding scheme. Information related to FI can be found in Appendix AA Go to appendix AB F35C-SURGERY-CODE to see edits.	
Revisions and History:	**Date**	**Description**

28.0 MEDICARE INDICATOR

COBOL Name:	F35C-MEDICARE-INDICATOR	
Location on Record:	**131-131**	
Definition:	Medicare Indicator indicates that this was a Medicare Crossover claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 Medicare Involvement Present Space No Medicare Involvement	
Comments and Special Considerations:	The Medicare Indicator is not provided for EPSDT, SD/MC or Delta claims. DDS, DSS, and Encounter data show only spaces in this field. Information related to FI can be found in Appendix AA Go to appendix AB F35C-MEDICARE-INDICATOR to see edits.	
Revisions and History:	**Date**	**Description**

29.0 ADMISSION DATE

COBOL Name:	F35C-ADMISSION-DATE	
Location on Record:	**132-139**	
Definition:	Admission Date identifies the date that the client was admitted to the facility on inpatient claims	
Format Description:	Data type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

30.0 DISCHARGE DATE

COBOL Name:	F35C-DISCHARGE-DATE	
Location on Record:	**140-147**	
Definition:	Discharge Date identifies the date that the client was discharged from the facility on inpatient claims	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

31.0 CHECK DATE

COBOL Name:	F35C-CHECK-DATE	
Location on Record:	**148-155**	
Definition:	Check Date identifies the date of the checks that paid the provider for the claim	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	5
	Picture Clause:	X(08)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

32.0 ADJUDICATION DATE

COBOL Name:	F35C-ADJUDICATION-DATE	
Location on Record:	**156-163**	
Definition:	Adjudication Date identifies the date upon which a claim was adjudicated.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD, where: CC = Century YY = Year MM = Month DD= Day	
Comments and Special Considerations:	For Encounter claims, if the records resulted from a capitated service, then the date used was the date the record was processed by the health plan. If the record resulted from a service provided as a non-capitated, fee for service arrangement, the date entered is when the health plan determined to pay for the reported service or supply. Go to appendix AB F35C-ADJUDICATION-DATE to see edits.	
Revisions and History:	**Date**	**Description**

33.0 PATIENT LIABILITY

COBOL Name:	F35C-PATIENT-LIABILITY	
Location on Record:	**164-168**	
Definition:	Patient Liability identifies the amount owed by the recipient for the services being billed for by the provider on this claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	This field will contain the amount the recipient has paid or obligated against his Share of Cost (SOC) on this claim. E.g., The recipient SOC is $100.00. He has previously paid or obligated for $39.00. The amount in this field will be $61.00. Go to appendix AB F35C-PATIENT-LIABILITY to see edits.	
Revisions and History:	**Date**	**Description**

34.0 CO-INSURANCE AMOUNT

COBOL Name:	F35C-CO-INSURANCE-AMOUNT	
Location on Record:	**169-173**	
Definition:	Co-Insurance Amount identifies the co-insurance amount billed to Medi-Cal for Medicare services.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-CO-INSURANCE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

35.0 OTHER COVERAGE AMOUNT

COBOL Name:	F35C-OTHER-COVERAGE-AMOUNT	
Location on Record:	**174-178**	
Definition:	Header Other Coverage Amount identifies amount paid by an insurance carrier or third party.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Numeric.	
Comments and Special Considerations:	See "DATA ELEMENT:DETAIL OTHER COVERAGE AMOUNT". Information related to FI can be found in Appendix AA Go to appendix AB F35C-OTHER-COVERAGE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**

36.0 HDR MEDI-CAL AMOUNT BILLED

COBOL Name:	F35C-HDR-MEDI-CAL-AMT-BILLED	
Location on Record:	**179-183**	
Definition:	Total Medi-Cal Billed Amount indicates the amount Medi-Cal was billed by the provider for the claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Must be numeric, and can be zeroes or negative. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	May be less than the sum of the detail Medi-Cal Billed Amount fields. Usually zeros on Medicare/Medi-Cal crossover claims for EDS See "DATA ELEMENT:DETAIL MEDI-CAL BILLED AMOUNT" for detail Medi-Cal Billed Amount information. Go to appendix AB F35C-HDR-MEDI-CAL-AMT-BILLED to see edits.	
Revisions and History:	**Date**	**Description**

37.0 HDR TOTAL MEDI-CAL AMOUNT PAID

COBOL Name:	F35C-HDR-MEDI-CAL-AMOUNT-PAID	
Location on Record:	**184-188**	
Definition:	Total Medi-Cal Paid Amount identifies the amount Medi-Cal reimbursed the provider for the claim.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Must be numeric, and can be zeroes or negative. If there is a negative Adjustment Indicator (2,3,5) then must be less than zero.	
Comments and Special Considerations:	This field is the sum of the detail Medi-Cal Reimbursed Amount fields. May be less than the sum of the detail Medi-Cal Paid Amount fields on a claim. Usually zeros on Medicare/Medi-Cal crossover claims. See "DATA ELEMENT:MEDI-CAL REIMBURSED AMOUNT" for Medi-Cal Reimbursed Amount information. See "DATA ELEMENT:DETAIL MEDI-CAL PAID AMOUNT" for detail Medi-Cal Paid Amount information. Information related to FI can be found in Appendix AA Go to appendix AB F35C-HDR-MEDI-CAL-AMOUNT-PAID to see edits.	
Revisions and History:	**Date**	**Description**

38.0 MEDICARE DEDUCTION AMOUNT

COBOL Name:	F35C-MEDICARE-DEDUCTION-AMOUNT	
Location on Record:	**189-193**	
Definition:	Medicare Deductible Amount indicates the Medicare deductible amount billed to Medi-Cal for this service.	
Format Description:	Data Type:	Packed
	Display Length:	1
	Storage Length:	5
	Picture Clause:	S9(7)V9(2) COMP-3
Allowed Values:	Must be alphanumeric, space, or low-values: A Medicare Part A regular deductible B Medicare Part B deductible C Both Part A and Part B deductible	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-MEDICARE-DEDUCTION-CODE to see edits.	
Revisions and History:	**Date**	**Description**

39.0 MEDICARE DEDUCTION CODE

COBOL Name:	F35C-MEDICARE-DEDUCTION-CODE	
Location on Record:	**194-194**	
Definition:	Medicare deduction Code identifies type of deductible amount reported in "DATA ELEMENT:MEDICARE DEDUCTIBLE AMOUNT" for Medicare claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Must be alphanumeric, space, or low-values: A Medicare Part A regular deductible B Medicare Part B deductible C Both Part A and Part B deductible	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-MEDICARE-DEDUCTION-CODE to see edits.	
Revisions and History:	**Date**	**Description**

40.0 FAMILY PLANNING CLAIM

COBOL Name:	F35C-FAMILY-PLANNING-CLAIM	
Location on Record:	**195-195**	
Definition:	Family Planning Indicator indicates family planning services were provided.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 Family Planning/Sterilization. 2 Family Planning/Other. Space Not a family planning claim.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

41.0 ADJUSTMENT INDICATOR

COBOL Name:	F35C-ADJUSTMENT-INDICATOR	
Location on Record:	**197-197**	
Definition:	Adjustment Indicator identifies the record as an adjustment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Can be numeric or space. <u>DHS Adjustment Codes</u> 1 Positive supplemental 2 Negative supplemental (negative only) 4 Positive side of void and reissue 3 Refund to Medi-Cal (negative only) 5 Negative side of void and reissue 6 Cash disposition (obsolete) Space Not an adjustment	
Comments and Special Considerations:	The adjustments may be either positive or negative. Information related to FI can be found in Appendix AA Go to appendix AB F35C-ADJUSTMENT-INDICATOR to see edits.	
Revisions & History :	**Date**	**Description**

42.0 DAYS STAY

COBOL Name:	F35C-DAYS-STAY	
Location on Record:	**198-199**	
Definition:	Days Stay indicates the number of days that the patient stayed in the hospital (Inpatient claims only).	
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	2
	Picture Clause:	S9(03) COMP-3
Allowed Values:	Numeric, with days stay values of -1 through -60 and 1 through 60. This field will contain zeroes if the claim is only for ancillary services. This field can be negative if it is an adjustment record	
Comments and Special Considerations:	The actual days paid by Medi-Cal are contained in the Units field. See "DATA ELEMENT:UNITS". Information related to FI can be found in Appendix AA Go to appendix AB F35C-DAYS-STAY to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

43.0 ADJUSTMENT CCN

COBOL Name:	F35C-ADJUSTMENT-CCN	
Location on Record:	**200-206**	
Definition:	This field (Adjustment CCN) is the CCN of the original claim being adjusted.	
Format Description:	Data Type:	Packed
	Display Length:	13
	Storage Length:	7
	Picture Clause:	S9(13) COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	This field is applicable only to Adjustment Claims and provides an audit trail of adjustment to adjusted claim. See "DATA ELEMENT:INTERNAL CONTROL NUMBER". Information related to FI can be found in Appendix AA Go to appendix AB F35C-ADJUSTMENT-CCN to see edits.	
Revisions and History:	**Date**	**Description**

44.0 HEADER FROM DATE OF SERVICE

COBOL Name:	HDR-FROM-DATE-OF-SERVICE	
Location on Record:	**207-214**	
Definition:	Header From Date of Service identifies the earliest 'From Date Of Service' of the detail segments.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(8)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

45.0 HEADER TO DATE OF SERVICE

COBOL Name:	HDR-TO-DATE-OF-SERVICE	
Location on Record:	**215-222**	
Definition:	Header To Date of Service identifies the latest 'Detail To Date of Service' of the detail segments.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

46.0 HDR AID CATEGORY

COBOL Name:	F35C-HDR-AID-CATEGORY	
Location on Record:	**227-228**	
Definition:	Aid Category identifies which aid code the claim was paid under.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Please refer to BENEFICIARY AID CODE for the code references. Information related to FI can be found in Appendix AA. Go to appendix AB F35C-AID-CATEGORY to see edits.	
Revisions and History:	**Date**	**Description**

47.0 FFP INDICATOR

COBOL Name:	F35C-FFP-IND	
Location on Record:	**229-229**	
Definition:	FFP Indicator identifies what FFP (Federal Financial Participation) rate was used for payment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = Unknown 1 = FMAP(Federal Medical Assistance Percentage) 2 = 90% 3 = NON-FFP (0%)	
Comments and Special Considerations:	This field is not used and will always be space-filled. Information related to FI can be found in Appendix AA Go to appendix AB F35C-FFP-IND to see edits.	
Revisions and History:	**Date**	**Description**
	1/11/02	Field is not used comment. ejof
	History can be found in History Appendix Z	

48.0 CROSSOVER STATUS CODE

COBOL Name:	F35C-CROSSOVER-STATUS-CODE	
Location on Record:	**230-230**	
Definition:	Crossover Status Code defines whether or not Medicare covers a recipient.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 = Medicare Part A Eligible 2 = Medicare Part B Eligible 3 = Both Medicare Part A and B Eligible Space = Not Medicare Eligible	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-CROSSOVER-STATUS-CODE to see edits.	
Revisions and History:	**Date**	**Description**

49.0 OTHER COVERAGE INDICATOR

COBOL Name:	F35C-OTHER-COVERAGE-INDICATOR	
Location on Record:	**231-231**	
Definition:	Other Coverage Indicator indicates that there was a non-Medicare other health insurance for the claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space - no other health insurance 1 - has other health insurance	
Comments and Special Considerations:	See "DATA ELEMENT:OTHER HEALTH CARE (OHC) COVERAGE CODE for the valid Other Health Care Coverage code values. Go to appendix AB F35C-OTHER-COVERAGE-INDICATOR to see edits.	
Revisions and History:	**Date**	**Description**

50.0 BIRTHDATE

COBOL Name:	F35C-BIRTHDATE	
Location on Record:	**232-239**	
Definition:	Birth Date identifies the Medi-Cal recipient's date of birth.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)?
Allowed Values:	Format OF CCYYMMDD, where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	This is the latest date of service for the period of service being reported by the provider in this claim. See "DATA ELEMENT:HEADER FROM DATE OF SERVICE (FROM DOS)" for more information. See "DATA ELEMENT:DETAIL TO DATE OF SERVICE" for Detail To Date of service information. Go to appendix AB F35C-HDR-TO-DATE-OF-SERVICE to see edits.	
Revisions and History:	**Date**	**Description**

51.0 CCS GHPP INDICATOR

COBOL Name:	F35C-CCS-GHPP-INDICATOR	
Location on Record:	**246-246**	
Definition:	CCS/GHPP Indicator indicates service authorized by the California Children's Services (CCS) or Genetically Handicapped Persons Program (GHPP).	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space or 0 = Not CCS/GHPP service 1 = CCS/GHPP service	
Comments and Special Considerations:	To determine which program applies to the claim, the age at the date of service must be calculated. CCS is for those under age 21 years, and GHPP is for those 21 years of Age and above. Background information regarding CCS and GHPP can be found in Appendix Y Go to appendix AB F35C-CCS to see edits.	
Revisions and History:	**Date**	**Description**

52.0 PROVIDER NAME

COBOL Name:	F35C-PROVIDER-NAME	
Location on Record:	**247-274**	
Definition:	Provider Name identifies the name of the billing provider.	
Format Description:	Data Type:	Character
	Display Length:	28
	Storage Length:	28
	Picture Clause:	X(28)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Contains the name of the facility, clinic, ambulance company, etc. Left justified, consisting of any or all of the following: LAST NAME space FIRST NAME space INITIAL or the company's name. Information related to FI can be found in Appendix AA Go to appendix AB F35C-PROVIDER-NAME to see edits.	
Revisions and History:	**Date**	**Description**

53.0 MINOR CONSENT SERVICE

COBOL Name:	F35C-MINOR-CONSENT-SERVICE	
Location on Record:	**275-276**	
Definition:	Minor Consent Service Code identifies the recipient as a minor consent eligible and to identify the minor consent services needed.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 = County Confidential Case-Limited Inquiry Access (this code does not appear on paid claims) 04 = Services related to sexually transmitted diseases (STDs), Mental Health, Sexual Assault, Drug and/or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 05 = Services related to Mental Health, Sexual Assault, Drug and/or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 06 = Services related to Sexual Assault, Drug and/or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 07 = Services related to Drug or Alcohol Abuse, Pregnancy or Family Planning and Venereal Disease 08 = Services related to Pregnancy or Family Planning Venereal Disease	
Comments and Special Considerations:	This is also known as the sensitive service code. Before the minor consent aid codes were implemented, the county controlled the minor consent values on MEDS. Now the counties cannot change them unless they contact Medi-Cal Eligibility Branch. See "BENEFICIARY AID CODES (MINOR CONSENT SERVICES)" for more information on Minor Consent aid codes. Information related to FI can be found in Appendix AA	
Revisions and History:	**Date**	**Description**

54.0 RESTRICTED SERVICE

COBOL Name:	F35C-RESTRICTED-SERVICE	
Location on Record:	**277-278**	
Definition:	Restricted Service Code identifies if the recipient has been placed on or removed from restricted status.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	00 = Restriction lifted 01 = Prior authorization for drugs 05 = Prior authorization for scheduled drugs 11 = Prior authorization for M.D. visits 12 = Prior authorization for M.D. visits and drugs 14 = Restricted to primary M.D. 15 = Restricted to primary M.D. and prior authorization for drugs 20 = Prior authorization for Dental visits 21 = Prior authorization for Dental visits and drugs 22 = Prior authorization for M.D. visits and Dental visits 23 = Prior authorization for M.D. visits, Dental visits and drugs 24 = Restricted to primary M.D. with prior authorization required for drugs and Dental visits 90 = Hospice services only 91 = Hospice services overlaid previous S/URS restriction 92 = Hospice services posted retroactively 93 = Hospice services retroactively overlaid previous S/URS restriction 95 = Long Term Care (LTC) restriction due to transfer of assets 96 = Long Term Care overlaid previous S/URS restriction	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

55.0 FI CLAIM TYPE

COBOL Name:	F35C-FI-CLAIM-TYPE	
Location on Record:	**279-280**	
Definition:	FI Claim Type identifies the type of claim used for this billing and the type of edits that were applicable.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 = Pharmacy 02 = Long Term Care 03 = Hospital Inpatient 04 = Outpatient 05 = Physician 06 = Crossover 07 = Vision 09 = TAR	
Comments and Special Considerations:	Different claims type have different data elements and edits that are applicable to the billing. This code identifies which claim was billed with special categories for vision and hospital outpatient/ inpatient due to special edits. Please refer to Data Element: DHS CLAIM TYPE for more information Information related to FI can be found in Appendix AA Go to appendix AB F35C-FI-CLAIM-TYPE to see edits.	
Revisions and History:	**Date**	**Description**

56.0 HEALTH PLAN CODE

COBOL Name:	F35C-HEALTH-PLAN-CODE	
Location on Record:	**281-283**	
Definition:	Health Plan Care Code (also known as Prepaid Health Plan Code) identifies the prepaid health plan that the recipient is enrolled in	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Santa Barbara = '502' San Mateo = '503' Solano = '504' Santa Cruz = '505' Orange = '506' Napa = '507' Monterey = '508' Yolo = '509' Marin = '510'	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

57.0 FI PROVIDER TYPE

COBOL Name:	F35C-FI-PROVIDER-TYPE.	
Location on Record:	**248-286**	
Definition:	FI Provider Type Code identifies the classification of the provider rendering health and medical services using the newer 3-digit coding.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Digit (0-9) Please refer to "Appendix G. PROVIDER TYPE CODES" for a list of the provider type codes.	
Comments and Special Considerations:	As of the March 2000 file, there are no COHS or FI providers that start with a '1'. So as of now both sets of fields have values in them. See "Appendix I. COMPARISON OF PROVIDER TYPE AND CATEGORY OF SERVICE CODES" on for a list of the provider type codes cross-referenced to Category of Service codes. Go to appendix AB F35C-FI-PROVIDER-TYPE to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

58.0 CATEGORY OF SERVICE

COBOL Name:	F35C-CATEGORY-OF-SERVICE	
Location on Record:	**287-289**	
Definition:	Category of Service identifies the category of service the service (procedure) code falls into and that the provider is qualified to render (using the newer 3-digit coding).	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Digits (0-9) Please refer to Appendix H. EDS CATEGORY OF SERVICE (COS)" for a list of the EDS category of service codes.	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-CATEGORY-OF-SERVICE-2 to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

59.0 PRIMARY DIAGNOSIS CODE

COBOL Name:	F35C-PRIMARY-DIAGNOSIS	
Location on Record:	**290-296**	
Definition:	Primary Diagnosis Code identifies the diagnosis code for the principal condition requiring medical attention.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric or spaces.	
Comments and Special Considerations:	Please refer to International Classification of Diseases-Clinical Modifications, Revision 9 (ICD-9-CM) for ICD-9 codes. For Short/Doyle Mental Health and Alcohol and Drug treatment claims, refer to Diagnostic and Statistical Manual of Mental Disorders (DSM) IV diagnostic codes as defined by American Psychiatric Diagnostic Service Manual Forth Edition. The ICD-9 codes can be 3 to 5 characters. The 3-digit version of the code is the most general description. The 4th and 5th character offer a more detailed description. Pharmacy, laboratory, assistant surgeons, and anesthesiologist claims may not have diagnosis codes because it is not required. Therefore, it is possible to find all zeroes or spaces in the diagnosis code field. See "DATA ELEMENT:SECONDARY DIAGNOSIS CODE (ICD)" for more Information on diagnosis codes. Go to appendix AB F35C-PRIMARY-DIAGNOSIS to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

60.0 SECONDARY DIAGNOSIS CODE

COBOL Name:	F35C-SECONDARY-DIAGNOSIS	
Location on Record:	**297-303**	
Definition:	Secondary Diagnosis Code identifies patient's secondary diagnosis, which requires supplementary medical treatment.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric or spaces.	
Comments and Special Considerations:	These codes are to be ICD-9-CM diagnosis codes, which can be 3 to 5 characters. See "DATA ELEMENT:PRIMARY DIAGNOSIS CODE (ICD)" for more information on diagnosis codes. Information related to FI can be found in Appendix AA Go to appendix AB F35C-SECONDARY-DIAGNOSIS to see edits.	
Revisions and History:	**Date**	**Description**

61.0 EMERGENCY INDICATOR

COBOL Name:	F35C-EMERGENCY-IND	
Location on Record:	**304-304**	
Definition:	Claim Emergency Indicator indicates whether the service was performed in an emergency situation.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Y = emergency. N = non-emergency. 0 = non-emergency. Space = non-emergency	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

62.0 ADMIT TYPE

COBOL Name:	F35C-ADMIT-TYPE	
Location on Record:	**305-305**	
Definition:	Inpatient Admission Necessity/Type Code indicates the necessity for admission to an inpatient hospital.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	When Form UB-92 (Claim Form Indicator = 'U') 1 = Emergency (transfer if Admit Source = 4, 5, or 6) 3 = Elective (transfer if Admit Source = 4, 5, or 6) 4 = Newborn (can be either a transfer or not since Admit Source is always a space for newborns) 9 = ? When not Form UB-92 (Claim Form Indicator not = 'U') 1 = Emergency 2 = Elective 3 = Delivery* 4 = Emergency (transfer) 5 = Elective (transfer) 6 = Delivery (transfer)* Encounter claims 1 = Emergency 2 = Elective 3 = Newborn 4 = Delivery	
Comments and Special Considerations:	See "DATA ELEMENT: CLAIM FORM INDICATOR“ for Claim Form Indicator information. See "DATA ELEMENT:ADMIT SOURCE" for the Admit source values. Information related to FI can be found in Appendix AA Go to appendix AB F35C-ADMIT-TYPE to see edits.	
Revisions and History:	**Date**	**Description**

63.0 PATIENT STATUS CODE

COBOL Name:	F35C-PATIENT-STATUS	
Location on Record:	**306-307**	
Definition:	FI Discharge/Patient Status Code indicates the status of the patient in Long Term Care or in an inpatient hospital on the through (TO) date of service on the claim.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	<u>UB92 valid values follow for hospital inpatient claims when the Claim Form Indicator is set to 'U'</u>: 01 = Discharged to home or self care 02 = Discharged/transferred to another acute hospital 03 = Discharged/transferred to a SNF 04 = Discharged/transferred to an ICF 20 = Expired 30 = Still patient or expected to return 31 = Admitted (First Interim Bill) 32 = Transfer to Transitional Care (effective April 1, 1996) <u>Valid values follow for Long Term Care claims</u>: 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 = Admitted/expired 11 = Admitted/discharged to acute hospital 12 = Admitted/discharged to home 13 = Admitted/discharged to other Long Term Care facility <u>Encounter Outpatient Patient Status Codes</u> 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 BD = Referred to WIC Services BC = Referred to CPSP Services	

Comments and Special Considerations:	See "DATA ELEMENT:DHS DISCHARGE/PATIENT STATUS CODE" for DHS's discharge codes. See "DATA ELEMENT: CLAIM FORM INDICATOR" for DHS's claim Form Indicator. Information related to FI can be found in Appendix AA. Go to appendix AB F35C-PATIENT-STATUS to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z .	

64.0 PRIMARY SURGERY CODE

COBOL Name:	F35C-PRIMARY-SURGERY-CODE	
Location on Record:	**308-314**	
Definition:	Inpatient Primary Surgery Code identifies the principal surgical procedure performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric. After September 22, 2004, primary surgery code will contain only ICD-9 volume 3 procedure codes. Before September 22, 2004, please refer to HCPCS (Health Care Financing Administration Common procedure Coding System), CPT-4s (Current Procedure Terminology, Fourth Edition), ICD-9 Volume 3 procedure codes for codes.	
Comments and Special Considerations:	See "DATA ELEMENT:INPATIENT SECONDARY SURGERY CODE" for the secondary surgery codes. Go to appendix AB F35C-PRIMARY-SURGERY-CODE to see edits.	
Revisions and History:	**Date**	**Description**

65.0 PRIMARY SURGERY CODE PROCVAL INDICATOR

COBOL Name:	F35C-PRI-SURG-CODE-PROCVAL-IND	
Location on Record:	**315-316**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

66.0 SECONDARY SURGERY CODE

COBOL Name:	F35C-SECONDARY-SURGERY-CODE	
Location on Record:	**317-323**	
Definition:	Inpatient Secondary Surgery Code identifies the secondary surgical procedure performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	7
	Storage Length:	7
	Picture Clause:	X(07)
Allowed Values:	Alphanumeric. After September 22, 2004, the secondary surgery code will contain ICD-9 volume 3 procedure codes. Before September 22, 2004, please refer to HCPCS (Health Care Financing Administration Common procedure Coding System), CPT-4s (Current Procedure Terminology, Fourth Edition), ICD-9 Volume 3 procedure codes for codes.	
Comments and Special Considerations:	See "DATA ELEMENT:INPATIENT PRIMARY SURGERY CODE" for the primary surgery codes. Go to appendix AB F35C-SECONDARY-SURGERY-CODE to see edits.	
Revisions and History:	**Date**	**Description**

67.0 SECONDARY SURGERY CODE PROCVAL INDICATOR

COBOL Name:	F35C-SEC-SURG-CODE-PROCVAL-IND	
Location on Record:	**324-325**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

68.0 SURGERY DATE

COBOL Name:	F35C-SURGERY-DATE	
Location on Record:	**326-333**	
Definition:	Inpatient Surgery Date identifies the date on which the principle surgery was performed in an inpatient hospital, if applicable.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD where: CC = Century YY = Year MM = Month DD = Day	
Comments and Special Considerations:	Go to appendix AB F35C-SURGERY-DATE to see edits.	
Revisions and History:	**Date**	**Description**

69.0 CLAIM FORM INDICATOR

COBOL Name:	F35C-CLAIM-FORM-INDICATOR	
Location on Record:	**334-334**	
Definition:	Claim Form Indicator identifies if the claim form used to input the claim is a UB - 92 or a HCFA - 1500 form.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	U = UB92 form input. H = HCFA form input. N = NCPDP Space = neither UB-92, NCPDP, nor HCFA-1500 form input.	
Comments and Special Considerations:	This field is required to determine which kind of Admit Source is listed for inpatient claims that come in on the UB-92 form. This field also is used to inform when the HCFA-1500 form is used. Go to appendix AB F35C-CLAIM-FORM-INDICATOR to see edits.	
Revisions and History:	**Date**	**Description**

70.0 ADMIT SOURCE

COBOL Name:	F35C-ADMIT-SOURCE	
Location on Record:	**340-340**	
Definition:	Admit Source identifies the reason a patient was admitted to a hospital.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space = Newborn or Not a transfer or not a UB-92 Claim form. 4 = Transfer from a Hospital 5 = Transfer from a Skilled Nursing Facility 6 = Transfer from another Health Care Facility	
Comments and Special Considerations:	The Admit Source Code is needed to determine the meaning of the values in the Admission Necessity Code if the Claim Form Indicator is 'U'. This field is always a space when the Claim Form Indicator is not 'U'. "DATA ELEMENT:INPATIENT ADMISSION NECESSITY CODE" for the Admission Necessity Code information. Go to appendix AB F35C-ADMIT-SOURCE to see edits.	
Revisions and History:	**Date**	**Description**

71.0 RELATED CAUSES CODES

COBOL Name:	F35C-RELATED-CAUSES-CODES	
Location on Record:	**341-346**	
Definition:	Related Causes Information identifies an accompanying cause of an illness, injury, or an accident.	
Format Description:	Data Type:	Character
	Display Length:	6
	Storage Length:	6
	Picture Clause:	X(02) occurs 3 times
Allowed Values:	Alphanumeric. Up to 3 codes with 2 characters per code. At least 1 code is required when the condition being reported is accident or employment related. <u>Code Definition</u> AA = Auto Accident AB = Abuse AP = Another Party Responsible EM = Employment OA = Other Accident	
Comments and Special Considerations:	Go to appendix AB F35C-RELATED-CAUSE-CODE to see edits.	
Revisions and History:	**Date**	**Description**

72.0 ADMITTING FACILITY PROVIDER NUMBER

COBOL Name:	F35C-ADMITG-FAC-PROV-NUM	
Location on Record:	**347-356**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

73.0 RECORD ID

COBOL Name:	F35C-RECORD-ID-NUMBER	
Location on Record:	**456-463**	
Definition:	Record Identification Number uniquely identifies any paid claim. Used for external users to help identify records that may be in error and link compound segments. Note: the fiscal intermediaries and other organizations that submit claims and encounter data to the State do not populate the Record Identification Number (RIN). The RIN is populated by the State for files that are sent to external users who require the RIN field	
Format Description:	Data Type:	Packed
	Display Length:	15
	Storage Length:	8
	Picture Clause:	S9(15) COMP-3
Allowed Values:	Numeric; will always be a positive value; must be in form YYMMDD######### (YYMMDD is the date the monthly file is processed. #'s represent a unique sequential number assigned to each claim for that file.)	
Comments and Special Considerations:	The purpose of the Record Identification Number (RIN) is to enable external data users and DHS to locate records with which there may be a problem. External users also requested the RIN for their systems so they can link the compound drug segments to the header. Previously, the ICN number as well as other fields that are used to identify claims proved unreliable for this purpose.	
Revisions and History:	**Date**	**Description**

74.0 EDIT FLAG

COBOL Name:	F35C-EDIT-FLAG	
Location on Record:	**464-464**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Valid values are: Space A C D R S	
Comments and Special Considerations:	Populated only by CA DHS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

75.0 EDIT FLAG 2

COBOL Name:	F35C-EDIT-FLAG-2	
Location on Record:	**465-465**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Valid values are: Space A C D R S	
Comments and Special Considerations:	Populated only by CA DHS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

76.0 EDIT ERROR CODE

COBOL Name:	F35C-EDIT-ERROR-CODE	
Location on Record:	**466-468**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Valid values are: Space A C D R S	
Comments and Special Considerations:	Populated only by CA DHS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

77.0 RECORD SOURCE CODE

COBOL Name:	F35C-RECORD-SOURCE-CODE	
Location on Record:	**469-470**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:	Populated only by CA DHS for use in MIS/DSS.	
Revisions and History:	**Date**	**Description**

78.0 SEGMENT TYPE M

COBOL Name:	F35C-SEGMENT-TYPE-M	
Location in Main Type Segment:	**001-001**	
Definition:	Segment Type identifies whether the segment is a main segment or compound drug segment.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	M = Main Segment Type C = Compound Drug Segment Type	
Comments and Special Considerations:	A compound drug claim record normally has one, and only one, main type segment as the first detail segment, followed by 0-40 compound drug segments. The number of compound drug segments depends upon the compound drug number of ingredients. The segment count in the claim header is thus normally one more than the compound drug number of ingredients. A compound drug claim record can have a segment count of zero, with no detail segments. (Prior to the time compound drug ingredients were reported, a drug claim can have multiple compound drugs reported on a claim. In that case, the record will have no compound drug segments.) Go to appendix AB F35C-SEGMENT-TYPE to see edits.	
Revisions and History:	**Date**	**Description**

79.0 CCN LINE NUMBER

COBOL Name:	F35C-CCN-LINE-NUMBER	
Location in Main Type Segment:	**002-003**	
Definition:	The last two characters of the Claim Control Number (CCN) are the claim line number and they are unique for each service.	
Format Description:	Data Type:	Numeric
	Display Length:	2
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:	Numeric	
Comments and Special Considerations:	Go to appendix AB F35C-CCN-LINE-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

80.0 DETAIL MEDI-CAL AMOUNT BILLED

COBOL Name:	F35C-DET-MEDI-CAL-AMT-BILLED	
Location in Main Type Segment:	**004-008**	
Definition:	Detail Medi-Cal Billed Amount identifies the amount billed for this service.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zeros or negative. **Negative only for Adjustment claim.	
Comments and Special Considerations:	The amount provider billed Medi-Cal for the service rendered or product provided. See "DATA ELEMENT:TOTAL MEDI-CAL BILLED AMOUNT" for total Medi-Cal Billed information. Go to appendix AB F35C-DET-MEDI-CAL-AMT-BILLED to see edits.	
Revisions and History:	**Date**	**Description**

81.0 DETAIL MEDI-CAL ALLOWED AMOUNT

COBOL Name:	F35C-DET-MEDI-CAL-ALLOWED-AMT	
Location in Main Type Segment:	**009-013**	
Definition:	Detail Medi-Cal Allowed Amount Paid (Previously named 'Detail Medi-Cal Amount Paid) identifies the maximum amount payable for this service by Medi-Cal.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zeros or negative.	
Comments and Special Considerations:	Previously named 'DETAIL MEDI-CAL AMOUNT PAID'. This field is actually the allowed amount and generally represents what Medi-Cal would pay before any adjustments are made for patient liability or other reasons. This is not necessarily the amount paid but the amount payable before coinsurance, liability, cutbacks, etc. are applied. See "DATA ELEMENT:TOTAL MEDI-CAL PAID AMOUNT" for total Medi-Cal Paid Amount information. Information related to FI can be found in Appendix AA Go to appendix AB F35C-DET-MEDI-CAL-AMOUNT-PAID to see edits.	
Revisions and History:	**Date**	**Description**

82.0 MEDI-CAL REIMBURSED AMOUNT

COBOL Name:	F35C-MEDI-CAL-REIMBURSE-AMOUNT	
Location in Main Type Segment:	**014-018**	
Definition:	Medi-Cal Reimbursed Amount identifies the actual amount reimbursed for this detail line procedure.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric	
Comments and Special Considerations:	This amount is the amount paid after Third Party and other deductions are made to the allowed amount. If there are no deductions, this field would contain the same value as the Detail Medi-Cal Paid Amount field. However, if the Medi-Cal Detail Paid Amount less deductions is greater than the Detail Medi-Cal Billed Amount, then this field would be set to the value in the Detail Medi-Cal Billed Amount. SEE "DATA ELEMENT:DETAIL MEDI-CAL PAID AMOUNT" FOR MORE INFORMATION ON THE DETAIL MEDI-CAL PAID/ALLOWED AMOUNT FIELD. Information related to FI can be found in Appendix AA Go to appendix AB F35C-MEDI-CAL-REIMBURSE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**

83.0 MEDICARE AMOUNT BILLED

COBOL Name:	F35C-MEDICARE-AMOUNT-BILLED	
Location in Main Type Segment:	**019-023**	
Definition:	Medicare Billed Amount identifies amount billed to Medicare.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zeros or negative.	
Comments and Special Considerations:	It is zeros on non-Medicare claims. Go to appendix AB F35C-MEDICARE-AMOUNT-BILLED to see edits.	
Revisions and History:	**Date**	**Description**

84.0 MEDICARE AMOUNT PAID

COBOL Name:	F35C-MEDICARE-AMOUNT-PAID	
Location in Main Type Segment:	**024-028**	
Definition:	Medicare Paid Amount identifies amount paid by Medicare.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP–3
Allowed Values:	Numeric, can be zero or negative.	
Comments and Special Considerations:	It is zeros on non-Medicare claims. Go to appendix AB F35C-MEDICARE-AMOUNT-PAID to see edits.	
Revisions and History:	**Date**	**Description**

85.0 DETAIL FROM DATE OF SERVICE

COBOL Name:	F53B-DET-FROM-DATE-OF-SERVICE	
Location in Main Type Segment:	**029-036**	
Definition:	Detail From Date of Service identifies the start date of the service on this detail.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD CC =Century, YY = Year, MM =Month, DD =Day	
Comments and Special Considerations:	This date can be whenever services were rendered, regardless of month of payment. For example: month of payment could be 20010401 and the claim month of service could be 20010101. See "DATA ELEMENT: HEADER FROM DATE OF SERVICE (FROM DOS)", for Header From Date of Service information. Go to appendix AB F35C-DET-FROM-DATE-OF-SERVICE to see edits.	
Revisions and History:	**Date**	**Description**

86.0 DETAIL TO DATE OF SERVICE

COBOL Name:	F53B-DET-TO-DATE-OF-SERVICE	
Location in Main Type Segment:	**037-044**	
Definition:	Detail To Date of Service identifies the end date of the service on this detail.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	CCYYMMDD CC =Century, YY = Year, MM =Month, DD =Day	
Comments and Special Considerations:	See "DATA ELEMENT: HEADER TO DATE OF SERVICE (TO DOS)" for Header To Date of Service information. Go to appendix AB F35C-DET-TO-DATE-OF-SERVICE to see edits.	
Revisions and History:	**Date**	**Description**

87.0 PRIMARY CARE CASE MANAGEMENT (PCCM) INDICATOR

COBOL Name:	F35C-PCCM-IND	
Location in Main Type Segment:	**045-045**	
Definition:	Primary Care Case Management Indicator identifies if this is a Primary Care Case Management record.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Y = PCCM N = Not PCCM 0 (zero) = Not PCCM Space = Not PCCM	
Comments and Special Considerations:	See "DATA ELEMENT: COPAY AMOUNT" for details on Co-pay Amount and information and see "DATA ELEMENT: COPAY INDICATOR" for details on the Co-pay Indicator.	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z	

88.0 OTHER HEALTH COVERAGE (OHC) CODE

COBOL Name:	F35C-OHC-CODE	
Location in Main Type Segment:	**046-046**	
Definition:	Other Health Care Coverage Code identifies the Other Health Care (OHC) circumstances for each service rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	These are the current values which subject to change A Any Carrier (includes multiple coverage) C CHAMPUS Prime HMO F Medicare HMO K Kaiser L Dental only policies P PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified V Variable-Any carrier other than the above, includes multiple coverage 9 Healthy Family Program (would be a K or P if the child was not enrolled in HF. Started 7/1/98.) Space No Coverage N No Coverage O Override - Used to remove cost avoidance OHC codes posted by DHS Recovery (OHC-Source of H, R, or T) --changes OHC to A or N.	
Comments and Special Considerations:	NOTE: Numeric '0' (ZERO) and '1' (one) are invalid values for OHC. Information related to FI can be found in Appendix AA	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z..	

89.0 EPSDT SERVICE INDICATOR

COBOL Name:	F35C-EPSDT-SERVICE-IND	
Location in Main Type Segment:	**047-047**	
Definition:	EPSDT Service Indicator identifies the kind of service for Early Periodic Screening, Diagnosis and Treatment (EPSDT) claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Z - For HCPCS codes Z5800-Z5999 and SMA code 00010 (Rural Health and FQHC) E - For any other EPSDT service as was determined by the TAR number. Space - that it is not an EPSDT service	
Comments and Special Considerations:	These are Medi-Cal benefits for those aged less than 21 years that are paid even if they are not Medi-Cal benefits and even if some other kind of edit would normally have prevented payment. These include EPSDT supplemental services but are not limited to supplemental services. Information related to FI can be found in Appendix AA	
Revisions and History:	**Date**	**Description**

90.0 MEDI-CAL INTERMEDIARY OPERATIONS (MIO) PLACE OF SERVICE (POS)

COBOL Name:	F35C-MIO-POS	
Location in Main Type Segment:	**048-048**	
Definition:	DHS Place of Service identifies where service was rendered.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	DHS POS HCFA-1500 Not HCFA-1500 0 = Emergency Room 23 B 1 = Inpatient Hospital 21 3 2 = Outpatient Hospital 22 5 3 = Nursing Facility, Level A/B 31, 32, 91, 96 4, C, F, M, (Y on drug Claim only) 4 = Home 12 2 5 = Office, Lab, Clinic 11, 24, 25, 53, 1, 6, 8, 9, A 65, 71, 72, 81 6 = ICF-DD 54, 92, 93 G, H, I 7 = Other 41, 42, 55, 62, 7, J, K, 99 8 = Transitional 97 N Inpatient	
Comments and Special Considerations:	EPSDT claims have low-values in this field. Go to appendix AB F35C-MIO-POS to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z	

91.0 TAR CONTROL NUMBER

COBOL Name:	F35C-TAR-CONTROL-NUMBER	
Location in Main Type Segment:	**049-059**	
Definition:	TAR Control Number identifies the Treatment Authorization Control number assigned to pre-authorize this service.	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	11
	Picture Clause:	X(11)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-TAR-CONTROL-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**

92.0 DRUG PROCEDURE AREA

COBOL Name:	F35C-DRUG-PROCEDURE-AREA	
Location in Main Type Segment:	**060-113**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	54
	Storage Length:	54
	Picture Clause:	X(54)
Allowed Values:	The Procedure Indicator determines the type of procedure. For each Procedure Indicator the following format is used. The field is 40 bytes. The formats below use the bytes required then fill the rest with trailing blanks. For example, an NDC code would occupy the first 11 bytes with the last 29 bytes filled with blanks. Please refer to Data Element: Procedure Indicator for procedure indicator used.	
	When the value of the Procedure Indicator is:	The Format of the procedure area will be:
	Space - EDS Long	11 spaces (use Long Term Care Accommodation code)
	Space - L.A. Wavier	11 spaces (use Long Term Care Accommodation code)
	0 - CDS (Delta Dental)	after 7/93, HCPCS used 6 spaces & 3 Numeric pre 8/93, 2 spaces
	1 - UB-92 for EDS	6 spaces & 4 numeric & 1 space HPSM & SBHI Inpatient after 1/1/92
	2 – EPSDT	6 spaces & 'A001
	2 – SMA	6 spaces & '0' & 4 numeric
	3 - National Drug Code (NDC)	11 characters
	3 - Universal Product Code (UPC)	11characters
	3 - Health Related Industries Code (HRI)	11 characters
	3 - State Drug Code after 3/94	11 characters length offset possible values 4 bytes --1 through 4 – LOW-VALUES, 4 bytes -- 5 through 8 – Numeric, 1 byte -- 9 – alpha (indicates drug strength) 2 bytes --10 & 11 – alphanumeric (drug manufacturer's code) See "**Comments and Special Considerations:**"
	3 - compound drugs after 3/94	'99999999996' & compound drug code = 2.
	4 - CPT-4	6 spaces & 5 Numeric characters
	6 - CHFC inpatient codes	6 spaces & 4 Numeric & 1 space
	7 - L.A. Wavier	6 spaces & '00' & 2 numeric & 1 space
	8 - SD/MC Outpatient	6 spaces & 5 numeric after 6/30/99 6 spaces & 4 Numeric & 1 space before 7/99
	8 - SD/MC Inpatient	11 spaces (use Accommodation code)
	9 - HCPCS Levels II and III	6 spaces & 1 Alpha & 4 numeric

Comments and Special Considerations:	See Data Element: Procedure Code or Drug Type for procedure code. See "Appendix W. Comparison of Paid Claims field for various plan code's field interrelationships. The F35C-PROCEDURE-AREA field is a multiple-use part of the record. The use and layout of the field are determined by the value in the field F35C-PROCEDURE-INDICATOR. When the value of the F35C-PROCEDURE-INDICATOR is "3" indicating the product is identified by a NDC, HRI, PIN, UPC or state drug code, one of the following two layouts are used for the F35C-PROCEDURE-AREA. Layout one: 20 F35C-NDC-UPC-HRI-CODE. 25 F35C-NDC-UPC-HRI-LABELER X(05). 25 F35C-NDC-UPC-HRI-PRODUCT X(04). 25 F35C-NDC-UPC-HRI-PACKAGE X(02). 20 FILLER X(29). Layout two: 20 F35C-MEDI-CAL-CODE-PREFIX X(04). 88 F35C-MEDI-CAL-DRUG VALUE LOW-VALUES. 20 F35C-MEDI-CAL-DRUG-AREA. 25 F35C-MEDI-CAL-DRUG-CODE. 30 F35C-MEDI-CAL-DRUG-CD X(04). 30 F35C-MEDI-CAL-DRUG-STR X(01). 25 F35C-MEDI-CAL-DRUG-MFG X(02). 20 FILLER X(29). If the value of the field F35C-MEDI-CAL-CODE-PREFIX is LOW-VALUES (this corresponds with the first four bytes of F35C-PROCEDURE AREA), then the product is identified by the values in the field F35C-MEDI-CAL-DRUG-CODE, otherwise the product is identified by the values in the field F35C-NDC-UPC-HRI-CODE. If the value of the field F35C-MEDI-CAL-CODE-PREFIX is LOW-VALUES, then the field F35C-MEDICAL-SUPPLY-INDICATOR must be "Y" and the values of the field F35C-MEDI-CAL-DRUG-CD must fall in the range "9900" through "9999". The value "Y" in the field F35C-MEDICAL-SUPPLY-INDICATOR does not always indicate a state drug code is used. State drug codes are used only when the F35C-MEDICAL-SUPPLY-INDICATOR is set to "Y" and the field F35C-MEDI-CAL-CODE-PREFIX contains LOW-VALUES. Information related to FI (fiscal intermediary) can be found in Appendix AA Go to appendix AB F35C-PROCEDURE-AREA and F35C-PROC-CODE-PREFIX to see edits.
Revisions and History:	**Date** / **Description** History can be found in History Appendix Z

93.0 DRUG PRODUCT ID QUALIFIER

COBOL Name:	F35C-DRUG-PRODUCT-ID-QUALIFIER	
Location in Main Type Segment:	**060-061**	
Definition:	Drug Product ID Qualifier identifies the type of code used in data element : PRODUCT ID	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric 03 - National Drug Code (NDC).	
Comments and Special Considerations:	Code qualifying the value in 'Product/ Service ID' (NCPDP 5.1 field number 407-D7). The following are the possible values for this field, as detailed in the NCPDP 5.1 standard (NCPDP Data Dictionary September, 1999). However, the only value Medi-Cal plans to use at this time is 03, National Drug Code (NDC). Space Not Specified 00 Not Specified 01 Universal Product Code (UPC) 02 Health Related Item (HRI) 03 National Drug Code (NDC) 04 Universal Product Number (UPN) 05 Department of Defense (DOD) 06 Drug Use Review/ Professional Pharmacy Service (DUR/ PPS) 07 Common Procedure Terminology (CPT4) 08 Common Procedure Terminology (CPT5) 09 Health Care Financing Administration Common Procedural Coding System (HCPCS) 10 Pharmacy Practice Activity Classification (PPAC) 11 National Pharmaceutical Product Interface Code (NAPPI) 12 International Article Numbering System (EAN) 13 Drug Identification Number (DIN) 99 Other	
Revisions and History:	**Date**	**Description**

94.0 DRUG UNIT OF MEASURE

COBOL Name:	F35C-UNIT-OF-MEASURE	
Location on the Record	**062-063**	
Definition:		
Format Description:	Data Type:	CHARACTER
	Display Length:	?
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	.	

95.0 DRUG BASIS OF COST DETERMINATION

COBOL Name:	F35C-DRUG-BASIS-OF-COST-DETERM	
Location in Main Type Segment:	**064-065**	
Definition:	Drug Basis of Cost Determination indicates whether or not drug dispensed was purchased under a Disproportionate Share/Public Health Service contract.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Space or 00 = Not Specified 09 = Other (Other means Disproportionate Share/Public Health Service contract in the Medi-Cal POS Network Specifications.)	
Comments and Special Considerations:	Data is received under the NCPDP 5.1(National Council of Prescription Drug Programs) transaction-using field 423-DN “Basis of Cost Determination”. We have declared “Other” to mean Disproportionate Share/Public Health Service contract in the Medi-Cal POS Network Specifications. However, the 09 value is mapped to 08 on the 35-file.	
Revisions and History:	**Date**	**Description**

96.0 DRUG REFILL NUMBER

COBOL Name:	F35C-DRUG-REFILL-NUMBER	
Location in Main Type Segment:	**066-067**	
Definition:	Drug Refill Number indicates the refill number of this prescription.	
Format Description:	Data Type:	Number
	Display Length:	1
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:	Numeric	
Comments and Special Considerations:	Go to appendix AB F35C-DRUG-REFILL-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**
	.	

97.0 DRUG PART D EXCLUDED INDICATOR

COBOL Name:	F35C-PART-D-EXCLUDED-IND	
Location in Main Type Segment:	**068-068**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric	
Comments and Special Considerations:	Go to appendix AB F35C-DRUG-REFILL-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**
	.	

98.0 DRUG NCPDP REJECT CODE

COBOL Name:	F35C-NCPDP-REJECT-CODE	
Location in Main Type Segment:	**069-071**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	Numeric	
Comments and Special Considerations:	This field is the primary/first code from the EDS 34 file record, which allows up to five codes. Go to appendix AB F35C-DRUG-REFILL-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**

99.0 DRUG DISPENSING FEE CODE

COBOL Name:	F35C-DRUG-DISPENSING-FEE-CODE	
Location in Main Type Segment:	**072-072**	
Definition:	Compound ingredient dispense fee code indicates whether ingredient is a medical supply.	
Format Description:	Data type:	Character
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	"I" or "M" = medical supply “A” through “H” not a medical supply All other values are invalid.	
Comments and Special Considerations:	EDS will not pay for a medical supply billed as a compound drug ingredient. The Dispensing Fee Code on the Formulary File indicates whether an NDC code is for a drug or medical supply. The field will be checked during pricing, and claims with medical supplies will be denied unless billed with the Process for Approved Ingredients field set to Y, in which case the ingredient will be priced at zero. An EDS compound drug paid claim could have an 'I' or an 'M' in this field, but only if the Process for Approved Ingredients field is set to Y. Go to appendix AB F35C-CMPND-INGR-DISP-FEE-CODE to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

100.0 DRUG DAYS SUPPLY

COBOL Name:	F35C-DRUG-DAYS-SUPPLY	
Location in Main Type Segment:	**073-074**	
Definition:	Drug Days Supply identifies the number of days that the prescription covered.	
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	2
	Picture Clause:	S9(03) COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	The prescription volume is reported in "DATA ELEMENT: UNITS". This field shows how many days that volume covers. Go to appendix AB F35C-DAYS-SUPPLY to see edits.	
Revisions and History:	**Date**	**Description**

101.0 DRUG UNIT PRICE

COBOL Name:	F35C-DRUG-UNIT-PRICE	
Location in Main Type Segment:	**075-079**	
Definition:		
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

102.0 DRUG UNITS

COBOL Name:	F35C-DRUG-UNITS	
Location in Main Type Segment:	**080-085**	
Definition:		
Format Description:	Data Type:	Packed
	Display Length:	3
	Storage Length:	6
	Picture Clause:	S9(08)V999 COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

103.0 DRUG PROCEDURE INDICATOR

COBOL Name:	F35C-DRUG-PROCEDURE-INDICATOR	
Location in Main Type Segment:	**086-086**	
Definition:	Procedure Indicator identifies the type of procedure code or drug code present in the procedure code field.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	0 - DELTA Dental Table of Dental Procedures (prior to 7/1/93 when HCPCS [Health Care Financing Administration Common Procedure coding system] replaced them) 1 - UB-92s ([Uniform Billing – 1992] Uniform Billing codes began on January 1, 1992.) 2 - SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes) Note: EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator. 3 – UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. SEE F35C-MEDICAL-SUPPLY-INDICATOR and F35C-PROCEDURE-AREA for more information on Medical Supply claims. 4 - CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Association's CPT-4 refers to procedures delivered by physicians.) 6 – California Health Facilities Commission (CHFC) 7 - Los Angeles Waiver/L. A. Waiver 8 - Short-Doyle/Medi-Cal (only on Plan Code 8) 9 - HCPCS Levels II and III (effective on October 1, 1992) Space- EDS Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used.	

Comments and Special Considerations:

See Data Element: Procedure Code or Drug Type for procedure code.
See "Appendix W. Comparison of Paid Claims field for various plan code's field interrelationships.
Go to appendix AB F35C-PROCEDURE-INDICATOR to see edits.
Information related to FI (fiscal intermediary) can be found in Appendix AA
A note on NDC, PIN, HRI and UPC and the NDDF.
NDC National Drug Code
HRI Health Related Item
UPC Universal Product Code
PIN Product Identification Number
NDDF (National Drug Data File) is based in the National Drug Code (NDC) coding scheme. For each item, the NDDF shows: Labeler (i.e., manufacturer or repackager); Package size; Wholesale price; Generic formulation; FDA generic equivalency ratings (i.e., Orange Book); Therapeutic class.
The NDC Format Indicator code identifies both the type and the format of the code.

Format Indicator	TYPE	Original	NDDF
0	PIN	11	011
1	NDC	4-4-2	04-4-2
2	NDC	5-3-2	5-03-2
3	NDC	5-4-1	5-4-01
4	UPC	5-5	5-03-2
5	UPC	5-5	5-4-01
6	UPC	5-5	5-4-10
7	HRI	4-4-2	04-4-2

Revisions and History:

Date	Description

History can be found in Appendix Z.

104.0 DRUG PRODUCT ID

COBOL Name:	F35C-DRUG-PRODUCT-ID	
Location in Main Type Segment:	**087-106**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	20
	Picture Clause:	X(20)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

104.1 DRUG UNIVERSAL PRODUCT NUMBER (UPN)

COBOL Name:	F35C-DRUG-UPN-NUMBER	
Location in Main Type Segment:	**087-106**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	19
	Picture Clause:	X(19)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

104.2 DRUG NATIONAL DRUG CODE (NDC)

COBOL Name:	F35C-DRUG-NDC-CODE	
Location in Main Type Segment:	**087-097**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	19
	Picture Clause:	X(11)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

104.3 DRUG MEDI-CAL DRUG CODE

COBOL Name:	F35C-DRUG-MEDI-CAL-CODE	
Location in Main Type Segment:	**087-090**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	4
	Picture Clause:	X(04)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

104.4 DRUG MEDI-CAL DRUG MANUFACTURER

COBOL Name:	F35C-DRUG-MEDI-CAL-DRUG-MFG	
Location in Main Type Segment:	**096-097**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	4
	Picture Clause:	X(02)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

105.0 OTHER PROCEDURE AREA

COBOL Name:	F35C-OTHER-PROCEDURE-AREA	
Location in Main Type Segment:	**114-139**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	26
	Picture Clause:	X(20)
Allowed Values:	Numeric	
Comments and Special Considerations:	This area is for reporting information on a service or product with a procedure code that is not longer than 5 characters, such as HCPCS or CPT-4 codes.	
Revisions and History:	**Date**	**Description**

106.0 OTHER PRODUCT ID QUALIFIER

COBOL Name:	F35C-OTHR-PROD-ID-QUALIFIER	
Location in Main Type Segment:	**114-115**	
Definition:	Compound ingredient product id qualifier identifies the type of information used to identify an ingredient (e.g., NDC, HRI, and UPN etc or other). At this time the only type of numeric identifier used in Medi-Cal is 03 (NDC number).	
Format Description:	Data type:	Character
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	03 National Drug Code (NDC) Space not specified 00 not specified 99 other	
Comments and Special Considerations:	If the value is 03, then the field F35C-CMPND-INGR-NDC must contain a valid National Drug Code (NDC). If the field value is not 03, then the field F35C-CMPND-INGR-PRODUCT-ID will be used as the identifier for the ingredient. Go to appendix AB F35C-CMPND-INGR-PROD-ID-QUAL to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

107.0 OTHER PROCVAL INDICATOR

COBOL Name:	F35C-OTHR-PROCVAL-INDICATOR	
Location in Main Type Segment:	**116-117**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Numeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

108.0 OTHER UNITS

COBOL Name:	F35C-OTHR-UNITS	
Location on the Record	**118-123**	
Definition:	?	
Format Description:	Data Type:	Packed
	Display Length:	11
	Storage Length:	6
	Picture Clause:	S 9(8) V999 COMP-3.
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

109.0 OTHER PROCEDURE TYPE

COBOL Name:	F35C-OTHR-PROCEDURE-TYPE	
Location on the Record	**124-124**	
Definition:	?	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

110.0 OTHER PROCEDURE INDICATOR

COBOL Name:	F35C-OTHR-PROCEDURE-INDICATOR	
Location on the Record	**125-125**	
Definition:	?	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	2
	Picture Clause:	X(01)
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

111.0 OTHER PROCEDURE CODE

COBOL Name:	F35C-OTHR-PROCEDURE-CODE	
Location on the Record	**126-130**	
Definition:	?	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	2
	Picture Clause:	X(05)
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	.	

112.0 OTHER INPATIENT LOCAL CODE

COBOL Name:	F35C-OTHR-INPATIENT-LOCAL-CODE	
Location on the Record	**136-139**	
Definition:	?	
Format Description:	Data Type:	Character
	Display Length:	11
	Storage Length:	4
	Picture Clause:	X(04)
Allowed Values:	Numeric.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	.	

113.0 PROCEDURE MODIFIERS OR TEETH

COBOL Name:	F35C-PROC-MODIFIERS-OR-TEETH	
Location in Main Type Segment:	**140-147**	
Definition:	For Dental Claim - Tooth or Modifier determines tooth or mouth area being treated. For Medical/Physician and Outpatient claims - Tooth or Modifier determines any special external circumstances connected to the service.	
Format Description:	Data Type:	Character
	Display Length:	02
	Storage Length:	08
	Picture Clause:	X(08)
Allowed Values:	Alphanumeric or space.	
Comments and Special Considerations:	See "Appendix V. APPROVED MODIFIERS" for a list of the approved modifiers. See "Appendix P. DELTA DENTAL CODES" for Delta Dental Tooth codes. Information related to FI can be found in Appendix AA	
Revisions and History:	**Date**	**Description**

114.0 ACCOMMODATION CODE

COBOL Name:	F35C-ACCOMMODATION–CODE	
Location in Main Type Segment:	148-150	
Definition:	Accommodation Code identifies type of accommodation or ancillary service being billed for inpatient claims only.	
Format Description:	Data Type:	Character
	Display Length:	3
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:	See "Appendix R. LONG TERM CARE (LTC) ACCOMMODATION CODES" for the long term care codes.	
Comments and Special Considerations:	The accommodation code is used to denote long term care facility accommodations. See "Appendix W. COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES" for an overview of various plan code fields interrelationships. Information related to FI can be found in Appendix AA. Go to appendix AB F35C-ACCOMMODATION-CODE to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z.	

115.0 DRUG MANUFACTURER

COBOL Name:	F35C-DRUG-MANAFACTURER	
Location in Main Type Segment:	**151-152**	
Definition:	Drug Manufacturer identifies the manufacturer of the pharmaceutical on drug claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This drug manufacturer field is no longer applicable upon implementation of the 11-byte procedure code field. The procedure code field will have the manufacturer code in the last two bytes.	
Revisions and History:	**Date**	**Description**

116.0 PRESCRIPTION NUMBER

COBOL Name:	F35C-PRESCRIPTION-NUMBER	
Location in Main Type Segment:	**153-160**	
Definition:	Prescription Number identifies pharmacies internal invoice number on pharmaceutical claims.	
Format Description:	Data Type:	Character
	Display Length:	8
	Storage Length:	8
	Picture Clause:	X(08)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA Go to appendix AB F35C-PRESCRIPTION-NUMBER to see edits.	
Revisions and History:	**Date**	**Description**

117.0 COPAY AMOUNT

COBOL Name:	F35C-COPAY-AMOUNT	
Location in Main Type Segment:	**161-165**	
Definition:	The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	Co-payment may be collected from Medi-Cal beneficiaries at the option of the provider. The provider in addition to his Medi-Cal payment retains co-payment amounts. Certain categories of beneficiaries are exempt from one or all types of co-payment. The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered. The amounts are in addition to the usual provider reimbursement and no deduction will be made from the amounts otherwise approved by EDS for payment to the provider. The collection of the co-payment by the provider is optional. A provider of service cannot, under law, deny care or services to an individual solely because of that person's inability to co-pay. The individual does, however, remain liable to the provider for any co-payment amount owed. Go to appendix AB F35C-COPAY-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**

118.0 OHC COPAY AMOUNT

COBOL Name:	F35C-OHC-COPAY-AMOUNT	
Location in Main Type Segment:	**166-170**	
Definition:	The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V99 COMP-3
Allowed Values:	Numeric	
Comments and Special Considerations:	Co-payment may be collected from Medi-Cal beneficiaries at the option of the provider. The provider in addition to his Medi-Cal payment retains co-payment amounts. Certain categories of beneficiaries are exempt from one or all types of co-payment. The co-payment amount is to be collected by or obligated to the provider at the time the service is rendered. The amounts are in addition to the usual provider reimbursement and no deduction will be made from the amounts otherwise approved by EDS for payment to the provider. The collection of the co-payment by the provider is optional. A provider of service cannot, under law, deny care or services to an individual solely because of that person's inability to co-pay. The individual does, however, remain liable to the provider for any co-payment amount owed. Go to appendix AB F35C-COPAY-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**

119.0 PRICE RESTRICTION

COBOL Name:	F35C-PRICE-RESTRICTION	
Location in Main Type Segment:	**171-171**	
Definition:	Price Restriction identifies drugs with dispensing restrictions for Pharmacy claims only.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	0 or space no restrictions 1 restrictions	
Comments and Special Considerations:	For drug, outpatient and medical claims, provider number of the rendering provider. For inpatient claims, provider number of the operating provider.	
Revisions and History:	**Date**	**Description**

120.0 RENDERING OPERATING PROVIDER NUMBER

COBOL Name:	F35C-RENDER-OPERATING-PROV-NUM	
Location in Main Type Segment:	**172-181**	
Definition:	Prescribing/Referring/Rendering Provider Number identifies the provider whom the recipient was to as a result of screening by another provider.	
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number	
Revisions and History:	**Date**	**Description**

121.0 RENDERING OERATING PROVIDER TAXONOMY

COBOL Name:	F35C- REND-OPER-PROV-TAXONONY	
Location in Main Type Segment:	**182-191**	
Definition:	Prescribing/Referring/Rendering Provider Taxonomy identifies provider type, classification, and specialization for the prescribing, referring, or rending provider.	
Format Description:	Data Type:	Character
	Display Length:	10
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Health Care Provider Taxonomy code list (provider specialty code) is available on the Washington Publishing Company web site: http://www.wpc-edi.com/. The Blue Cross Blue Shield Association and ASC X12N TG2 WG15 maintains this taxonomy.	
Comments and Special Considerations:	Go to appendix AB F35C-PRESC-REF-REND-PROV-TAXON to see edits.	
Revisions and History:	**Date**	**Description**

122.0 RENDERING OPERATING PROVIDER OWNER NUMBER

COBOL Name:	F35C-REND-OPER-PROV-OWNER-NUM	
Location in Main Type Segment:	**192-193**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

123.0 REFERRING PRESCRIBING PROVIDER NUMBER

COBOL Name:	F35C-REF-PRESCRIB-PROV-NUM	
Location in Main Type Segment:	**194-203**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	This field can contain NPI or other provider numbers such as the Medi-Cal provider number	
Revisions and History:	**Date**	**Description**

124.0 REFERRING PRESCRIBING PROVIDER TAXONOMY

COBOL Name:	F35C-REFER-PRESC-PROV-TAXONOMY	
Location in Main Type Segment:	**204-213**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	9
	Storage Length:	10
	Picture Clause:	X(10)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

125.0 EPSDT REFERRAL CODE

COBOL Name:	F35C-EPSDT-REFERR-CDS	
Location in Main Type Segment:	**214-215**	
Definition:	EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Referral Code identifies if this claim is a CHDP screen-related service; e.g., if a CHDP (Child Health and Disability Prevention) referral preceded this claim.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	01 CHDP screen-related service 00 not a CHDP screen-related service	
Comments and Special Considerations:	The CHDP (Child Health and Disability Prevention) program is the name for California's EPSDT (Early and Periodic Screening, Diagnosis and Treatment) program. If a Medi-Cal provider enters a '3' in the family planning/CHDP box on claim form 40-1 or HCFA-1500, then the claim is for a CHDP screen related service.	
Revisions and History:	**Date**	**Description**

126.0 COPAY INDICATOR

COBOL Name:	F35C-COPAY-IND	
Location in Main Type Segment:	**216-216**	
Definition:	Copay Indicator determines the kind of copay	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	N or space or low-values No Copay Deduction A Adjusted Copay (not currently used) H Copay taken on another detail L Limited Copay (allowable less than Copay) S Standard Copay applied Z Copay applicable but allowable was zero Only the 'L' and 'S' will have valid dollar amounts in the Copay amount field. The remainder will be set to zero dollars. Go to appendix AB F35C-COPAY-IND to see edits.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z	

127.0 FI TYPE OF SERVICE

COBOL Name:	F35C-FI-TOS	
Location in Main Type Segment:	**217-217**	
Definition:	FI Type of Service characterizes the type of service with which a procedure code is associated.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Alphanumeric	
Comments and Special Considerations:	Information related to FI can be found in Appendix AA.	
Revisions and History:	**Date**	**Description**

128.0 DETAIL OTHER COVERAGE AMOUNT

COBOL Name:	F35C-DET-OTHER-COVERAGE-AMOUNT	
Location in Main Type Segment:	**218-222**	
Definition:	Detail Other Coverage Amount identifies the amount of money paid by an insurance carrier or third party for this service. Does not include Medicare payment.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP-3
Allowed Values:	Numeric.	
Comments and Special Considerations:	Go to appendix AB F35C-DET-OTHER-COVERAGE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z	

129.0 ADDITIONAL FEE

COBOL Name:	F35C-ADDITIONAL-FEE	
Location in Main Type Segment:	**223-227**	
Definition:	Detail Other Coverage Amount identifies the amount of money paid by an insurance carrier or third party for this service. Does not include Medicare payment.	
Format Description:	Data Type:	Packed
	Display Length:	9
	Storage Length:	5
	Picture Clause:	S9(07)V9(2) COMP-3
Allowed Values:	Numeric.	
Comments and Special Considerations:	Go to appendix AB F35C-DET-OTHER-COVERAGE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**
	History can be found in History Appendix Z	

130.0 ORIGINAL PLACE OF SERVICE

COBOL Name:	F35C-ORIG-POS-2	
Location in Main Type Segment:	**228-229**	
Definition:	Original Place of Service identifies where the service was rendered.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Alphanumeric or space. This coding scheme is different from the DHS coding scheme and reflects the codes used on the claim forms by the provider. There are two sets of place of service (POS) codes that will be found here depending on whether the HCFA-1500 was used or another claim form was used. The HCFA-1500 POS codes are two-digit codes. The other POS codes are one-digit codes and will have a trailing space to fill this two-byte field. <u>One–digit POS codes with a trailing space used on all but the form HCFA-1500</u> 1 Office 2 Home 3 Inpatient hospital 4 Nursing facility level B (SNF 5 Outpatient hospital 6 Independent laboratory 7 Other 8 Independent kidney treatment center 9 Clinic A Surgery clinic B Emergency room C Nursing facility level A (ICF) F Subacute care facility G Intermediate Care Facility-Developmentally Disabled H Intermediate Care Facility-Developmentally Disabled-habilitative IIntermediate Care Facility-Developmentally Disabled- Nursing Origin Place of Service <u>Other one-digit POS codes with a trailing space (continued</u>) J Non-home K Mobile Van M Pediatric Subacute N Non-ICF/SNF for drug claims only <u>HCFA-1500 two-digit POS Codes</u> 11 Office 12 Patient's home 21 Inpatient hospital	

	22 Outpatient hospital 23 Emergency room (hospital) 24 Ambulatory surgical center 25 Birthing center 26 Military treatment center (Not Valid for Medi-Cal Billing) 31 Skilled nursing facility 32 Nursing home/nursing facility 33 Custodial care facility(Not Valid for Medi-Cal Billing) 34 Hospice(Not Valid for Medi-Cal Billing) 41 Ambulance (land) 42 Ambulance (air or water) 51 Inpatient psychiatric facility**(**Not Valid for Medi-Cal Billing) 52 Day care facility/psyche. Facility(Not Valid for Medi-Cal Billing) 53 Community mental health center 54 Specialized treatment center/intermediate care 55 Residential treatment center/substance abuse 56 Psychiatric residential treatment center(Not Valid for Medi-Cal Billing) 61 Comprehensive inpatient rehab facility(Not Valid for Medi-Cal Billing) 62 Comprehensive outpatient rehab facility 65 Independent kidney disease treatment center 71 State or local public health clinic 72 Rural health clinic 81 Independent laboratory 91 Nursing Facility Level B (Adult Subacute) 92 Intermediate Care Facility (Developmentally Disabled, (ICF/DD)) 93 Intermediate Care Facility (Developmentally Disabled habilitative, ICF/DD-H) 96 Pediatric Subacute 97 Transitional Inpatient Care (effective 1/1/96) 99 Other
Comments and Special Considerations:	Information related to FI can be found in Appendix AA. Go to appendix AB F35C-ORIG-POS-2 to see edits.
Revisions and History:	**Date** / **Description** History can be found in Appendix Z

131.0 ENHANCED THERAPEUTIC CLASS (SMART KEY)

COBOL Name:	F35C-SMART-KEY	
Location in Main Type Segment:	**230-253**	
Definition:	First Databank Smart Key describes the specifics of a drug. It is used for both NDC and state drug codes.	
Format Description:	Data Type:	Character
	Display Length:	24
	Storage Length:	24
	Picture Clause:	X(24)
Allowed Values:	Field(as of 1993) Bytes Generic Therapeutic Class (GTC) (GTC) broad classification; e.g. 20=Anti-infective 2 Specific Therapeutic Class (STC) Specific classification; e.g.0478=Tetracycline 4 Generic Name/ (HICL) Hierarchical Ingredient Code List identifies the specific Generic entity; e.g. 04003=Tetracycline HCI 5 Drug Strength; (STR) e.g. 0600=250mg 4 Dosage Form (DOSE) e.g. 500=capsule 3 Route of Administration (RT) e.g. 01=oral 2 Package Size (PS) e.g. 008=100each 3 Unit Dose/Unit of Use (UDUU) Identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use 1	
Comments and Special Considerations:	The strength is defined two ways. If the range values are 0**001-099**9, then the value represents milligrams. So a value of 0005 is less than 0500, and 0005 means 0.02 mg and 0550 equals 130 mg. The other range of 1000 to 2000 is a percentage. That means that a SKEY-STG of 1000 is less than a SKEY-STR of 1100. So that means that you cannot compare 0150 to 1000 because you can't compare milligrams to percentages. You can change milligrams to percentages and visa versa. The conversion table is so large, that First DataBank only offers this by	

	electronic media, no on paper. The SKEY-PS specifies the package quantity and its unit of measure (each, ml, or gram). This field can be combined with all other sub-fields for specific or general searches. The thirty most common package sizes are in the rage of 001 - 030. The Unit Dose/Use only has 3 values. This field should be considered an extension of the SKEY-PS, but it could be used as an independent field. The Smart Key data is confidential, whoever wants it will have to buy the info from the 'First Data Bank'. What DHS can release is just the NDC. The Smart Key is part of First DataBank's drug information system and is composed of eight fields. It is called SKEY for short and it "leverages existing National Drug Data File (NDDF(TM)) data with two new codified fields resulting in a unique field, initially consisting of seven independent codes: High level therapeutic class, specific therapeutic class code, modified hierarchical ingredient code list sequence number, a new strength code, dosage form code, route of administration code and a new package size code." But try to get detailed information from their web site and you can't. You need an ID and password to do a search using SMART KEY as of June 2000. The Smart Key "accommodates both general as well as specific classification of drugs, with ingredient, strength, dosage, route and package size identification." It is possible to by using the SKEY-HICL (Hierarchical Ingredient Code List) and SKEY-RT (Route of administration) to find all of one kind of product and how it is given by those two codes, such as oral diazepam products. This will find them all without regard to manufacturer, size or dosage form. "The Smart Key was designed for purchasing agents and for applications requiring formulary definition. Applications used for selecting and stratifying drug products on the basis of product groups, require a great deal of flexibility. For instance, it may be necessary to identify all NDCs (National Drug Codes), with a certain combination of ingredients, dose, route, package size, and in unit dose form. The Smart Key would allow this identification, without having to specify NDCs. From this specific Smart Key definition all current NDC could then be selected and made part of the request for bid." The quoted information is from the Smart Key Specification dated April 2, 1993, copyrighted by The Hearst Corporation.
Revisions and History:	**Date** / **Description** History can be found in Appendix Z.

132.0 MEDICAL SUPPLY INDICATOR

COBOL Name:	F35C-MEDICAL-SUPPLY-IND	
Location in Main Type Segment:	**254-254**	
Definition:	Medical Supply Indicator indicates whether this drug code is for a medical supply.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	"Y"	The claim must be a Pharmacy, Medical/Physician or Outpatient claim. If the field F35C-MEDI-CAL-CODE-PREFIX is not equal to LOW-VALUES, then an NDC, UPN, UPC, or HRI code for a medical supply is used. Otherwise a state drug code for a medical supply is used. For a state drug code to be used and be valid, the following must apply, 1. The field F35C-MEDI-CAL-CODE-PREFIX must contain LOW-VALUES, 2. The field F35C-MEDI-CAL-DRUG must contain the a value of 9900 through 9999, 3. The field F35C-MEDI-CAL-DRUG-STR must contain a value of "A" through "Z", and 4. The F35C-PROCEDURE-INDICATOR must = '3'
	"N"	Not a medical supply, if the claim is a Pharmacy, Medical/Physician or Outpatient claims.
	Space	Not a Pharmacy, Outpatient, or Medical/Physician claim.
Comments and Special Considerations:	See the field F35C-PROCEDURE-AREA for a complete explanation on the relationship between the F35C-PROCEDURE-AREA and the F35C-MEDICAL-SUPPLY-IND Go to appendix AB F35C-MEDICAL-SUPPLY-IND to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised by V1R15

133.0 TOOTH SURFACES

COBOL Name:	F35C-TOOTH-SURFACES	
Location in Main Type Segment:	**255-259**	
Definition:	Tooth Surface Location is a 5-byte area used for denoting tooth surfaces, 1 byte for up to 5 occurrences per procedure code. Each byte indicates a tooth surface location for Dental claims.	
Format Description:	Data Type:	Character
	Display Length:	5
	Storage Length:	5
	Picture Clause:	X(05)
Allowed Values:	There are five 1-byte using the code as follow: B Buccal Cheek side D Distal Side of the tooth facing the back of the mouth * F Facial Top and bottom 8 teeth you can see when you smile L Lingual Tongue side M Mesial Side of the tooth facing the front of the mouth * I Incisal The cutting edge of the incisor teeth O Occlusal The grinding or biting surface G Gingival At the gum line * The distal surface of the tooth face, the mesial surface of the next tooth back.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	History can be found in Appendix Z.	

134.0 BILLED CODE INDICATOR

COBOL Name:	F35C-BILLED-CODE-IND	
Location in Main Type Segment:	**260-260**	
Definition:	Billed Code Indicator provides information about the original contents of the Procedure Code field before any cross-referencing took place. It is populated internally by DHS.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	N 'NDC' S 'Spaces' R 'Reject' C 'Compound' A 'Cancer' T 'TAR' M 'Medi-Cal' J 'Junk' E 'Error'	
Comments and Special Considerations:	Paid Claims data sources supply a SPACE in this field. This field has always been on the appended 35-file record. Drug claims come in with either an 11-digit NDC or a 5-digit State drug code in the Procedure Code field. ITSD runs all drug claims through a program that looks at the Drug Formulary file and tries to find the corresponding obsolete 5-digit State drug code value for the NDC that was billed. This is because the Procedure Code field in the Long Paid Claims and Short Paid Claims only has room for the 5-digit State drug code. The program also tries to find the corresponding NDC for any 5-digit State drug code that was billed**.** Go to appendix AB F35C-BILLED-CODE-IND to see edits.	
Revisions and History:	**Date**	**Description**

135.0 DETAIL FFP INDICATOR

COBOL Name:	F35C-DET-FFP-IND	
Location in Main Type Segment:	**261-261**	
Definition:	Detailed FFP (Federal Financial Participation) Indicator currently used only on FPACT claims from EDS to indicate the level of Medicaid Federal Financial Participation, if any, that the state may claim.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	Space Detail FFP not set 1 Detail FFP FMAP Rate 2 Detail FFP 90 percent 3 Detail FFP non FFP	
Comments and Special Considerations:	The value depends on the claim type. For LTC,XOVER, and VSN claims, the value is a space. Go to appendix AB F35C-DET-FFP-IND to see edits.	
Revisions and History:	**Date**	**Description**

136.0 REVENUE TYPE CODE

COBOL Name:	F35C-REVENUE-TYPE-CODE	
Location in Main Type Segment:	**262-263**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:	**Revenue Type Codes** NC Non Contract **Note:** Includes Sick Baby not associated with delivery – Non Contract CM Contract – Per Diem **Note:** Includes Sick Baby not associated with delivery – Contract CD Contract – Per Discharge OB Contract – OB Per Discharge All Inclusive BT Bone Marrow Transplant HT Heart Transplant HL Heart-Lung Transplant KT Kidney Transplant LS Liver, Small Bowel or Combined Liver-Small Bowel Transplant LU Lung Transplant PT Pancreas Transplant KP Kidney Pancreas Transplant EC ECMO IN INO SE Sick Baby associated with delivery – Contract SN Sick Baby – Mom discharged – Contract SD Sick Baby associated with delivery – Non Contract SM Sick Baby – Mom discharged – Non Contract PA Psych Adolescent PB Psych Adult	
Revisions and History:	**Date**	**Description**

137.0 REVENUE CODE

COBOL Name:	F35C-REVENUE-CODE	
Location in Main Type Segment:	**264-267**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	4
	Picture Clause:	X(04)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

138.0 DUR ALERT DATA

COBOL Name:	F35C-DUR-ALERT-DATA	
Location in Main Type Segment:	**268-273**	
Definition:	DUR Alert Data indicates Drug Utilization and Review alerts	
Format Description:	Data Type:	Character
	Display Length:	6
	Storage Length:	6
	Picture Clause:	X(06)
Allowed Values:	Alpha	
Comments and Special Considerations:	There are three 2-byte sub-fields in the following order: DUR Conflict Alert (Reason for Service Code): Code identifying the type of utilization conflict detected or the reason for the pharmacist's professional service. DUR Intervention Alert (Professional Service Code): Code identifying the pharmacist intervention when a conflict code has been identified or service has been rendered. DUR Outcome Alert (Result of Service Code): Action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	
Revisions and History:	**Date**	**Description**

138.1 DUR CONFLICT ALERT

COBOL Name:	F35C-DUR-CONFLICT-ALERT	
Location in Main Type Segment:	**268-269**	
Definition:	DUR Conflict Alert identifies the type of utilization conflict detected or the reason for the pharmacist's professional service.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	The following codes are from NCPDP 5.1. DA Drug-Allergy Conflict AT Additive Toxicity PG Drug-Pregnancy Conflict ID Ingredient Duplication MC Drug-Disease Conflict (Reported Diagnosis from Medical Claim) PA Drug-Age Alert (Pediatric or Geriatric)	

	DD Drug-Drug Interaction HD High Dose TD Therapeutic Duplication LD Low Dose ER Over-utilization (Early Refill) MX Incorrect Duration of Therapy LR Under-utilization (Late Refill) SX Drug-Gender Conflict However, the following values are available under the NCPDP 5.1 telecommunications standard, and may appear as conflict codes. AD Additional Drug Needed AN Prescription Authentication AR Adverse Drug Reaction AT Additive Toxicity CD Chronic Disease Management CH Call Help Desk CS Patient Complaint/ Symptom DA Drug- Allergy DC Drug- Disease (Inferred) DD Drug- Drug Interaction DF Drug- Food interaction DI Drug Incompatibility DL Drug- Lab Conflict DM Apparent Drug Misuse DS Tobacco Use ED Patient Education/ Instruction ER Overuse EX Excessive Quantity HD High Dose IC Iatrogenic Condition ID Ingredient Duplication LD Low Dose LK Lock In Recipient LR Under-use MC Drug- Disease (Reported) MN Insufficient Duration MS Missing Information/ Clarification MX Excessive Duration NA Drug Not Available NC Non- covered Drug Purchase ND New Disease/ Diagnosis NF Non- Formulary Drug NN Unnecessary Drug NP New Patient Processing NR Lactation/ Nursing Interaction NS Insufficient Quantity OH Alcohol Conflict PA Drug- Age PC Patient Question/ Concern PG Drug- Pregnancy PH Preventive Health Care PN Prescriber Consultation PP Plan Protocol PR Prior Adverse Reaction

	PS Product Selection Opportunity RE Suspected Environmental Risk RF Health Provider Referral SC Suboptimal Compliance SD Suboptimal Drug/ Indication SE Side Effect SF Suboptimal Dosage Form SR Suboptimal Regimen SX Drug- Gender TD Therapeutic TN Laboratory Test Needed TP Payer/ Processor Question
Comments and Special Considerations:	Go to appendix AB F35C-DUR-CONFLICT-ALERT to see edits.
Revisions and History:	**Date** / **Description**

138.2 DUR INTERVENTION ALERT

COBOL Name:	F35C-DUR-INTERVENTION-ALERT	
Location in Main Type Segment:	**270-271**	
Definition:	DUR Intervention Alert identifies the pharmacist intervention when a conflict code has been identified or service has been rendered.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	Medi-Cal requests that only the following codes be used: M0 (M zero) Prescriber Consulted P0 (P zero) Patient Consulted R0 (R zero) Pharmacist Consulted Other Source However, the following values are available under the NCPDP 5.1 telecommunications standard, and may appear as intervention codes: 00 No intervention AS Patient assessment CC Coordination of care DE Dosing evaluation/ determination FE Formulary enforcement GP Generic product selection MA Medication administration M0 Prescriber consulted MR Medication review PE Patient education/ instruction	

	PH Patient medication history PM Patient monitoring P0 Patient consulted PT Perform laboratory test R0 Pharmacist consulted other source RT Recommend laboratory test SC Self- care consultation SW Literature search/ review TC Payer/ processor consulted TH Therapeutic product interchange
Comments and Special Considerations:	Go to appendix AB F35C-DUR-INTERVENTION-ALERT to see edits.
Revisions and History:	**Date** / **Description**

138.3 DUR OUTCOME ALERT

COBOL Name:	F35C-DUR-OUTCOME-ALERT	
Location in Main Type Segment:	**272-273**	
Definition:	DUR Outcome Alert identifies action taken by a pharmacist in response to a conflict or the result of a pharmacist's professional service.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:	The following codes are from NCPDP 5.1. <u>Outcome Code</u> 1A Filled, false positive 1F Filled with different quantity 1B Filled prescription as is 1G Filled with prescriber approval 1C Filled with different dose 2A Prescription not filled 1D Filled with different directions 1E Filled with different drug 2B Prescription not filled – directions clarified However, the following values are available under the NCPDP 5.1 telecommunications standard, and may appear as intervention codes: <u>Result of Service Code</u> 00 Not specified 1A Filled As Is, False Positive 1B Filled Prescription As Is 1C Filled, With Different Dose 1D Filled, With Different Directions 1E Filled, With Different Drug 1F Filled, With Different Quantity 1G Filled, With Prescriber Approval 1H Brand- to- Generic Change	

	1J Rx- to- OTC Change 1K Filled with Different Dosage Form 2A Prescription Not Filled 2B Not Filled, Directions Clarified 3A Recommendation Accepted 3B Recommendation Not Accepted 3C Discontinued Drug 3D Regimen Changed 3E Therapy Changed 3F Therapy Changed- cost increased acknowledged 3G Drug Therapy Unchanged 3H Follow- Up/ Report 3J Patient Referral 3K Instructions Understood 3M Compliance Aid Provided 3N Medication Administered
Comments and Special Considerations:	Go to appendix AB F35C-DUR-OUTCOME-ALERT to see edits.
Revisions and History:	

Date	Description

139.0 COMPOUND CODE

COBOL Name:	F35C-COMPOUND-CODE	
Location in Main Type Segment:	**274-274**	
Definition:	Indicates whether a drug claim is for a compound drug.	
Format Description:	Data type:	Character
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	Space = not a drug claim '0' = Compound not specified '1' = Not a compound drug '2' = Compound drug	
Comments and Special Considerations:	This field alone determines whether or not the claim is a compound drug claim. If the claim type is '3' (pharmacy): • For a compound drug, F35C-COMPOUND-CODE must be '2'. • If not for a compound drug, F35C-COMPOUND-CODE must be '0' or '1'. If the claim type is not '3' (pharmacy), then F35C-COMPOUND-CODE must be space. Go to appendix AB F35C-COMPOUND-CODE to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

140.0 COMPOUND DRUG ATTACHMENT

COBOL Name:	F35C-COMPOUND-DRUG-ATTACHMENT	
Location in Main Type Segment:	**275-275**	
Definition:	Identifies whether or not a compound drug attachment listing a compound drug's ingredients is attached to the drug claim form.	
Format Description:	Data type:	Numeric
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	9(01)
Allowed Values:	0 = No 'C' segment present OR not a compound drug 1 = Compound drug claim, 'C' segments are present	
Comments and Special Considerations:	If the field F35C-COMPOUND-CODE is a '2', the field F35C-COMPOUND-DRUG-ATTACHMENT may be 1 or 0. • If 0 then there can be no 'C' segments attached. • If 1 then there must be at least one 'C' segment attached. If the field F35C-COMPOUND-CODE is NOT a '2', • The F35C-COMPOUND-DRUG-ATTACHMENT field must be 0. • There can be no 'C' segments attached. A compound drug claim record (effective with SDN6043) normally has one, and only one, main - type 'M' - segment as the first detail segment, followed by 0 to 40 compound drug segments. Claims processed by EDS will have 0 to 25 segments. Other data sources may provide up to 40. A compound drug record may have 0 compound drug segments, but must always have at least one main segment. A compound drug claim record cannot have a segment count of zero, with no detail segments, as the information that the drug is a compound is located on the main segment. Without a main segment it is impossible to know a claim is for a compound drug. A drug claim record may have multiple main type segments that are flagged as "compound drug", but if there are multiple main type segments there can be no compound drug segments. In that case the value of F35C-COMPOUND-DRUG-ATTACHMENT in each of the main segments must be 0. That condition could occur on drug claims prior to implementation of SDN 02024 on 9/22/2003, or on drug claims from sources other than EDS, the main Medi-Cal Fiscal Intermediary. **Other record types:** For non-compound drug claims the value of this field should be zero. For non-drug claims the value of this field should be zero. Go to appendix AB F35C-COMPOUND-DRUG-ATTACHMENT to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

141.0 COMPOUND DRUG NUMBER OF INGREDIENTS

COBOL Name:	F35C-COMPOUND-DRUG-NBR-INGRED	
Location in Main Type Segment:	**276-277**	
Definition:	This field indicates how many type 'C' (compound drug) segments are attached to the header.	
Format Description:	Data type:	Numeric
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:		
Comments and Special Considerations:	• 0-25 EDS allows maximum of 25 segments (24 if a container count is reported). • 0-40 Other data sources may report up to 40 'C' segments. This field does NOT report the actual number of ingredients in the compound drug. That is recorded in the field F35C-CMPND-ACTUAL-NBR-INGR. For an EDS claim the value of F35C-CMPND-ACTUAL-NBR-INGR and F35C-COMPOUND-NBR-INGRED must be equal if there are 24 or fewer 'C' segments. Go to appendix AB F35C-COMPOUND-DRUG-NBR-INGRED to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

142.0 CCS GHPP LEGAL COUNTY

COBOL Name:	F35C-CCS-GHPP-LEGAL-COUNTY	
Location in Main Type Segment:	**278-279**	
Definition:	As part of SDN047, each CCS/GHPP claim line may have a TAR (SAR), and each TAR can have a different Legal County. This only affects the EDS and Delta claims.	
Format Description:	Data Type:	Character
	Display Length:	2
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

143.0 CCS GHPP FUNDING CATERGORY

COBOL Name:	F35C-CCS-GHPP-FUNDING-CATERGORY	
Location in Main Type Segment:	**280-280**	
Definition:	As part of SDN047, each CCS/GHPP claim line may have a TAR (SAR), and each TAR can have a different funding category. This only affects the EDS and Delta claims.	
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:	1 = Diagnostic 2 = Treatment 3 = Therapy 5 = HF-Treatment 6 = HF-Therapy	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

144.0 FINANCIAL INDICATOR

COBOL Name:	F35C-FINANCIAL-INDICATOR	
Location in Main Type Segment:	**281-281**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	1
	Picture Clause:	X(01)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

145.0 FUNDING INDICATOR

COBOL Name:	F35C-FUNDING-INDICATOR	
Location in Main Type Segment:	**282-284**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	3
	Picture Clause:	X(03)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

146.0 DETAIL AID CATEGORY

COBOL Name:	F35C-DET-AID-CATEGORY	
Location in Main Type Segment:	**285-286**	
Definition:		
Format Description:	Data Type:	Character
	Display Length:	1
	Storage Length:	2
	Picture Clause:	X(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

147.0 MAIN SEGMENT ID NUMBER

COBOL Name:	F35C-MAIN-SEGMENT-ID-NBR-X	
Location in Main Type Segment:	**779-780**	
Definition:		
Format Description:	Data Type:	Number
	Display Length:	1
	Storage Length:	2
	Picture Clause:	9(02)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

148.0 SEGMENT TYPE C

COBOL Name:	F35C-SEGMENT-TYPE-C	
Location in Compound Drug Segment:	**001-001**	
Definition:	The segment type must be 'C' for a compound drug segment.	
Format Description:	Data type:	Character
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	M = Main C = Compound	
Comments and Special Considerations:	The segment type field indicates whether the segment is a main segment -- type 'M' or compound drug segment -- type 'C'. There are no other valid values. See 2.0 description above. Go to appendix AB F35C-SEGMENT-TYPE-C to see edits.	
Revisions and History:	**Date**	**Description**

148.1 COMPOUND DOSAGE FORM

COBOL Name:	F35C-CMPND-DOSAGE-FORM	
Location in Compound Drug Segment:	**002-003**	
Definition:	Compound dosage form identifies the type of the complete compound mixture.	
Format Description:	Data type:	Character
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	Compound dosage form description code Blank = not specified 01 = capsule 02 = ointment 03 = cream 04 = suppository 05 = powder 06 = emulsion 07 = liquid 10 = tablet 11 = solution 12 = suspension 13 = lotion 14 = shampoo 15 = elixir 16 = syrup	

	17 = lozenge 18 = enema	
Comments and Special Considerations:	For claims submitted to EDS, the claim is rejected if the code is not a valid NCPDP value or if it is blank. Go to appendix AB F35C-CMPND-DOSAGE-FORM to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.2 COMPOUND INCENTIVE AMOUNT

COBOL Name:	F35C-CMPND-INCENTIVE-AMOUNT	
Location in Compound Drug Segment:	**004-008**	
Definition:	Compound incentive amount identifies the additional incentive amount billed.	
Format Description:	Data type:	Packed
	DISPLAY length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Incentive amount – 99 cents per container	
Comments and Special Considerations:	Currently, F35C-CMPND-INCENTIVE-AMOUNT will contain the sterility test fee billed. F35C-CMPND-INCENTIVE-AMOUNT field may be zero. If the claim is a negative adjustment F35C-CMPND-INCENTIVE-AMOUNT may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-INCENTIVE-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.3 COMPOUND FEE

COBOL Name:	F35C-CMPND-FEE	
Location in Compound Drug Segment:	**009-013**	
Definition:	Compound fee identifies the compounding fee billed by the pharmacist. This is a fee that is paid in addition to the regular dispensing fee.	
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Compounding fee – depends on the kind of compound. No set value.	

Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-FEE to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.4 COMPOUND INCENTIVE AMOUNT PAID

COBOL Name:	F35C-CMPND-INCENTIVE-AMOUNT-PD	
Location in Compound Drug Segment:	**014-018**	
Definition:		
Format Description:	Data type:	Packed
	Display length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:	Currently, this field will contain the sterility test fee paid. Incentive amount paid should not exceed 99 cents per container.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.5 COMPOUND ACTUAL NUMBER OF INGREDIENTS

COBOL Name:	F35C-CMPND-ACTUAL-NBR-INGR	
Location in Compound Drug Segment:	**019-020**	
Definition:	This element gives the actual number of ingredients that were used to create the compound drug.	
Format Description:	Data type:	Numeric
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	0 to 99	

Comments and Special Considerations:	This element indicates the total number of ingredients in the compound, not the number of compound drug segments. F35C-CMPND-ACTUAL-NBR-INGR must be greater than or equal to the value in F35C-COMPOUND-NBR-INGRED, the field that does indicate the number of compound drug segments attached. For an EDS claim the value of F35C-CMPND-ACTUAL-NBR-INGR and F35C-COMPOUND-NBR-INGRED must be equal if there are 24 or fewer 'C' segments.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.6 COMPOUND ROUTE OF ADMINISTRATION

COBOL Name:	F35C-COMPND-ROUTE-OF-ADMIN	
Location in Compound Drug Segment:	**021-022**	
Definition:	Compound route of administration identifies the route of administration of the complete compound mixture.	
Format Description:	Data type:	Numeric
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	00 = not specified 01 = buccal 02 = dental 03 = inhalation 04 = injection 05 = intraperitoneal 06 = irrigation 07 = mouth/throat 08 = mucous membrane 09 = nasal 10 = ophthalmic 11 = oral 12 = other/miscellaneous 13 = otic 14 = perfusion 15 = rectal 16 = sublingual 17 = topical 18 = transdermal 19 = translingual 20 = urethral 21 = vaginal 22 = enteral	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

	Nov 2003	Revised

148.7 COMPOUND UNIT FORM INDICATOR

COBOL Name:	F35C-CMPND-UNIT-FORM-IND	
Location in Compound Drug Segment:	**023-023**	
Definition:	This field indicates the unit form in which the compound drug is dispensed.	
Format Description:	Data type:	Numeric
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	9(01)
Allowed Values:	1 = each 2 = grams 3 = milliliters	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.8 COMPOUND CONTAINER COUNT

COBOL Name:	F35C-CMPND-CONTAINER-COUNT	
Location in Compound Drug Segment:	**024-025**	
Definition:	This field indicates the count of the containers used to create the compound drug.	
Format Description:	Data type:	Packed
	DISPLAY length:	3
	Storage length:	2
	Picture clause:	S9(03) COMP-3
Allowed Values:		
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.9 COMPOUND PROCESS APPROVED INGREDIENTS

COBOL Name:	F35C-CMPND-PROCESS-APPRVD-INGR
Location in Compound Drug Segment:	**026-026**

Definition:	There is an approved list of ingredients for a particular compound drug and an approved price for the compound drug. More expensive ingredients may be substituted, however they will be reimbursed only for the amount of the approved ingredients. This field is used when the pharmacy wishes to be paid for the standard fee, despite having used some more expensive ingredients.	
Format Description:	Data type:	Character
	DISPLAY length:	1
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:	Y = Process claim using standard ingredients / charges. N = Adjudicate the claim using ingredients / charges actually submitted. Space = N/A, not specified. If unapproved ingredients are included in the compound and this field is space, the claim will be rejected.	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.10 COMPOUND INGREDIENT AREA

COBOL Name:	F35C-CMPND-INGREDIENT-AREA	
Location in Compound Drug Segment:	**067-106**	
Definition:	Compound ingredient info shows information for each specific ingredient in the compound drug.	
Format Description:	Data type:	Character
	Display length:	143
	Storage length:	143
	Picture clause:	X(164)?
Allowed Values:		

Comments and Special Considerations:	This is a group element that contains information specific to each reported ingredient in the compound drug. It contains the following fields: F35C-CMPND-INGR-NDC F35C-CMPND-INGR-PRODUCT-ID F35C-CMPND-INGR-PROD-ID-QUAL F35C-CMPND-INGR-BASIS-OF-COST F35C-CMPND-INGR-DISP-FEE-CODE F35C-CMPND-INGR-METRIC-QTY F35C-CMPND-INGR-BILLED-AMOUNT F35C-CMPND-INGR-ALLOWED-AMOUNT F35C-CMPND-INGR-REIMBURSE-AMT F35C-CMPND-INGR-SMART-KEY. F35C-CMPND-INGR-SMART-KEY-GTC F35C-CMPND-INGR-SMART-KEY-STC F35C-CMPND-INGR-SMART-KEY-HICL F35C-CMPND-INGR-SMART-KEY-STR F35C-CMPND-INGR-SMART-KEY-DOSE F35C-CMPND-INGR-SMART-KEY-RT F35C-CMPND-INGR-SMART-KEY-PS F35C-CMPND-INGR-SMART-KEY-UDUU F35C-CMPND-INGR-CUTBACK-REASON	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.11 COMPOUND INGREDIENT NATIONAL DRUG CODE

COBOL Name:	F35C-CMPND-INGR-NDC	
Location in Compound Drug Segment:	**067-077**	
Definition:	Compound ingredient National Drug Code is the NDC of the compound drug ingredient.	
Format Description:	Data type:	Character
	DISPLAY length:	11
	Storage length:	11
	Picture clause:	X(11)
Allowed Values:	Valid NDC codes	
Comments and Special Considerations:	• This field contains the NDC for the ingredient only when the field F35C-CMPND-INGR-PROD-ID-QUAL = '03' • Please refer to U.S. Food and Drug Administration web site http://www.fda.gov/cder/ndc/ for the National Drug Code directory. Go to appendix AB F35C-CMPND-INGR-NDC to see edits.	
Revisions and History:	**Date**	**Description**

	Nov 2003	Revised

148.12 COMPOUND INGREDIENT UPN

COBOL Name:	F35C-CMPND-INGR-UPN	
Location in Compound Drug Segment:	**067-085**	
Definition:		
Format Description:	Data type:	Character
	DISPLAY length:	11
	Storage length:	11
	Picture clause:	X(19)
Allowed Values:	Valid NDC codes	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.13 COMPOUND INGREDIENT PRODUCT ID

COBOL Name:	F35C-CMPND-INGR-PRODUCT-ID	
Location in Compound Drug Segment:	**067-086**	
Definition:	Compound ingredient product id identifies the ingredient used in a compound.	
Format Description:	Data type:	Character
	DISPLAY length:	20
	Storage length:	20
	Picture clause:	X(20)
Allowed Values:		
Comments and Special Considerations:	This field contains the product id information for an ingredient only when the field F35C-CMPND-INGR-PROD-ID-QUAL is NOT = '03'. This field may contain free-form text information such as 'egg white' or water. Go to appendix AB F35C-CMPND-INGR-PRODUCT-ID to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.14 COMPOUND INGREDIENT PRODUCT ID QUALIFIER

COBOL Name:	F35C-CMPND-INGR-PROD-ID-QUAL

Location in Compound Drug Segment:	**117-118**	
Definition:	Compound ingredient product id identifies the ingredient used in a compound.	
Format Description:	Data type:	Character
	Display length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:		
Comments and Special Considerations:	This field contains the product id information for an ingredient only when the field F35C-CMPND-INGR-PROD-ID-QUAL is NOT = '03'. This field may contain free-form text information such as 'egg white' or water. Go to appendix AB F35C-CMPND-INGR-PRODUCT-ID to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.15 COMPOUND INGREDIENT BASIS OF COST DETERMINATION

COBOL Name:	F35C-CMPND-INGR-BASIS-OF-COST	
Location in Compound Drug Segment:	**119-120**	
Definition:	Compound ingredient basis of cost indicates the basis used to compute the cost (i.e. whether not disproportionate share/public health service was present).	
Format Description:	Data type:	Character
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	X(02)
Allowed Values:	Compound Ingredient Basis Of Cost Determination Blank = Not Specified 01 = AWP (Average Wholesale Price) 02 = Local Wholesaler 03 = Direct 04 = EAC (Estimated Acquisition Cost) 05 = Acquisition 06 = MAC (Maximum Allowable Cost) 07 = Usual & Customary 09 = Other (Indicates Disproportionate Share / Public Health Service)	
Comments and Special Considerations:	Data is received under the NCPDP 5.1 (National Council of Prescription Drug Programs) transaction, using field 423-DN “Basis of Cost Determination”. Go to appendix AB F35C-CMPND-INGR-BASIS-OF-COST to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.16 COMPOUND INGREDIENT DISPENSING FEE CODE

COBOL Name:	F35C-CMPND-INGR-DISP-FEE-CODE	
Location in Compound Drug Segment:	**121-121**	
Definition:		
Format Description:	Data type:	Character
	DISPLAY length:	2
	Storage length:	1
	Picture clause:	X(01)
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.17 COMPOUND INGREDIENT METRIC QUANTITY

COBOL Name:	F35C-CMPND-INGR-METRIC-QTY	
Location in Compound Drug Segment:	**122-127**	
Definition:	Compound ingredient metric quantity expresses the amount in metric decimal units of the product included in the compound mixture.	
Format Description:	Data type:	Packed
	DISPLAY length:	11
	Storage length:	6
	Picture clause:	S9(8)V9(3) COMP-3
Allowed Values:	Ingredient metric quantity – varies from NDC to NDC. Maximum for each NDC is found on the Formulary File, and can be overridden by a TAR.	
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-INGR-METRIC-QTY to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.18 COMPOUND INGREDIENT BILLED AMOUNT

COBOL Name:	F35C-CMPND-INGR-BILLED-AMOUNT
Location in Compound Drug Segment:	**128-132**

Definition:	Compound ingredient billed amount identifies the ingredient cost for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	DISPLAY length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:		
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-INGR-BILLED-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**

148.19 COMPOUND INGREDIENT ALLOWED AMOUNT

COBOL Name:	F35C-CMPND-INGR-ALLOWED-AMOUNT	
Location in Compound Drug Segment:	**133-137**	
Definition:	Compound ingredient allowed amount identifies the Medi-Cal allowed amount for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	DISPLAY length:	9
	Storage length:	5
	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:		
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-INGR-ALLOWED-AMOUNT to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.20 COMPOUND INGREDIENT REIMBURSE AMOUNT

COBOL Name:	F35C-CMPND-INGR-REIMBURSE-AMT	
Location in Compound Drug Segment:	**138-142**	
Definition:	Compound ingredient reimburse amount identifies the Medi-Cal reimbursement amount for the metric decimal quantity of the product in the compound mixture.	
Format Description:	Data type:	Packed
	DISPLAY length:	9
	Storage length:	5

	Picture clause:	S9(7)V9(2) COMP-3
Allowed Values:		
Comments and Special Considerations:	This field may be zero. If the claim is a negative adjustment this field may be a negative number, otherwise it must be positive or zero. Go to appendix AB F35C-CMPND-INGR-REIMBURSE-AMT to see edits.	
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

148.21 COMPOUND SMART KEY

COBOL Name:	F35C-CMPND-INGR-SMART-KEY	
Location in Compound Drug Segment:	**143-166**	
Definition:	First databank smart key describes the specifics of a drug. It is used for both NDC and state drug codes.	
Format Description:	Data type:	Character
	DISPLAY length:	24
	Storage length:	24
	Picture clause:	X(24)
Allowed Values:	For Claims other than EDS, this field should be all spaces. For EDS claims the following are the valid values.	
	Fields	**Bytes**
	F35C-CMPND-INGR-SMART-KEY-GTC - dosage form (dose) e.g. 500 = capsule	2
	F35C-CMPND-INGR-SMART-KEY-STC - DRUG STRENGTH; (STR) e.g. 0600 = 250mg	4
	F35C-CMPND-INGR-SMART-KEY-HICL - generic name/ (HICL) hierarchical ingredient code list identifies the specific generic entity; e.g. 04003 = Tetracycline HCL	5
	F35C-CMPND-INGR-SMART-KEY-STR - generic therapeutic class (GTC) (GTC) broad classification; e.g. 20 = anti-infective	4
	F35C-CMPND-INGR-SMART-KEY-DOSE - package size (PS) e.g. 008 = 100each	3
	F35C-CMPND-INGR-SMART-KEY-RT - route of administration (RT) e.g. 01 = oral	2
	F35C-CMPND-INGR-SMART-KEY-PS - specific therapeutic class (STC) specific classification; e.g.0478 = tetracycline	3

	F35C-CMPND-INGR-SMART-KEY-UDUU - unit dose/unit of use (UDUU) identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use	1
Comments and Special Considerations:	See data element: F35C-SMART-KEY for the definition. F35C-CMPND-SMART-KEY is specific to the individual ingredient. Go to appendix AB F35C-CMPND-INGR-SMART-KEY to see edits.	
Revisions and History:	Nov 2003	Revised

148.22 COMPOUND INGREDIENT CUTBACK REASON

COBOL Name:	F35C-CMPND-INGR-CUTBACK-REASON	
Location in Compound Drug Segment:	**167-169**	
Definition:	If the amount paid for an ingredient is less than the amount billed, then this field contains a code identifying the reason for the change.	
Format Description:	Data type:	Character
	DISPLAY length:	3
	Storage length:	3
	Picture clause:	X(03)
Allowed Values:	See LiveLink for table of values.	
Comments and Special Considerations:		
Revisions and History:	Nov 2003	Revised

149.0 COMPOUND INGREDIENT INFO

COBOL Name:	F35C-CMPND-INGREDIENT-INFO	
Location in Compound Drug Segment:	**537-679**	
Definition:		
Format Description:	Data type:	Character
	Display length:	143
	Storage length:	143
	Picture clause:	X(164)?
Allowed Values:		
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**

150.0 COMPOUND GENERAL INFO

COBOL Name:	F35C-CMPND-GENERAL-INFO	
Location in Compound Drug Segment:	**472-536**	
Definition:	F35-CMPND-GENERAL-INFO is a group data element and contains information that applies to the compound drug as a whole. The data in this area is identical on each compound drug segment for the claim	
Format Description:	Data type:	Character
	DISPLAY length:	65
	Storage length:	65
	Picture clause:	X(65)
Allowed Values:	See individual fields below: F35C-CMPND-DOSAGE-FORM F35C-CMPND-INCENTIVE-AMOUNT F35C-CMPND-FEE F35C-CMPND-INCENTIVE-AMOUNT-PD F35C-CMPND-ACTUAL-NBR-INGR F35C-CMPND-ROUTE-OF-ADMIN F35C-CMPND-UNIT-FORM-IND F35C-CMPND-CONTAINER-COUNT F35C-CMPND-PROCESS-APPRVD-INGR	
Comments and Special Considerations:		
Revisions and History:	**Date**	**Description**
	Nov 2003	Revised

151.0 COMPOUND SEGMENT ID NUMBER

COBOL Name:	F35C-CMPND-SEGMENT-ID-NBR-X	
Location in Compound Drug Segment:	**779-780**	
Definition:	This number identifies the compound segment within the claim. In combination with the F35C-RECORD-ID-NUMBER this is a unique key for the segment. This is used by MIS/DSS to facilitate analysis and maintenance.	
Format Description:	Data type:	Numeric
	DISPLAY length:	2
	Storage length:	2
	Picture clause:	9(02)
Allowed Values:	02 - 26 for EDS claims 02 - 41 for non-EDS The main segment will always be segment number 1 on a compound drug claim (see Compound Drug Attachment for details).	
Comments and Special Considerations:	This field is populated by ITSD for Medi-Cal claims. All other sources should report spaces in field F35C-CMPND-SEGMENT-ID-NBR-X. SEE ALSO MAIN SEGMENT ID NBR	
Revisions and History:	Nov 2003	Revised

APPENDICES

APPENDIX A. GLOSSARY

If you have an Id at HWDC you can find abbreviations on line! The data set name is: HD.PAIDCLM.DHS.ABBREVS.

There is a list of more than 800 abbreviations that the Department of Health Services (DHS) uses! There is instructions on how to find on just the abbreviation you are searching for.

A	Adult (age 21 to 65)
A & I	Audits & Investigations (DHS)
A/R	Accounts Receivable
AAC	Aid for Adoption of Children
AAC	Augmentative and Alternative Communication(devices for speech)
AAP	Adoption Assistance Program
AB	Assembly Bill
ABD	Aged, Blind, or Disabled
ABD-MN	Aged, Blind, or Disabled--Medically Needy
ABEND	Abnormal END of a computer program job
ACE	Assistance to Children in Emergency
ACIN	All County Information Notices
ACL	All County Letter (issued by DSS)
ACL	Adjudicated Claim Lines
ACM	Asset Clearance Match System
ACMS	Automatic Case Management System
ACWDL	All County Welfare Directors Letter (issued by DHS)
ADAM	Automated District Attorney Matching (System)
ADHC	Adult Day Health Center
ADP	Department of Alcohol and Drugs Programs
AEVS	Automatic Eligibility Verification System
AFDC	Aid to Families with Dependent Children
AFDC	Aid to Financially Dependent Corporations
AFDC-MN	Aid to Families with Dependent Children--Medically Needy
AFLP	Adolescent Family Life (Pregnant Teen) Program
AFP	Alpha Fetal Protein testing (done at DHS's Berkeley labs)
AHF	Anti-Hemophilia Factors
AHS	Alternative Health Systems
AIDS	Acquired Immune Deficiency Syndrome
AIM	Access for Infants and Mothers
AKA	Also Known As (Expert Witness)
AN	Action Notice
ANEC	Abused, Neglected, or Exploited Children
APD	Advance Planning Document
APP	Aid Paid Pending
APPR	Average Private Pay Rate (for Nursing facility services)
APSB	Aid to Potentially Self-Supporting Blind
AR	Authorized Representative (for Medi-Cal Beneficiary(form MC360))
ARC	AIDS Relations Complex (or AIDS Related Conditions)
ARDS	Automated Remittance Data Service
ARF	Action Request File
ASCII	American Standard Code for Information Exchange (7-bit + parity)
ASR	Approved Services Report (Dams report from MSD)
ATD	Aid To Disabled
AU	Assistance Unit (AFDC)
BabyCal	Medi-Cal for babies

BBA	Balanced Budget Act
BCEDP	Breast Cancer Early Detection Program
BCP	Budget Change Proposal
BCP	Breast Cancer Program
BEER	Beneficiary Earnings Exchange Record
BENDEX	Beneficiary Data Exchange
BENE	Beneficiary
BENE ID	Beneficiary ID number
BEOMB	Beneficiary Explanation Of Medi-Cal Benefits
BHI	Boarding Homes and Institutions
BIC	Benefit Identification Card
BID	Beneficiary ID number
BLS	Basic Life Support
BPI	Business Process Improvement
BPST	Billing Process System Testing
BSU	Billing Support Unit
BUR	Beneficiary Utilization Review
C	Children under 21
CA	California
CAAP	California Alternative Assistance Program
CACI	Change Assessment, Control and Implementation
CAHF	California Association of Health Facilities
CalOPTIMA	Cal. Orange Prevention and Treatment Integrated Medical Plan
CalWORKS	California Work Opportunity and Responsibility to Kids Plan
CALPOS	California Point of Sale (for Pharmacy claims processing)
CA-MMIS	California Medicaid Management Information System
CAT	Computerized Axial Tomography (same as CT)
CATS	Common Application Transaction System
CBA/IP	Cost Benefit Analysis/Implementation Plans
CBO	Community Based Organization
CBC	Complete Blood Count
CBDMP	California Birth Defects Monitoring Program
CBC	California Birth Certificates
CC	Cost Center
CCLHO	California Conference of Local Health Officers
CCN	Claim Control Number
CCR	California Code of Regulations
CCS	California Children Services
CCU	Critical Care Unit
CDA	California Department of Aging
CDB	Central Data Base
CDMMIS	California Dental Medicaid Management Information System
CDL	California Driver's License
CDR	Claims Detail Request
CDR	Claims Detail Report
CDS	California Dental Services
CEC	Continuing Eligibility for Children
CERTS	Claims and Eligibility Real-Time System
CETA	Comprehensive Employment and Training Act
CFNP	Certified Family Nurse Practitioner
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniform Services
CHDP	Child Health and Disability Prevention Program
CHDTP	Child Health, Disability and Treatment Program
CHFC	California Health Facilities Commission
CHI	California Health Initiative

CHIC	California Health Identification Card
CHIPP	California Health Information Planning Project
CHS	Center for Health Statistics
CHS	Capitated Health Services
CI	Cochlear Implant
CICS	Customer Information Control System (MEDS is a CICS application)
CID	Central Issuance of ID Cards
CIF	Claims Inquiry Forms
CIN	Client Index Number (newer definition of CIN)
CIN	California Identification Number (original definition of CIN)
CLHF	Congregate Living Health Facilities
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMAC	California Medi-Cal Assistance Commission
CMAG	County Meds Advisory Group
CMC	Computer Media Claims
CMD	Computer Media Document
CMP	Competitive Medical Plans
CMIS	Contract Management Information System
CMIPS	Case Management, Information and Payrolling System
CMS	Children Medical Services
CMSP	County Medical Services Program
CNM	Certified Nurse Midwife
CNST	Children Not in School or Training
COB	Close Of Business
COBRA	Consolidated Omnibus Budget Reconciliation Act
COHS	County Operated Health Systems
COLA	Cost Of Living Allowance
COS	Category of Service
CP	Confirmed Pregnancy
CP	Continental Plaza (DHS's building on North 7th Street in Sac.)
CPNP	Certified Pediatric Nurse Practitioners
CPSP	Comprehensive Prenatal Services Program
CPT-4	Current Procedure Terminology, Fourth Edition
CPU	Central Processing Unit
CRNA	Certified Registered Nurse Anesthetist
CRP	Cuban Refugee Program
CRT	Cathode Ray Tube
CRVS	California Relative Value Studies
CS	Change Support
CSC	Computer Sciences Corporation
CSN	California Standard Nomenclature (now called CPT)
CSIU	Case Screening and Investigation Unit
CT	Computerized Tomography (same as CAT)
CTP	Children's Treatment Program (Formerly CHDTP before 8/94)
CVSO	County Veterans Service Offices
CWD	County Welfare Department
CWDA	County Welfare Directors Association
CWO	County Welfare Office
CWS	Child Welfare System
D & C	Dilation and Curettage
DACON	Daily Consumption (of pharmacy products)
DA/FSO	District Attorney/Family Support Office
DA&A	Drug Addiction and/or Alcoholism
DAC	Disabled Adult Child
DAEVS	Digital Automated Eligibility Verification System
DASD	Direct Access Storage Device

DB2	Database 2 (an IBM relational data base language)
DBP	Department of Benefit Payments (now DSS)
DCD	Data Correlation and Documentation System
DCMS	Data Center Management System
DD	Data Definition
DD	Developmentally Disability
DD-H	Developmentally Disability--Habilitative
DD-N	Developmentally Disability--Nursing
DDE	Direct Data Entry
DDH	Developmentally Disability--Habilitative
DDN	Developmentally Disability--Nursing
DDS	Department of Developmental Services
DDS	Doctor of Dental Surgery
DED	Disability Evaluation Division
DED	Data Element Dictionary
DEFRA	Deficit Reduction Act
DELTA	Delta Dental Services
DGS	Department of General Services
DHHS	Department of Health and Human Services (Federal)
DHS	Department of Health Services
DI	Disability Insurance
DIB	Disability Insurance Benefits
DME	Durable Medical Equipment
DMH	Department of Mental Health
DOB	Date Of Birth
DOF	Department of Finance
DOH	Department of Health
DOJ	Department of Justice
DOP	Date of Payment
DOS	Date of Service
DOS	Disk Operating System
DOSE	Dosage Form (part of the Smart Key)
DOT	Directly Observed Therapy (for TB program patients)
DP	Data Processing
DP	Dialysis only Program
DP/NF	Distinct Part/Nursing Facility
DPA	Durable Powers of Attorney
DPAHC	Durable Powers of Attorney for Health Care
DPAP	Durable Powers of Attorney for Property Management
DPO	Discharge Planning Option
DPT	Discharge Planning TAR
DPVP	Direct Purchase Vaccine Program
DRA	Disaster Recovery Action
DSB	Data Systems Branch
DSP	Dialysis Supplement Program
DSS	Department of Social Services
DTP	Diphtheria, Tetanus, Pertussis
DUR	Drug Utilization Review
DUR	Drug Use Review
DX	Diagnosis
E & M	Evaluation and Management (procedures)
EA	Emergency Assistance
EAPC	Expanded Access to Primary Care
EA-UP	Emergency Assistance--Unemployed Parent
EBCDIC	Extended Binary-Coded Decimal Interchange Code (8-bit)
EBS	Electronic Billing System

EC	Eligibility Counter
ECA	Entrant Cash Assistance
ECF	Extended Care Facility
ECG	Electrocardiogram
ECS	Earning Clearance System
EDC	Estimated Date of Confinement (approximate date pregnancy ends)
EDD	Employment Development Department
EDI	Electronic Data Interchange
EDP	Electronic Data Processing
EDS	Electronic Data Systems
EEO	Equal Employment Opportunity
EFDP	Early Fraud Detection Program
EFT	Electronic Fund Transfer
EHF	Eligibility History File
EGHP	Employer Group Health Plan
EKG	Electrocardiogram
EMA	Entrant Medical Assistance
EMC2/TAO	Electronic Mail Communications Center/Totally Automated Office
EOB	Explanation Of Benefits
EOMB	Explanation Of Medicare Benefits
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ESAC	Eligibility Status Action Code
ESC	Eligibility Status Code
ESWL	Extracorporeal Shock Wave Lithotripsy
EVC	Eligibility Verification Confirmation
EVC	Eligibility Verification Control
EW	Eligibility Worker
FAC	Federal Allowable Cost (Drugs)
FAME	Fiscal intermediary Access to Medi-Cal Eligibility
FBR	Federal Benefit Rate
FBU	Family Budget Unit (part of the Beneficiary Id number)
FC	Foster Care
FDA	Food and Drug Administration
FDB	Food and Drug Branch (within DHS)
FFP	Federal Financial Participation
FFS	Fee For Service
FG	Family Group
FHC	Federally Qualified Health Centers
FHOP	Family Health Outcomes Project
FI	Fiscal Intermediary
FIMD	Fiscal Intermediary Management Division
FMAP	Federal Medical Assistance Percentage (matching Fed funds %)
FNS	Food and Nutrition Service (federal)
FO	Field Office
FPACT	Family P.A.C.T. (Planning Access Care & Treatment)
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FS	Food Stamp Program
FS/NF	Free-Standing/Nursing Facility
FSD	Family Support Division
FSR	Feasibility Study Report
FTB	Franchise Tax Board
FY	Fiscal Year
GA	General Assistance
GAC	General Acute Care
GACH	General Acute Care Hospital

GAIN	Greater Avenues for Independence Program
GAL	Global Address List (used by OUTLOOK for E-mail)
GHPP	Genetic Handicapped People Program
GIS	Geographic Information Systems
GMC	Geographic Managed Care
GOSHN	Governor's Office Special Hospital Negotiator
GR	General Relief
GTC	Generic Therapeutic Class (part of the Smart Key)
GYN	Gynecology
HAP	Health Access Programs
HCBS	Home and Community Based Services
HCDF	Health Care Deposit Fund
HCFA	Health Care Financing Administration
HCP	Health Care Plans
HCPCS HCFA	Common Procedure Coding System
HCPP	Health Care Prepayment Plans
HDU	Health Demographics Unit
HF	Healthy Families
HFAV	Healthy Families Administrative Vendor
HFPA	Hospital Facility Planning Area
HHA	Home Health Agency
HHS	Home and Human Services
HI	Health Initiative
HIC	Health Insurance Claim
HIC-NO	Medicare HIC Number
HICL	Hierarchical Ingredient Code List/Generic Name (part of the Smart Key)
HIIU	Health Insurance Identification Unit
HIO	Health Insuring Organization
HIP	Hospital In Patient
HIPAA	Health Insurance Portability and Accountability Act
HIPD	Health Insurance Payment Demand
HIPP	Health Insurance Premium Payment
HIS	Health Insurance System
HIU	Health Insurance Unit
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HMS	Health Management Systems
HOP	Hospital Out Patient
HPSM	Health Plan of San Mateo
HRI	Health Related Industries
HSA	Health Service Area
HWDC	Health and Welfare Data Center
I/O	Inpatient/Outpatient
I/O	Input/Output
ICD	International Classification of Diseases (diagnosis code)
ICDA	International Classification of Diseases, Adapted
ICDA	International Classification of Diseases, Adapted
IDTF	Independent Diagnostic Testing Facility
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICN	Internal Control Number
ICU	Intensive Care Unit
IDMS	Integrated Data Management System
IE	Ineligible (SOC aid code for MEDS and SOC database)
IEVS	Income and Eligibility Verification System
IFD	Integrated Earnings Clearance/Fraud Detection System

IHMC	In Home Medical Care
IHSS	In Home Supportive Services
IMAP	Information Management Annual Plan
IMD	Institutions for Mental Diseases
INA	Immigration and Nationality Act of 1990
INS	Immigration and Naturalization Services (Federal)
IPL	Initial Program Load
IPP	Individual Program Plan
IRCA	Immigration Reform and Control Act (became law in 1986)
IRS	Internal Revenue Service (Federal)
IS	Information System
ISAWS	Interim Statewide Automated Welfare System
ISIS	Integrated Statewide Information System for WIC
ISM	In-Kind Support and Maintenance
IT	Information Technology
IVR	Interactive Voice Response
IZ	Immunization System
JAD	Joint Application Design
JCL	Job Control Language
KDE	Key Data Entry
LAN	Local Area Network
L&C	Licensing and Certification
LCSW	Licensed Clinical Social Worker
LEA	Local Education Authority
LEADER	Los Angeles Eligibility Automated Determination Evaluation Report
LHD	Local Health Directors
LMW	Licensed Midwife
LOA	Letter Of Authorization
LPC	Long Paid Claims
LPR	Lawful Permanent Resident (under IRCA of 1986)
LTC	Long Term Care
LTR	Lawful Temporary Resident
LTNG	Long Term Non grant Status
MAC	Maximum Allowable Cost
MAIC	Maximum Allowable Ingredient Cost
MAO	Medi-Cal Assistance Only
MAPC	Maximum Allowable Product Cost (for Medical Supplies list)
MAR	Management Administrative Reports
MARS	Management and Administrative Report System
MBU	Medi-Cal Family Budget Unit
MCN	Managed Care Network
MC	Medi-Cal
MC-177	Record of Health Care Costs Document (form number)
MCC	Medi-Cal for Children
MCCA	Medicare Catastrophic Coverage Act
MCE	Medical Care Evaluation
MCH	Maternal and Child Health Branch of DHS
MCN	Managed Care Network
MCO	Medi-Cal Only
MCOD	Medi-Cal Operations Division
MCP	Managed Care Plan
MCPP	Medi-Cal Procurement Project
MCPD	Medi-Cal Policy Division
MCR	Medicare
MDL	Microbial Disease Laboratory
MDS	Minimum Data Set (for nursing home resident assessment and care)

MEB	Medi-Cal Eligibility Branch
MEM	Medi-Cal Eligibility Manual
MEDS	Medi-Cal Eligibility Data System
MEDS ID	MEDS ID is a unique identifier and can be a SSN or Pseudo SSN
MEF	MEDS Extract File
MFBU	Medi-Cal Family Budget Unit
MFG	Manufacturer
MFR	Medi-Cal Federal Reporting System
MHP	Mental Health Plan
MI	Medically Indigent
MIA	Medically Indigent Adult
MIC	Medically Indigent Children (no longer in use)
MIO	Medi-Cal Intermediary Operations
MIS	Management Information System
MMC	Medi-Cal Managed Care
MMCEB	Medi-Cal Managed Care Expansion Branch
MDR	Medi-Cal Drug Reporting (system)
MMCD	Medi-Cal Managed Care Division
MMEF	MEDS Monthly Extract File (same as MEF)
MMIS	Medicaid Management Information System
MN	Medically Needy
MNO	Medically Needy-Only
MOE	Month Of Eligibility
MOP	Month Of Payment
MOPI	MEDS Online POS (Point of Service) Inquiry
MOS	Month Of Service
MQT	Medicaid Qualifying Trust
MPI	Medical Public Inquiry
MPS	Medi-Cal Provider Software
MR	Mental Retardation
MRB	Medical Review Branch
MRI	Magnetic Resonance Imaging
MRMIB	Managed Risk Medical Insurance Board
MRN	Medicare Remittance Notice (replaces the EOMB form)
MRMIP	Major Risk Medical Insurance Program
MSD	Medi-Cal Short Doyle
MSSP	Multipurpose Senior Services Program
MTS	Medi-Cal Transaction Software
MTE	Medical Transportation/Emergency
MTR	Medi-Cal expenditures and Treatment Reporting system
NAFS	Non-Assistance Food Stamps
NARD	National Association of Retail Druggists
NBC	Normal Birthing Center
NCPDP	National Council Prescription Drug Program (reject codes)
NDI	Non-Industrial Disability Insurance (State)
NDC	National Drug Code
NDDF	National Drug Data File(TM)
NDM	Network Data Mover (sends IEVS request files to Baltimore)
NF	Nursing Facility
NF	Nursing Facility Level A = Intermediate Care Facility
NF	Nursing Facility Level B = Skilled Nursing Facility
NICU	Neonatal/Newborn Intensive Care Unit
NMP	Non-Physician Medical Practitioner
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier

NHSP	Newborn Hearing Screening Program Other PA Other Public Assistance
OB	Obstetrics
O/C	Other Coverage
O&P	Orthotic and Prosthetic
OAG	Office of Auditor General
OAS	Old Age Security
OASDI	Old Age, Survivors and Disability Insurance
OB	Obstetrics
OB8	Office Building #8 (DSS's building at 714 P St. in Sacramento)
OB9	Office Building #9 (DHS's building at 744 P St. in Sacramento)
OBRA	Omnibus Budget Reconciliation Act
OC	Other Coverage
OCC	Out-of-County-Care
OCCS	Out-of-County-Care Service
OCHS	Office of County Health Services
OCR	Optical Character Recognition
OCS	Other Coverage Section (part of PSD's Recovery Branch)
OFP	Office of Family Planning
OHC	Other Health Care coverage code
OIG	Office of Inspector General
OIL	Operating Instruction Letter
OIT	Office of Information Technology
OMCC	Office of Managed Care Coordination
OPTIMA	Orange Prevention & Treatment Integrated Medical Assistance Plan (CalOPTIMA is Orange county's full name for the Health Initiative
ORR	Office of Refugee Resettlement
OSHPD	Office of Statewide Health Planning and Development
OUCH	Occupational Urgent Care Health Services
OV	Office Vision (=PROFS)
PA	Physician Assistant
PA	Public Assistance
PACT	Planning Access Care & Treatment
PANVALET	Program Management System
PAS	Pre-Admission Screening
PASARR	Pre-Admission Screening and Annual Resident Review
PC	Personal Computer
PC	Professional Component
PCCM	Primary Care Case Management
PCFH	Primary Care and Family Health
PCG	Prenatal Care Guidance Program
PCPP	Primary Care Provider Program
PCSP	Personal Care Services Program
PD	Presumptive Disability (for babies born < 37 wks or < 2lb 10 oz)
PDHC	Pediatric Day Health Care (for medically fragile kids 2/2000)
PE	Presumptive Eligibility (of pregnant women)
PE	Personnel Equivalent
PET	Positron Emission Tomography
PEU	Provider Enrollment Unit
PFT	Pulmonary Function Tests
PHF	Public Health Facility
PHP	Prepaid Health Plan
PHRED	Prepaid Health Research, Evaluation, and Demonstration
PIA	Prison Industry Authority
Pic	Picture (used in COBOL programs to define alphanumeric fields)
PIN	Personal Identification Number
PIN	Provider Identification Number

PIR	Post Implementation Review
PL	Public Law (Federal)
PLTCCM	Primary Long Term Care Case Management
PMF	Provider Master File(from EDS)
PMIF	Pooled Money Investment Fund
POE	Proof of Eligibility
POS	Place of Service
POS	Point of Sale (for Pharmacy claims processing)
POS	Point of Service
PPM	Physicians Performed Microscopy
PPU	Premium Payment Unit
PROFS	Professional Office System (also called Office Vision)
PRP	Private Resettlement Program
PRUCOL	Permanently Residing Under the Color of Law
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
PS	Package Size (part of the Smart Key)
PSC	Provider Support Center
PTN	Provider Telecommunications Network
PUBS	Percutaneous Umbilical Blood Sampling
PVS	Payment Verification System
PWE	Principal Wage Earner
QA	Quality Assurance
QDWI	Qualified Disabled Working Individual
QI	Qualified Individual
QI	Quality Improvement
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice (EDS forms)
RAD	Remittance Advice Details (replaces RA for LTC, In & Outpatient)
RACF	Resource Access Control Facility
RAW	Replacement Agricultural Worker
RCA	Refugee Case Assistance
RD	Renal Dialysis
RDP	Refugee Demonstration Project
RDW	Record Descriptor Word
REHF	Recipient Eligibility History File - replaced by FAME
REI	Recognition Equipment, Inc. (EDS OCR equipment)
REOMB	Recipient Explanation of Medi-Cal Benefits
RF	Reference File (Like RFF035)
RFP	Request For Proposal
RG	Refused Grant
RHC	Rural Health Clinics
RHF	Redwood Health Foundations (ended 06/30/91)
RJE	Remote Job Entry
RMA	Refugee Medical Assistance
RR	Responsible Relative (SOC aid code for MEDS and SOC database)
RRB	Railroad Retirement Board Number
RRP	Refugee Resettlement Program
RSDI	Retirement, Survivors, and Disability Income
RTD	Resubmission Turnaround Document
RVS	Related Values Studies
S & I	Suspended and Ineligible
SACSS	Statewide Automated Child Support System
SAM	State Administrative Manual
SAVE	Systematic Alien Verification for Entitlements
SAW	Special Agricultural Worker
SAWS	Statewide Automated Welfare System

SBHI	Santa Barbara Health Initiative
SC	Special Circumstances
SCCHO	Santa Cruz County Health Options
SCI	State Client Index
SCO	State Controller's Office
SCPHMCN	Sonoma County Partners for Health Managed Care Network (1/1/97)
SD	Short Doyle
SD/MC	Short-Doyle/Medi-Cal
SDI	State Disability Insurance
SDHS	State Department of Health Services
SDN	System Development Notice
SDSS	State Department of Social Services
SDX	State Data Exchange
SED	Seriously Emotionally Disturbed
SFD	Specific Functional Design
SGA	Substantial Gainful Activity
SH	State Hospitals (Now called Developmental Centers 1/2000)
SIS	Satisfactory Immigration Status
SIU	Special Investigative Unit
SKEY	Smart KEY (mnemonic of First Data Bank's Smart Key)
SLD	Similar Legal Device
SLIAG	State Legalization Impact Assistance Grant
SLMB	Special Low-Income Medicare Beneficiary Program
SMA	Scheduled Maximum Allowance
SMI	Serious Mental Illness
SNA	System Network Architecture
SNF	Skilled Nursing Facility (Nursing Facility Level B)
SO	Services Only
SOC	Share Of Cost
SOFP	State Only Family Planning
SP-DED	State Programs Disability Evaluation Division
SPC	Short Paid Claims
SPE	Single Point of Entry (to sign up for Medi-Cal or Healthy Families, etc.)
SPECT	Single Photon Emission Computed Tomography
SPH	Solano Partnership Health Plan (start date 4/1/94)
SPR	System Performance Review
SPR	Special Program Report
SQL	Structured Query Language (used to access DB2 files)
SS	Social Security
SSA	Social Security Administration
SSI	Supplemental Security Income
SSI/SSP	Supplemental Security Income/State Supplemental Payment
SSN	Social Security Number
SSP	State Supplemental Payment
STC	Specific Therapeutic Class (part of the Smart Key)
STI	Sexually Transmitted Infection
STP	Special Treatment Programs
STR	Drug Strength (part of the Smart Key)
STR	Systems Trouble Report
SUEM	Source User Edit Module
SURS	Surveillance Utilization Review System
SVR	System Variance Report
TANF	Temporary Assistance for Needy Families
TAR	Treatment Authorization Request
TB	Tuberculosis

TC	Transitional Care
TCM	Targeted Case Management
TCN	TAR Control Number
TCP/IP	Transmission Control Protocol/Internet Protocol
TEVS	Testing IEVS (for county testing and training purposes)
TIC	Transitional Inpatient Care
TIN	Taxpayer Identification Number
TLA	Three-Letter Acronym
TMC	Transitional Medi-Cal
TMF	TAR Master File
TMJ	TransMandibular Jaw
TMS	Tape Management System
TOS	Type of Service
TPA	Tissue Plasminogen Activator
TPL	Third Party Liability
TPN	Total Parenteral Nutrition
TPQY	Third Party Query (SSA Inquiry)
TSD	Technical System Design
TSO	Time Share Option
TSU	Technical Support Unit
TST	Test(ing)
TRS	Temporary Resident Status (Under IRCA of 1986)
TTG	Toll-free Telephone Group
U	Unemployed parent
UA	Units digit of Aid code
UB-92	Uniformed Billing (1992) codes
UDUU	Unit Dose/Unit of Use (part of the Smart Key)
UG	User Group
UI	Unemployment Insurance
UME	Unusually Medical Expenses
UP	Unemployed Parent
UPC	Universal Product Code
UPIN	Universal Provider Identification Number
UPS	Uninterruptible Power Supply
URVG	Uniform Relative Value Guide (for anesthesia codes unit values)
USC	United States Code
UTI	Urinary Tract Infections
VC	Vendor Code
VDTS	Voice Drug TAR System
VFC	Vaccines For Children
VOLAG	Voluntary Resettlement Agency
VOLSER	Volume Serial Number
VRU	Voice Response Unit
VTAM	Virtual Telecommunications Access Method
W & I	California Welfare and Institutions Code
WAN	Wide Area Network
WCAB	Workers Compensation Appeals Board
WIC	Women, Infants, and Children Welfare persons receiving TMC due to reuniting of spouses or marriage
WTD	Week To Date
XO	Medicare Crossover (Both Medicare and Medi-Cal)
XOVER	Medicare Crossover (Both Medicare and Medi-Cal)
YTD	Year To Date

APPENDIX B. BENEFICIARY AID CODES (GENERAL)

For more up-to-date Aid Codes information please check the following web site
http://www.dhs.ca.gov/mcss/GeneralInfo/Aid_Code_Documn.PDF

01	Refugee Cash Assistance (No SOC) (FFP)
0A	RCA - Exempt from Grant Cuts (No SOC) (FFP)
02	Refugee Medical Assistance/Entrant Medical Assistance (SOC/No SOC) (FFP)
03	Adoption Assistance Program (AAP)--FEDERAL (No SOC) (FFP)
04	Adoption Assistance Program/Aid for Adoption of Children(AAC)(No SOC/FFP
&05	Seriously Emotionally Disturbed (Cash Grant Only) (No SOC)
$#07	Asset Waiver Program (OBRA INFANT)-Emergency Services Only(No SOC/FFP)
08	Entrant Cash Assistance (ECA) (No SOC)(no FFP for ages 21+)
&09	Food Stamps Only (F/S)
10	AGED (SSI/SSP) Cash Grant (No SOC) (FFP)
*&11	AGED-Services only (SO) (OPTIONAL)
*&12	AGED-Special Circumstances (SC)
13	AGED-Long Term Care (LTC) (SOC/No SOC) (FFP)
14	AGED-Medically Needy (MN) (No SOC) (FFP)
16	AGED-Title II DisregardPicLKE (?? what is this program -- may be TYPO) Disregard Eligibility (No SOC) (FFP)
17	AGED-Medically Needy (MN)-Share of Cost (SOC) (FFP)
18	AGED-In-Home Support Services (IHSS) (Cash) (No SOC) (FFP)
1H	AGED-MN-No SOC-Aged and Disabled Poverty Level Program
1U	AGED-MN-No SOC-Aged and Disabled Poverty Level Program-Not Qualified Alien-Emergency Services only
20	BLIND (SSI/SSP) Cash Grant (No SOC) (FFP)
*&21	BLIND-Services Only (SO)
*&22	BLIND-Special Circumstances (SC)
23	BLIND-Long Term Care (LTC) (SOC/No SOC) (FFP)
24	BLIND-Medically Needy (MN) (No SOC) (FFP)
26	BLIND-Title II Disregard (PICKLE) (No SOC) (FFP)
27	BLIND-Medically Needy (MN)-Share of Cost (SOC) (FFP)
28	BLIND-In-Home Support Services (IHSS)-(CASH) (No SOC) (FFP)
2A	Abandoned Baby Program (no SOC)
30	AFDC-Family Group (FG)-CASH (No SOC) (FFP)
*&31	AFDC-FG-Services Only
32	AFDC-FG-State Only CalWORKS Cash Grant (No SOC)(non-FFP cash grant FFP for Medi-Cal eligible)
33	AFDC-Unemployed Parent-State Only CalWORKS Cash Grant (No SOC) (non-FFP cash grant FFP for Medi-Cal eligible)
34	AFDC-Medically Needy (MN) (No SOC) (FFP)
35	AFDC-Unemployed Parent CalWORKS Cash Grant (No SOC) (FFP)
36	DISABLED-COBRA-WIDOW/ERS (No SOC) (FFP)
37	AFDC-Medically Needy (MN)-Share of Cost (SOC) (FFP)

Key to the symbols used:

-	FFP based on age
+	No FFP
=	FFP based on services
*	Optional
&	No Medi-Cal card(s) issued for this aid code
#	Restricted Medi-Cal card(s) issued for this aid code
@	CMSP ID card(s) issued for this aid code
$	On MEDS in the Special Program Segmen

38	EDWARDS vs. KIZER Continuing Medi-Cal pending eligibility(No SOC) (FFP)
39	AFDC/CalWORKS Transitional Medi-Cal Six months continuing(No SOC) (FFP)
3A	AFDC-California Alternative Assistance Program-Family Group(No SOC)declined a federal cash grant and instead will receive childcare(FFP)
3C	AFDC-California Alternative Assistance Program-Unemployed Parent(No SOC) declined a federal cash grant and instead will receive childcare (FFP)
3E	CalWORKS Legal Immigrant - Family Group (No SOC) (FFP)
3G	AFDC-FG (State Only) Exempt from Grant Cuts (No SOC)(non-FFP cash grant FFP for Medi-Cal eligible)
3H	AFDC-Unemployed Parent (State Only) Exempt from Grant Cuts(No SOC)(non- FFP cash grant FFP for Medi-Cal eligible)
3L	CalWORKS Legal Immigrant - FG (No SOC) (No SOC) (FFP)
3M	CalWORKS Legal Immigrant - U (No SOC) (No SOC) (FFP)
3N	Mandatory Coverage (No SOC) (FFP)
3P	AFDC-U Exempt from Grant Cuts (No SOC) (FFP)
3R	AFDC-FG Exempt from Grant Cuts (No SOC) (FFP)
=3T	INITIAL TRANSITIONAL MEDI-CAL (TMC) (No SOC) (FFP)
3U	CalWORKS Legal Immigrant - U (No SOC) (No SOC) (FFP)
=3V	SECTION 1931(B) EMERGENCY AND PREGNANCY ONLY (No SOC) (FFP)
40	AFDC-Foster Care (FC)/Non-Federal (No SOC)
*&41	AFDC-Foster Care (FC)-Services Only (SO)
42	AFDC-Foster Care (FC)/Federal (No SOC) (FFP)
$#44	Income Disregard Program (Pregnancy-Related/Postpartum) (No SOC) (FFP)
45	Children supported by Public Funds (No SOC) (FFP)
$47	Income Disregard Program (Citizen Infant-Full Scope) (No SOC)
=#48	Income Disregard Program(OBRA Pregnancy Related/Postpartum)(No SOC)
#49	Income Disregard Program(IRCA Pregnancy-Related/Postpartum)(No SOC)
4A	Adoption Assistance Program (AAP) State Only (No SOC)
4C	AFDC-Voluntarily Placed (Fed) Voluntary Foster Care (No SOC) (FFP)
4F	Kinship Guardianship Assistance Payment (Kin-GAP) (Federal) (FFP)
4G	Kinship Guardianship Assistance Payment (Kin-GAP) (State Only)
4K	Emergency Assistance Foster Care (Probation) (No SOC) (FFP)
4M	Former Foster Care Children (FFCC) 18 through 20 Years of Age (No SOC)
&#@50	CMSP IRCA Alien (Out of County Care) (SOC/No SOC)
+ #53	Medically Indigent (MI)-(LTC)-STATE ONLY (Limited Scope)(SOC/No SOC)
54	Four Month Continuation (No SOC) (FFP)
=#55	Non-PROCOL Undocumented Aliens in Long Term Care (LTC)-IRCA/OBRA (No SOC)
= #58	Non-immigrant/Undocumented Aliens Restricted Medi-Cal Benefits(SOC/NoSOC)
59	Additional Transitional Medi-Cal (TMC) (No SOC)
=5F	OBRA Aliens: Restricted to Pregnancy and Emergency Services
5G	OBRA UNDOCUMENTED ALIENS/NONIMMIGRANT ALIENS-EMERGENCY SERVICES ONLY
5H	INCOME DISREGARD PROGRAM and ASSET WAIVER PROVISION PREGNANT)
5K	Emergency Assistance Foster Care (Child Welfare Services) (FFP)
5M	OBRA Non-Immigrant/Undocumented Pregnant Women (formerly 7Cs)
5N	OBRA Non-Immigrant/Undocumented Pregnant Women (formerly 5Fs)

Key to the symbols used:

-	FFP based on age
+	No FFP
=	FFP based on services
*	Optional
&	No Medi-Cal card(s) issued for this aid code
#	Restricted Medi-Cal card(s) issued for this aid code
@	CMSP ID card(s) issued for this aid code
$	On MEDS in the Special Program Segmen

=5T	CONTINUING TRANSITIONAL MEDI-CAL (TMC) (No SOC) (FFP)
=5W	FOUR MONTH CONTINUING ELIGIBILITY (No SOC) (FFP)
+5X	SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) (No SOC)
+5Y	SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) (No SOC) (State-only)
60	DISABLED (SSI/SSP) (No SOC)
*&61	DISABLED-Services Only (SO) (OPTIONAL)
*&62	DISABLED-Special Circumstances (SC)
63	DISABLED-Long Term Care (LTC) (SOC/No SOC)
64	DISABLED-Medically Needy (MN) (No SOC)
+65	DISABLED-SGA/ABD-MN (IHSS) (SOC/No SOC)
66	DISABLED-PICKLE Eligibility (No SOC)
67	DISABLED-Medically Needy (MN) (SOC)
68	DISABLED-IHSS (Cash) (No SOC)
$#69	Income Disregard Program (OBRA Infant-Emergency Services Only) (No SOC)
6A	Disabled Adult Child(ren)(DAC)-Blind (No SOC)
6C	Disabled Adult Child(ren)(DAC)-Disabled (No SOC)
6N	PRWORA/Former SSI No Longer Disabled-Appeal Status (No SOC)
6P	PRWORA/Former SSI No Longer Disabled Children-Appeal Status (No SOC)
6R	No Longer Disabled Children-Appeal Status (No SOC)
6W	Aid to the Disabled - DDS Waiver (SOC/No SOC)
+$#70	Asset Waiver Program (Citizen and OBRA Pregnancy) (No SOC)
+$#71	Dialysis/Dialysis Supplement Program (SOC/No SOC)
$72	133% Program (Citizen Child) (No SOC)
+$#73	Total Parenteral Nutrition (TPN)/TPN Support (SOC/No SOC)
$#74	133% Program (OBRA) (Undocumented/Nonimmigrant Child) (No SOC)
+$#75	Asset Waiver Program (IRCA Pregnancy/Related/Postpartum) (No SOC)
$#76	0-Day Postpartum (No SOC)
+ $79	Asset Waiver Program (Citizen Infants-Full Scope of Coverage) (No SOC)
$7A	100% Program (Citizen child age 6 thru 19-Full scope) (No SOC)
= $#7C	100% Program (OBRA) Emergency and Pregnancy-related Services (No SOC)
7F	Presumptive Elig. (PE) for Pregnant Woman-Pregnancy Verification (No SOC)
7G	Presumptive Elig. (PE) for Pregnant Woman-Ambulatory Prenatal Care(No SOC
7H	Medi-Cal Tuberculosis Program. Outpatient TB-related only. (No SOC)
+&7M	Minor Consent Services aged 12-20 without counseling(SOC/No SOC)
&7N	Minor Consent Service for pregnant minors (No SOC)
+&7P	Minor Consent Services aged 12-20 with counseling (SOC/No SOC)
+&7R	Minor Consent Services under age 12 (SOC/No SOC)
+7X	Healthy Families Bridge Benefits - No SOC
$#80	Qualified Medicare Beneficiary (QMB) (No SOC)
+81	Medically Indigent (MI) Adult-Aid Paid Pending (APP) (SOC/No SOC)
82	Medically Indigent (MI) Person Under 21 (No SOC)
83	Medically Indigent (MI) Person Under 21 (SOC)
&84	MI-A (No SOC)
&85	MI-A (SOC)
86	Medically Indigent (MI)-Pregnant-No Share of Cost (No SOC)
87	Medically Indigent (MI)-Pregnant-Share of Cost (SOC)
&8A	Qualified Disabled Working Individual (QDWI)

Key to the symbols used:

-	FFP based on age
+	No FFP
=	FFP based on services
*	Optional
&	No Medi-Cal card(s) issued for this aid code
#	Restricted Medi-Cal card(s) issued for this aid code
@	CMSP ID card(s) issued for this aid code
$	On MEDS in the Special Program Segmen

&8C Special Low-Income Medicare Beneficiary (SLMB)
8D QUALIFIED INDIVIDUAL-135% (QI-1)
8F CMSP Companion Aid Code
8G Qualified Severely Impaired Disabled Working Individual (No SOC)
+8H Family P.A.C.T. (Also known as SOFP-State Only Family Planning(SOC-N/A)
8K QUALIFIED INDIVIDUAL-175% (QI-2)
8N Child - 133% - Emergency Services/Property Disregard (No SOC)
8P Child - 133% - Full Scope of Coverage/Property Disregard (No SOC)
8R Child - 100% - Full Scope of Coverage/Property Disregard (No SOC)
=8T Child - 100% - Emergency Services/Property Disregard (No SOC)
9A Breast Cancer Early Detection Program (BCEDP) (No SOC)
9H Healthy Families services only (no Medi-Cal) (No SOC)
*&90-99 General Relief/General Assistance (GR/GA) (OPTIONAL)
IE Ineligible person for Medi-Cal benefits in the case.
IE used for SOC.
RR Responsible Relative allowed to use medical expenses to meet SOC.

Key to the symbols used:
- FFP based on age
+ No FFP
= FFP based on services
* Optional
& No Medi-Cal card(s) issued for this aid code
# Restricted Medi-Cal card(s) issued for this aid code
@ CMSP ID card(s) issued for this aid code
$ On MEDS in the Special Program Segmen

B.1 BENEFICIARY AID CODE BY CATEGORY

B.1.1 CASH GRANT-PUBLIC ASSISTANCE

AID CODE & DESCRIPTION

***0A RCA - EXEMPT FROM GRANT CUTS (NO SOC) Refugee Cash Assistance (FFP)** -- Includes unaccompanied children. Covers all eligible refugees during their first 8 months in the U.S. Unaccompanied minors are not subject to the 8-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project. This code went into effect May 1, 1996.(No FFP for age 21+)

***01 RCA - (NO SOC) Refugee Cash Assistance (FFP)--** Includes unaccompanied children. All eligible refugees may receive benefits during their first 8 months in the U.S. Unaccompanied minors are not subject to the 8-month limitation provision. (See 45 CFR, Part 400, and Section 50257, Title 22, CCR.)(2)

03 AAP - FEDERAL Adoption Assistance Program (FFP) -- A program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance. (See Sections 50227 & 50246 and Aid Code 04 under "BENEFICIARY AID CODES (MEDICALLY INDIGENT)"

*** 08 ECA Entrant Cash Assistance (FFP)** -- Cuban/Haitian entrants, including unaccompanied children who are eligible, may received Entrant Cash Assistance benefits during their first 8 months in the U. S (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the 8-month limitation provision. (See 45 CFR, Part 400, and Section 50257, Title 22, CCR.). No FFP for age 21+. (2)

10 AGED Supplemental Security Income/State Supplemental Payment (SSI/SSP) Aid to the Aged (FFP) -- A cash assistance program administered by the Social Security Administration (SSA) which pays a cash grant to needy persons 65 years of age or older.

20 BLIND Supplemental Security Income/State Supplemental Payment (SSI/SSP) Aid to the Blind (FFP) -- A cash assistance program administered by the Social Security Administration (SSA) which pays a cash grant to needy blind persons of any age.

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2 * FFP is available under the Title XIX program for individuals under 21 years of age. Other federal funds are available through the Refugee Resettlement Program for both children and adults. Effective May 31, 1991, the Refugee Cash Assistance (RCA) and the Refugee Medical (RMA) program was reduced from 12 months to 8 months. Before that, effective October 1, 1988, the RCA and RMA program was reduced from 18 months to 12 months. However, full federal funding was expanded for the costs of General (GA) and General Medical Assistance (GMA) for the following 12-month period, so that full federal funding was still available for 24 months. These reductions also applied to the Cuban/Haitian entrant programs (EMA), which follow the same criteria.

60 DISABLED Supplemental Security Income/State Supplemental Payment (SSI/SSP) Aid to the Disabled (FFP) -- A cash assistance program administered by the Social Security Administration (SSA) which pays a cash grant to needy persons of who meet the federal definition of a disability.

30 AFDC-FG Aid to Families with Dependent Children (AFDC) -Family Group (FFP) -- Aid to families with dependent children in a family group in which the child(ren) is deprived because of the absence, incapacity, or death of either parent. (See MPP Section 40-103 and Section 50205, Title 22, CCR.)

**** 32 STATE-ONLY AFDC-FG Aid to Families with Dependent Children (AFDC) -Family Group (non-FFP cash grant FFP for Medi-Cal eligible)--** Aid to families in which the child is deprived because of the absence, incapacity, or death of either parent, who do NOT meet all federal requirements, but State rules require the individual(s) be aided. Examples of these recipients are the pregnant woman with no other eligible children prior to the last trimester of her pregnancy, and assistance units, which have qualified for aid because of a State court decision but do not meet all federal requirements. (3)

**** 33 STATE-ONLY AFDC-U State-Only Aid to Families with Dependent Children (AFDC) - Unemployed Parent (non-FFP cash grant FFP for Medi-Cal eligible)** -- Aid to pregnant women before their last trimester who meet the federal definition of an unemployed parent but are not eligible because they have no other children living in the home.(3)

35 AFDC-U Aid to Families with Dependent Children- Unemployed Parent (FFP cash grant) -- Aid to families in which a child is deprived because of the unemployment of a parent and the unemployed parent meets all federal AFDC eligibility requirements. (See MPP Section 40-103 and Section 50205, Title 22, CCR.)(4)

3A AFDC-CALIFORNIA ALTERNATIVE ASSISTANCE PROGRAM-FAMILY GROUP Aid to Families with Dependent Children who are AFDC eligible but declined an AFCD cash grant and instead will receive childcare assistance and Medi-Cal under the California Alternative Assistance Program. This program is effective May 1994.

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3 ** If State Only AFDC-U Cash Grant -- Only individuals under 21 years of age, pregnant women, and certain adults over 21 are eligible for Medi-Cal benefits.

4 State only AFDC-U individuals 21 and 1 month of age or older are not eligible for Medi-Cal benefits and do not receive cards.

3C AFDC-CALIFORNIA ALTERNATIVE ASSISTANCE-- PROGRAM-UNEMPLOYED PARENT Aid to Families with Dependent Children who are AFDC eligible but declined an AFCD cash grant and instead will receive child care assistance and Medi-Cal under the California Alternative Assistance Program. This program is effective May 1994.

3G AFDC-FG (STATE ONLY) EXEMPT FROM GRANT CUTS Aid to Families with Dependent Children – Family Group (non-FFP cash grant FFP for Medi-Cal eligible) – Provides aid to families in which a child is deprived because of the absence, incapacity, or death of either parent, who do NOT meet all federal requirements, but State rules require the individual(s) be aided. Examples of these recipients AFDC eligibility requirements. This population is the same as aid code 32, except from grant reductions on behalf other Assistance Payments Demonstration Project/California Work Pays Payments Demonstration Project. This code went into effect May 1, 1996.

3H AFDC-U (STATE ONLY) EXEMPT FROM GRANT CUTS Aid to Families with Dependent Children - Unemployed (non-FFP for Medi-Cal eligible) -- Provides aid to pregnant women before their last trimester who meet the federal definition of an unemployed parent but are not eligible because they have no other children living in the home. This population is the same as aid code 33, except from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Payments Demonstration Project. This code went into effect May 1, 1996.

3P AFDC-U EXEMPT FROM GRANT CUTS Aid to Families with Dependent Children - Unemployed Parent (FFP cash grant FFP cash grant) – Aid to families in which a child is deprived because of the unemployment of a parent and the unemployed parent meets all federal

AFDC eligibility requirements. This code was implemented November 1995 in order to identify and track families changed from aid code 35 to 3P. These recipients will be exempt from cash grant cuts being imposed upon the general AFDC population pursuant to the Assistance Payments Demonstration Project/California Work Pays Payments Demonstration Project. The exempt group includes the following Assistance Units (Aus):

(1) AUs where the parent(s) or caretaker relative is a recipient of Supplemental Security Income/State Supplementary Payment benefits.
(2) AUs where the parent(s) or caretaker relative is a recipient of In-Home Supportive Services/Personal Care Services Program benefits.
(3) AUs where the parent(s) or caretaker relative is a recipient of temporary disability-based income.
(4) (4) Child-only AUs when the caretaker relative is an unaided, non-parent

3R AFDC-FG EXEMPT FROM GRANT CUTS Aid to Families with Dependent Children (AFDC) - Family Group (FFP) -- Aid to families with dependent children in a family group in which the child(ren) is deprived because of the absence, incapacity, or death of either parent. This code was implemented November 1995 in order to identify and track families changed from aid code 30 to 3R. These recipients will be exempt from cash grant cuts being imposed upon the general AFDC population pursuant to the Assistance Payments Demonstration Project/California Work Pays Payments Demonstration Project. The exempt group includes the following Assistance Units(AUs):

(1) AUs where the parent(s) or caretaker relative is a recipient of Supplemental Security Income/State Supplementary Payment benefits.

(2) AUs where the parent(s) or caretaker relative is a recipient of In-Home Supportive Services/Personal Care Services Program benefits.

(3) AUs where the parent(s) or caretaker relative is a recipient of temporary disability-based income.

(4) Child-only AUs when the caretaker relative is an unaided, non-parent.

40 AFDC-FC/NON FED (STATE FC) Aid to Families with Dependent Children (AFDC) (non-Fed) – The purpose of the Aid to Families with Dependent Children-Foster Care Program is to provide financial assistance for those children who are in need of substitute parenting and who have been placed in foster care. (See MPP Section45-100.) Also see aid codes 42 (listed below) and also 45 under "BENEFICIARY AID CODES (MEDICALLY INDIGENT)".

42 AFDC-FC/FED Aid to Families with Dependent Children- Foster Care (Federal) (FFP) -- See aid codes 40 (listed above) and also 45 under "BENEFICIARY AID CODES (MEDICALLY INDIGENT)".

4C AFDC-FC VOLUNTARY Aid to Families with Dependent Children - Foster Care Voluntarily Placed (Federal) (FFP) -- The purpose of the AFDC-Foster Care Program is to provide financial assistance for those children who are in need of substitute parenting and who have been voluntarily placed in foster care. (Also see Aid Codes 40, 42 {listed above} and 45 under "BENEFICIARY AID CODES (MEDICALLY INDIGENT)".

4M FORMER FOSTER CARE CHILDREN (FFCC) 18 THROUGH 20 YEARS OF AGE Provides full-scope Medi-Cal Benefits to former foster care children who were receiving foster care benefits on their 18th birthday in aid codes 40, 42,45, 4C, and 5K and who are under 21 years of age. No SOC. Recipients in aid code 4M will be eligible for full-scope Medi-Cal benefits with no share of cost. The eligibility message will be "Recipient Medi-Cal Eligible With No Share Of Cost." Effective October 1,2000.

B.1.2 CASH GRANT-NO MEDI-CAL CARDS ISSUED

THERE IS NOT MEDI-CAL CARD ISSUED FOR THESE AID CODES.

These aid codes will never be seen on the Paid Claims files.

+05 SED Seriously Emotionally Disturbed Children-- Cash grant only for residential placement necessary for education. (See Section 18350-18355 W&I Code, AB 3632.)

+12 AGED-SC (OPTIONAL) Aid to the Aged-Special Circumstances -- Special circumstances payments to aged adult recipients of SSI/SSP and SSP only.

+22 BLIND-SC (OPTIONAL) Aid to the Blind-Special Circumstances -- Special circumstances payments to blind adult recipients of SSI/SSP and SSP only.

+62 DISABLED-SC (OPTIONAL) Aid to the Disabled-Special Circumstances -- Special circumstances payments to disabled adult recipients of SSI/SSP and SSP only.

+90-99 GR/GA (OPTIONAL) General Relief/General Assistance for county use in the local General Relief/General Assistance Program. Each county determines its definitions.

B.1.3 OTHER-PUBLIC ASSISTANCE PROGRAMS

03 AAP Adoption Assistance Program (FFP) -- A program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance. No cash grant award. (See Section 50277, Title 22, CCR.) See aid code 03 under "BENEFICIARY AID CODES (CASH GRANT-PUBLIC ASSISTANCE)"for the cash grant definition of the aid code.

4A AAP--STATE-ONLY Adoption Assistance Program (no FFP)-- this program covers AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s). Children in this aid code are eligible for full scope Medi-Cal benefits with no Share of Cost (SOC) and are valid for Local Education Agency Medi-Cal billing option and Child Health Disability Prevention (CHDP) programs. It became effective along with aid codes 4F and 4G on February 1, 2000. The Medi-Cal eligibility message reading: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST."

4F KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (KIN-GAP) CASH ASSISTANCE Kin-GAP program (FFP) – this program is for children in relative placement receiving cash assistance with Federal Financial Participation on cash payments. Children in this aid code are eligible for full-scope Medi-Cal benefits with no Share of Cost (SOC) and are valid for Local Education Agency Medical billing option and Child Health Disability Prevention (CHDP) programs. It became effective along with aid codes 4A and 4G on February 1, 2000. The Medical eligibility message reading: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHAREOF COST."

4G KINSHIP GUARDIANSHIP ASSISTANCE PAYMENT (KIN-GAP) CASH ASSISTANCE Kin-GAP program (no FFP) --this program is for children in relative placement receiving cash assistance with no Federal Financial Participation on cash payments. Children in this aid code are eligible for full-scope Medi-Cal benefits with no Share of Cost (SOC) and are valid for Local Education Agency Medi-Cal billing option and Child Health Disability Prevention (CHDP) programs. It became effective along with aid codes 4A and 4F on February 1, 2000. The Medi-Cal eligibility message reading: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST."

*****16 AGED-PICKLE Aid to the Aged-Pickle Eligible (FFP)--** Persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients according to provisions of the Lynch v. Rank lawsuit.
(5)

*****26 BLIND-PICKLE Aid to the Blind-Pickle Eligible (FFP)** -- Persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit.(5) (See Aid Code 16 for definition of Pickle eligible .) Prior to the implementation of Aid Code 6A, the Disabled Adult Child(ren)/Blindness are included in Aid Code 26.

*****36 DISABLED-COBRA-WIDOW/ERS Aid to Disabled Widow/er(FFP)** -- Persons who began receiving SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs (Cost Of Living Allowance) were disregarded. These persons are eligible for zero share-of-cost(SOC) benefits as public assistance recipients in accordance with the pro Reduction Act (COBRA).(5)
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5 *** Note: These aid codes also include persons who were discontinued from cash grant status due to the 20% Social Security increase under Public Law 32-336. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with Section 50247, Title 22, CCR.

*****66 DISABLED-PICKLE Aid to the Disabled-Pickle Eligibles (FFP)** -- Persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. These persons were discontinued from SSI/SSP as a result of the individual becoming entitled on or after July 1, 1987 to SSA child's benefits payable on the basis of a disability that began before age 22, or because of an increase in childhood disability benefits. No age limit for this aid code. Prior to the implementation of Aid Code6C, the Disabled Adult Child(ren)/Disabled are included in Aid Code 66.(5)

6A DISABLED ADULT CHILD(REN)-BLINDNESS Aid to the Blind Disabled Adult Child(ren) (DAC) (FFP) --Must be at least 18 years of age and have previously received Supplemental Security Income/State Supplementary Payment (SSI/SSP) which began before the person reached age 22. Operational as of December 1994 month of eligibility.

6C DISABLED ADULT CHILD(REN)-DISABLED Aid to the Blind Disabled Adult Child(ren) (DAC) (FFP) --Must be at least 18 years of age and have previously received Supplemental Security Income/State Supplementary Payment (SSI/SSP) which began before the person reached age 22. Operational as of December 1994 month of eligibility.

18 AGED-IHSS Aid to the Aged-In-Home Supportive Services (IHSS) (FFP) -- Persons 65 years of age or older receiving In-Home Supportive Services, but not a SSI/SSP cash grant, provided they are using their net income (if any) in excess of the cash grant maximum payment level to pay to ward the IHSS. (Includes persons who are eligible for IHSS under Chapter 1362 of the Statues of 1978.) (See Section 50245, Title 22, CCR.)(6)

28 BLIND-IHSS Aid to the Blind-In-Home Supportive Services (FFP) -- Persons who meet the federal definition of blindness and are eligible for In-Home Supportive Services. See Aid Code 18 for definition of eligibility for IHSS.(6)

68 DISABLED-IHSS Aid to the Disabled-In-Home Supportive Services (FFP) -- Persons who meet federal definition of disability and are eligible for In-Home Supportive Services. See Aid Code 18 for definition of eligibility for IHSS.(6)

B.1.4 CONTINUING MEDI-CAL - NO SHARE OF COST

38 EDWARDS VS. MYERS Continuing Medi-Cal Eligibility (FFP) -- Edwards v. Kizer court order provides for uninterrupted no share-of-cost Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for MediCal only has been determined and an appropriate Notice of Action sent. (See Medi-Cal Eligibility Procedures Manual 4-0.)
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6 Refer to aid code 65 under "BENEFICIARY AID CODES (MEDICALLY NEEDY, NO SHARE OF COST)" for definitions.

B.1.5 TRANSISTIONAL MEDI-CAL – NO SOC

The six month Initial TMC (aid code 39), six month Continuing TMC (aid code 59), and Second Year TMC (aid code 5X) program provide continued full-scope (no Share of Cost) Medi-Cal benefits to citizens or qualified aliens discontinued from CalWORKS or Section 1931(b) Medi-Cal programs due to increased earnings from employment.

The TMC program is being expanded to include persons with restricted benefits for the first federally funded year (Initial and Continuing TMC) and the second year of state-only funded TMC(Second Year TMC). The Four Months Continuing Eligibility program is being expanded to include persons with restricted benefits if they are ineligible for Section 1931(b) due to increased collection of child or spousal support.

Section 1931(b) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 allows aliens who do not have satisfactory immigration status (SIS) to now received Section 1931(b) if they meet the income, property, and deprivation requirements of the AFDC program as it existed on July 16, 1996. The new aid codes are 3T, 3V, 5T, 5W, and 5Y and they became active March 1, 1999 with eligibility message reading: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST."

These aid codes are not valid for Local Education Agency (LEA) Medi-Cal Billing Option program. Aid codes 3T, 3V,5T, and 5W are valid for the Child Health Disability Prevention (CHDP) program, but aid code 5Y is not.

39 INITIAL TRANSITIONAL MEDI-CAL (TMC) (NO SOC) Six Months Continuing Eligibility (FFP) -- Persons discontinued from cash grant due to increased earning or increased hours of employment, or loss of the $30 and 1/3 disregard but eligible for Medi-Cal only. (See Sections 50373 and 50243.5.)

54 FOUR MONTH CONTINUATION (NO SOC) Four Months Continuing Eligibility (FFP) -- This program provides continued full-scope (no Share of Cost) Medi-Cal benefits to citizens or qualified aliens discontinued from CalWORKS or Section 1931(b) Medi-Cal programs due to increased earnings from due to increased due to increased collection of child/spousal support payments. (See Sections 50243 and 50373,Title 22, CCR.)

59 ADDITIONAL TRANSITIONAL MEDI-CAL (TMC) (NO SOC) Additional Six Months Continuing Eligibility (FFP) -- Persons discontinued from AFDC due to the expiration of the $30 plus 1/3 disregard, increased earnings or hours of employment, but eligible for Medi-Cal only, may receive this extension of TMC. (See aid code 39 and Section 50373 and 50243.5., Title 22, CCR.)

5X SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) (NO SOC) Second year of full-scope (no share of cost) TMC benefits and is state-only funded. In order to capture FFP for pregnant women

eligible under aid code 5X, counties will assign a second special program (pregnancy-related) aid code, which will have a higher priority rating than aid code 5X. The EDS Aid Code Priority Table (1806) will cause any pregnancy-related services for these recipients to be paid under aid code 44 or 48 so that FFP can be claimed. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." Implemented December 1, 1998.

3T INITIAL TRANSITIONAL MEDI-CAL (TMC) (NO SOC) (FFP) Aid code 3T provides six months of emergency and pregnancy-related Initial TMC benefits (no share of cost) for aliens who do not have SIS and have been discontinued from Section 1931(b) due to increased earnings from employment. The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY AND PREGNANCY RELATED SERVICES WITH NO SHAREOF COST."

SECTION 1931(B) EMERGENCY AND PREGNANCY ONLY (NO SOC)(FFP) Aid code 3V provides emergency and pregnancy-related benefits (no share of cost) for aliens without SIS who meet the income, property, and deprivation requirements of the AFDC program as it existed on July 16, 1996. The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY AND PREGNANCY RELATED SERVICES WITH NO SHARE OF COST."

5T CONTINUING TRANSITIONAL MEDI-CAL (TMC) (NO SOC) (FFP) Aid code 5T provides an additional six months of emergency and pregnancy-related TMC benefits (no share of cost)to qualifying aid code 3T recipients.

5W FOUR MONTH CONTINUING ELIGIBILITY (NO SOC) (FFP) Aid code 5W provides four months of emergency and pregnancy-related benefits (no share of cost) for aliens without SIS who are no longer eligible for Section 1931(b) due to increased collection of child/spousal support.

5Y SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) (NO SOC)(STATE-ONLY) Aid code 5Y provides a second year of continuing emergency and pregnancy-related benefits (no share of cost) to qualifying 5T recipients 19 years of age or older. Aid code 5Y is state-only funded. Assembly Bill 2780 requires the Department of Health Services seek Federal Financial Participation (FFP) for pregnant women who are eligible for pregnancy-related benefits. In order to capture FFP for pregnant women eligible under aid code 5Y, counties will assign them special program aid code 48, which will have a higher priority rating than aid code 5Y. The EDS Aid Code Priority Table (1806) will cause any pregnancy-related services for these recipients to be paid under aid code 48 so that FFP can be claimed.

B.1.6 MEDICALLY NEEDY, NO SHARE OF COST

14 AGED-MN Aid to the Aged-Medically Needy (FFP) --Persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.

24 BLIND-MN Aid to the Blind-Medically Needy (FFP)-- Persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.

34 AFDC-MN Aid to Families with Dependent Children-Medically Needy (FFP) --Families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.

64 DISABLED-MN Aid to Disabled-Medically Needy (FFP) --Persons who meet the federal definition of disability who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.

6J SB 87 PENDING DISABILITY Senate Bill (SB) 87 Pending Disability Program (FFP). This program requires that when non-disability linkage to Medi-Cal is lost and the client claims disability, Medi-

Cal coverage must continue uninterrupted during the re-determination period. This program establishes full scope Medi-Cal benefits for recipients aged 21 to 65. Not valid for Local Education Agency or CHDP billing. No share of cost required of the beneficiaries. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLEWITH NO SHARE OF COST." This aid code is effective August 1, 2001.

65 DISABLED-SGA/ABD-MN (IHSS) NO SOC (NOT ELIGIBLE FOR CASH) Aid to Disabled-Substantial Gainful Activity (SGA)/Aged, Blind, Disabled (ABD)-Medically Needy (MN)/ (In-Home Supportive Services) (IHSS)(non-FFP) -- Persons who: (a) were once determined to be disabled according to provisions of the SSI/SSP program (Section 1614, Part A, Title XVI, Social Security Act) and were eligible for SSI/SSP, but who became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations. They must continue to suffer from the physical or mental impairment, which was the basis of the disability determination. Or (b) are aged, blind, or disabled medically needy and have the costs of in-home supportive services deducted from their monthly income. (SOC may be required of some beneficiaries - see "BENEFICIARY AID CODES (MEDICALLY NEEDY-SOC)" under aid code 65.)

B.1.7 POVERTY LEVEL PROGRAMS – NO SHARE OF COST

76 60-DAY POSTPARTUM 60-Day Postpartum Program (FFP) --Provides Medi-Cal at no share of cost to women who, while pregnant, were eligible for, applied for and received Medi-Cal benefits. They may continue to be eligible for all-postpartum services and family planning. This coverage begins on the last day of pregnancy and ends on the last day of the month in which the 60th day occurs.

INCOME DISREGARD PROGRAM - (185 PERCENT PROGRAM)/BERGESON BILL

For Pregnant Women and Infants under One Year Old

Eligibility for this program, which receives state and federal funding, requires pregnant women and infants to meet all other program eligibility criteria and have family incomes not in excess of 185% of the federal poverty level.

Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 60th day following delivery occurs.

Newborn babies are billed under the mother's id. The mother's restricted card (aid codes 44, 48, and 49) can be used to bill for medical services furnished to newborns during the month of delivery and the month following.

44 INCOME DISREGARD PROGRAM (PREGNANT) Pregnant (FFP) U.S Citizen/Permanent Resident Alien/PRUCOL Alien (Permanent Resident Under Color Of Law) -- Provides family planning, pregnancy-related, and postpartum services for any age female if family income is at or below 185% of federal poverty level. Pregnancy-related services only. No FFP for routine prenatal care.

The Income Disregard program provides pregnancy-related services, including services for conditions that complicate pregnancy, to otherwise eligible pregnant women who are either:

(1) U.S. citizens,

(2) lawfully admitted for permanent residence,

(3) PRUCOL, or

(4) conditional residents.

Coverage may begin no earlier than the first day of the month for which pregnancy is known. (7)

47 INCOME DISREGARD PROGRAM (INFANT) Infant (FFP) U. S. Citizen/Permanent Resident Alien/ PRUCOL Alien (Permanent Resident Under Color Of Law) -- Provides full Medi-Cal benefits to infants up to age one and beyond one year, when inpatient status, began before first birthday, continues and family income is at or below 185% of either be:

(1) U.S. citizens,

(2) lawfully admitted for permanent residence,

(3) PRUCOL, or

(4) conditional residents.

48 INCOME DISREGARD PROGRAM (PREGNANT) Pregnant - Undocumented/Nonimmigrant Alien (But Otherwise Eligible) -- Provides family planning, pregnancy-related, and postpartum services for any age female if family income is at or below 185% of federal poverty level. Routine prenatal care s non-FFP. Labor, delivery, and emergency prenatal care are FFP. The period of coverage and scope of benefits are the same as aid code 44.(7)

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7 Pregnant women under 185% will remain in the 185% aid code during the 60-day Postpartum period, unless their income exceeds 185%. If their income exceeds 185%, their aid code should be 76, under the regular 60-day Postpartum Program.

49 INCOME DISREGARD PROGRAM (PREGNANT) Pregnant – Amnesty Alien -- Provides family planning, pregnancy related, and postpartum services for any age female if family income is at or below 185% of federal poverty level. (50% Title XIX and 50% SLIAG.) Immigration Reform and Control Act of 1986 (IRCA) provided for a State Legalization Impact Assistance Grant (SLIAG) to reimburse state costs for providing benefits to aliens applying for or granted amnesty, Special Agricultural Worker (SAWs) status, or Replenishment Agricultural Worker (RAWs)status.(7)

69 INCOME DISREGARD PROGRAM (INFANT) Infant (FFP) -Undocumented/Nonimmigrant Alien (But Otherwise Eligible) -- Provides emergency services only for infants under one year of age and beyond one year when inpatient status began before first birthday, continues and family income is at or below 185% of federal poverty level. The eligibility message will read: "Valid for Emergency Svs Only." Eligibility worker alerts will be sent to county welfare departments beginning at 11 months of age and ongoing until record is terminated or changed to a different category.

ASSET WAIVER PROGRAM - 200 PERCENT PROGRAM

The program was established by emergency legislation with an effective date of October 1, 1989. This program was funded with Proposition 99 (anti-smoking) money originally.

Eligibility for this program, which receives only state funding, requires pregnant women and infants to meet all other program eligibility criteria and have family incomes not in excess of 200% of the federal poverty level.

Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postnatally to the end of the month in which the 60th day following delivery occurs.

Newborn babies are billed under the mother's id. The mother's restricted card (aid codes 70 and 75) can be used to bill for medical services furnished to newborns during the month of delivery and the month following.

07 ASSET WAIVER PROGRAM (INFANT) **Infant-**Undocumented/Nonimmigrant Alien (But Otherwise Eligible) -- Provides emergency services only for infants up to age one year, and beyond one year when inpatient status began before first birthday, continues and family income is between 185% and 200% of the federal poverty level. The eligibility message will read: "Valid for Emergency Svs Only." No FFP.

70 ASSET WAIVER PROGRAM (PREGNANT) Pregnant U. S. Citizen/Permanent Resident Alien/ PRUCOL Alien (Permanent Resident Under Color Of Law) -- or Undocumented/Nonimmigrant Alien (But Otherwise Eligible) – Provides family planning, pregnancy-related, and postpartum services under the state only funded expansion of the Medi-Cal program for a pregnant woman having income between 185% and **200% of federal poverty level.**

75 ASSET WAIVER PROGRAM (PREGNANT) Pregnant Amnesty Alien-- Provides family planning, pregnancy related, and postpartum services under the state only funded expansion of the Medi-Cal program for a pregnant woman having income at or below 200% of federal poverty level.

79 ASSET WAIVER PROGRAM (INFANT) Infant-U.S. Citizen/Permanent Resident Alien/ PRUCOL/Alien -- Provides full Medi-Cal benefits to infants up to the age of 1 year, and beyond 1 year when inpatient status, which began before the first birthday, continues and family income is between 185% and 200% of the federal poverty level.

133 PERCENT PROGRAM--FOR CHILDREN FROM ONE TO SIX YEAR OLD

The Medi-Cal 133 Percent Program, mandated by the federal Omnibus Budget Reconciliation Act (OBRA) of 1989, provides, depending upon immigration status, full scope of Medi-Cal services or emergency services only to children from one to six years of age.

As of the June 1990 Month of Eligibility, the aid codes 72 and 74 will no longer be in the Medi-Cal Special Treatment Programs. See aid codes 71 and 73 under "BENEFICIARY AID CODES (MEDI-CAL SPECIAL TREATMENT)"

The child with aid code 72 or 74 who is an inpatient receiving medical services during a continuous period which began before and continues beyond his or her sixth birthday will continue to be eligible until the end of the continuous stay.

NOTE: 133 Percent program recipients are not covered under Medi-Cal County Health Systems or other prepaid health care contracts. All claims for these recipients must be submitted to EDS, the Fiscal Intermediary.

72 CHILD - 133% **Child-U. S. Citizen, Permanent Resident Alien/PRUCOL Alien (FFP)** -- The 133Percent Program provides full scope benefits to children who have obtained age one but not age six whose family income does not exceed 133 percent of the federal poverty level and who are either: (1) U.S. citizens, (2) lawfully admitted for permanent residence, (3) PRUCOL (Permanent Resident Under Color Of Law),or (4) conditional residents. Coverage for the child shall end upon attainment of his/her sixth birthday.

74 CHILD - 133% **Child - Undocumented/Nonimmigrant Alien(But Otherwise Eligible) (FFP)** – The 133 Percent Program provides emergency services to children who have obtained age one but not age six whose family income does not exceed 133 percent of the federal poverty level and who are either: (1) undocumented status, or (2)temporary visa. The period of coverage is the same as aid code 72. SB 903 and AB217 amended Section 14148.75 of the Welfare and Institutions Code to disregard the property of children in the 100 and 133 Percent Programs. Effective March 1, 1998, a resource determination will no longer be required for children applying for Medi-Cal if the family income is at or below 133 percent of

the federal poverty level (FPL) for children ages one to six, or at or below 100 percent of FPL for children ages six to nineteen.

DHS is planning to implement a simplified application form that will be used for children applying for Medi-Cal and the Healthy Families Program. Although no extensive property questions will be asked, there will be a few questions which eligibility workers will use to identify those children who will be presumed to be property ineligible unless the property disregard provision is applied. This application will be in use as of July 1, 1998.

8N CHILD - 133% - EMERGENCY SERVICES/PROPERTY DISREGARD,NO SOC Aid code 8N will be assigned to children who would have qualified The for existing aid code 74 except that they have excess resources. This code covers children from age 1 up to age 6. Children in aid code 8N will be eligible for emergency services only with no share of cost. The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY SERVICES WITH NO SHARE OF COST. "This code became active December 1, 1998.

8P CHILD -133% - FULL SCOPE OF COVERAGE/PROPERTY DISREGARD, NO SOC Aid code 8P will be assigned to children who would have qualified The for existing aid code 72 except that they have excess resources. This code covers children from age 1 up to age 6. Children in aid code 8P will be eligible for full-scope MediCal benefits with no share of cost. This aid code is valid for the Local Education Agency Medi-Cal Billing Option program. It is also valid for Child Health Disability Prevention (CHDP) Program. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This code became active December 1, 1998.

100 PERCENT PROGRAM--FOR CHILDREN BORN AFTER SEPTEMBER 30, 1983 AND AT LEAST SIX YEARS OLD

Beginning November 1, 1991, and retroactive to July 1, 1991,Medi-Cal eligibility will be extended on a phase-in basis to children born after September 30, 1983, and who are at least six years old. Children in this program will remain eligible through 18 years of age.

The oldest child eligible for this program was born October 1, 1983. A child born on or before September 30, 1983 is not eligible.

The child with aid code 7A or 7C who is an inpatient receiving medical services during a continuous period which began before and continues beyond his or her 19th birthday will continue to be eligible until the end of the continuous stay.

NOTE: 100 Percent program recipients are not covered under Medi-Cal County Health Systems or other prepaid health care contracts. All claims for these recipients must be submitted to EDS, the Fiscal Intermediary.

7A CHILD - 100% Child Born After September 30, 1983 -age 6 to 19 (full scope) (FFP) – The 100 Percent Program provides full-scope benefits to children who have obtained age six but not age 19 whose family income does not exceed 100 percent of the federal poverty level and who are either:(1) U.S. citizens, (2) lawfully admitted for permanent residence, (3)PRUCOL (Permanent Resident Under Color Of Law), or (4) conditional residents. Coverage for the child shall end upon attainment of his/her 19th birthday.

7C CHILD - 100% Child Born After September 30, 1983 age 6 to 19 (Restricted scope) – The 100 Percent Program provides restricted benefits to children who have obtained age six but not age 19 whose family income does not exceed 100 percent of the federal poverty level. Coverage for the child shall end upon attainment of his/her 19th birthday. For aid code 7C recipients limited to emergency services, the following services are covered when ordered by the primary provider: pharmacy, radiology, laboratory, dialysis, dialysis-related and kidney transplants.

SB 903 and AB217 amended Section 14148.75 of the Welfare and Institutions Code to disregard the property of children in the 100 and 133 Percent Programs. Effective March 1, 1998, a resource determination will no longer be required for children applying for Medi-Cal if the family income is at or below 133 percent of the federal poverty level (FPL) for children ages one to six, or at or below 100 percent of FPL for children ages six to nineteen.

DHS is planning to implement a simplified application form that will be used for children applying for Medi-Cal and the Healthy Families Program. Although no extensive property questions will be asked, there will be a few questions which eligibility workers will use to identify those children who will be presumed to be property ineligible unless the property disregard provision is applied. This application will be in use as of July 1, 1998.

8R CHILD - 100% - FULL SCOPE OF COVERAGE/PROPERTY DISREGARD, NO SOC Aid code 8R will be assigned to children who would have qualified The for existing aid code 7A except that they have excess resources. This code covers children from age 6 up 19. Children in aid code 8R will be eligible for full-scope Medi-Cal benefits with no share of cost. This aid code is valid for the Local Education Agency Medi-Cal Billing Option program. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This code became active December 1, 1998.

8T CHILD -100% - EMERGENCY SERVICES/PROPERTY DISREGARD, NO SOC Aid code 8T will be assigned to children who would have qualified The for existing aid code 7C except that they have excess resources. This code covers children from age 6 up 19. Children in aid code 8T will be eligible for emergency services and pregnancy related services only with no share of cost. It is valid for Child Health Disability Prevention (CHDP) Program. The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY AND PREGNANCY RELATED SERVICES WITH NO SHARE OF COST." This code became active December 1,1998.

QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM

The Qualified Medicare Beneficiary (QMB) Program is a Medi-Cal program for certain Medicare beneficiaries who have limited income and resources. Under this program, Medi-Cal pays for Medicare Part A and B premiums. Medi-Cal payments for Medicare coinsurance and deductibles (i.e. Medicare cost sharing expenses) are issued within Medi-Cal guidelines.

80 QUALIFIED MEDICARE BENEFICIARY (QMB) Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind or disabled individuals. (See Section 50258,Title 22, CCR (FFP).)Aid code 80 went into effect January 1, 1990.

8A QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI) Qualified Disabled Working Individual (QDWI) (FFP)-- Provides state paid Medicare Part A premiums for working individuals under the age of 65. No Medi-Cal card will be issued; the Medicare card will be used for services.

8C SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB) Specified Low-Income Medicare Beneficiaries (SLMB)(FFP) -- Provides state paid Medicare Part B premiums for certain specified low-income Medicare beneficiaries. No Medi-Cal card will be issued; the Medicare card will be issued for Part B services.

Aid code 8C became effective December,1994.

8G QUALIFIED SEVERLY IMPAIRED WORKING INDIVIDUAL PROGRAM.NO SOC. Qualified Severely Disabled Working Individual -- Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.

Aid code 8G became effective December, 1996.

QUALIFIED INDIVIDUAL (QI) PROGRAM

The Qualified Individual Programs is a Medi-Cal program for certain Medicare beneficiaries who have limited income and resources. There are two programs, QI-1 and QI-2, but they are collectively referred to as the QI program. This build on the QMB and SLMB programs. Under QI-1 program, Medi-Cal pays for Medicare Part B premium, while the QI-2 program reimburses once a year a portion of all Medicare Part B premiums which an individual paid during months in the prior year when he/she was eligible as a QI-2. There may or may not be a share of cost.

General things are listed below. For more detail, please contact the Medi-Cal Eligibility Branch.

When a person applies for the QI program, it must first be determined that she/he is ineligible for the QMB or SLMB programs. It doesn't matter whether the individual completed form MC 210 or MC14A. Apart from the income standard, the eligibility determination follows the methodologies of the QMB/SLMB program. Applicants must meet the usual requirements such as California residency and eligibility for Medicare. As in the QMB/SLMB programs, those eligible for only emergency and pregnancy related services are not eligible for the QI program.

Income Standards:

1. QMB:If the otherwise eligible individual's net nonexempt income is equal to or less than 100 percent of the Federal Poverty Level (FPL), the individual is eligible under the QMB program.

2. SLMB:If the otherwise eligible individual's net nonexempt income is above 100 percent of the FPL but is less than 120 percent of FPL, the individual is eligible under the SLMB program.

3. QI-1:If the otherwise eligible individual's net nonexempt income is above 120 percent of the FPL but is less than 135 percent of FPL, the individual is eligible under the QI-1 program.

3. QI-2:If the otherwise eligible individual's net nonexempt income is above 135 percent of the FPL but is less than 175 percent of FPL, the individual is eligible under the QI-2 program.

Property limits are the same as for the QMB/SLMB programs. The property limit is $4,000 for a single individual and $6,000 for a couple.

8D QUALIFIED INDIVIDUAL-135% (QI-1) Under QI-1 program, Medi-Cal pays for Medicare Part B premium. The individual's net nonexempt income is above 120 percent of the Federal Poverty Level but is less than 135 percent of FPL, the individual is eligible under the QI-1 program. There may or may not be a share of cost. Aid code 8D went into effect December 1, 1998.

8K QUALIFIED INDIVIDUAL-175% (QI-2) Under QI-2 program, the Medi-Cal program reimburses once a year a portion of all Medicare Part B premiums which an individual paid during months in the prior year when he/she was eligible as a QI-2. There may or may not be a share of cost. The individual's net nonexempt income is above 135 percent of the Federal Poverty Level but is less than 175 percent of FPL, the individual is eligible under the QI-2 program. Aid code 8K went into effect December 1, 1998.

B.1.8 MEDICALLY NEEDY-SOC

Some Medically Needy (MN) recipients must meet a specified Share of Cost (SOC) for medical expenses before they can be certified for Medi-Cal benefits.

A share of cost is like a deductible. It is the amount the recipient must pay or agree to pay each month for health care services and prescription drugs. Once the recipient has paid or promised to pay that amount, Medi-Cal will pay the rest of the recipient's medical costs for the month. The share of cost is determined by subtracting a "maintenance need" amount from the recipient's income. The maintenance need amount is the amount of the recipient's income kept to pay for non-medical expenses -- food, clothing, housing, etc.

For those recipients receiving paper Medi-Cal cards, Share of Cost must be met before Medi-Cal will pay. In effect, Medi-Cal ID cards are not issued until these recipients prove their stipulated medical SOC has been paid or obligated. Form MC-177-SA-M, Record of Health Care Costs, is issued to MN recipients to provide this proof. SOC and this form also applies to CMSP recipients. Once the recipient has met his or her SOC, a Medi-Cal ID card showing the certification date will be issued by the Department of Health Services. Share of Cost recipients with certified ID cards are entitled to full Medi-Cal benefits. Starting on March 1, 1994 some recipients will begin using plastic Medi-Cal Beneficiary Identification Cards (BICs). To determine if a recipient with a plastic BIC has a Share of Cost, and to clear a Share of Cost Liability, the providers must use the Automated Eligibility Verification System (AEVS), or a Point of Service (POS) device, or a PC with Claims and Eligibility Real-Time System (CERTS) software and a modem installed, or a vendor supplied software.

For the BIC holders to meet the share of cost and to turn on the plastic Medi-Cal card, the recipient must take the card to the medical provider who will use it to get Medi-Cal information about how much share of cost is owed. As the recipient pays or promises to pay the share of cost, the provider will report that information to Health Services. Once the amount paid equals the share of cost amount, the providers will be told that the recipient is eligible for Medi-Cal for the rest of the month.

17 AGED-MN-SOC Aid to the Aged-Medically Needy, Share of Cost (FFP) -- See Aid Code 14 under "BENEFICIARY AID CODES (MEDICALLY NEEDY, NO SHARE OF COST)" for definition of AGED-MN. Share of cost is required of the beneficiaries.

27 BLIND-MN-SOC Aid to the Blind-Medically Needy, Share of Cost (FFP) -- See Aid Code 24 under "BENEFICIARY AID CODES (MEDICALLY NEEDY,NO SHARE OF COST)"for definition of BLIND-MN. Share of cost is required of the beneficiaries.

37 AFDC-MN-SOC Aid to Families with Dependent Children-Medically Needy, Share of Cost (FFP) -- See aid code 34 under "BENEFICIARY AID CODES (MEDICALLY NEEDY, NO SHARE OF COST)" for definition of AFDC. Share of cost is required of the beneficiaries.

65 DISABLED-SGA/ABD-MN (IHSS)-SOC Aid to Disabled Substantial Gainful Activity/Aged, Blind Disabled-Medically Needy (In-Home Supportive Services)-Share of Cost (Non-FFP)-SOC -- Share of cost is required of the beneficiaries; however, this aid code may also be no share of cost. See Aid Code 65 under "BENEFICIARY AID CODES (MEDICALLY NEEDY, NO SHARE OF COST)" for definition of disabled-SGA/ABD-MN.

67 DISABLED-MN-SOC Aid to the Disabled-Medically Needy, Share of Cost (FFP) -- See Aid Code 64 under "BENEFICIARY AID CODES (MEDICALLY NEEDY, NO SHARE OF COST)" for definition of disabled-SGA/ABD-MN. Share of cost is required of the beneficiaries.

6W AID TO THE DISABLED - DDS WAIVER This code will identify recipients currently receiving benefits under aid code 64 or 82 who qualify for Department of Developmental Services (DDS) waivers. These waivers are for persons who need more or special medical services because they wish to live in the home or community rather than be institutionalized. There are no age limitations for this new aid code and recipients will not be required to participate in managed care plans. Recipients covered by aid code 6W will receive full-scope Medi-Cal benefits and may or may not have SOC. The eligibility message can read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." or "MEDI-CAL RECIPIENT HAS A SHARE OF COST OF DOLLARS." This aid code is effective March 1, 1998.

6R SB 87 PENDING DISABILITY Senate Bill (SB) 87 Pending Disability Program (FFP). This program requires that when non-disability linkage to Medi-Cal is lost and the client claims disability, Medi-Cal coverage must continue uninterrupted during the re-determination period. This program establishes full scope Medi-Cal benefits for recipients aged 21 to 65. Not valid for Local Education Agency or CHDP billing. A share of cost is required of the beneficiaries. The eligibility message will read: "MEDI-CAL RECIPIENT HAS A SHARE OF COST OF DOLLARS." This aid code is effective August 1, 2001. This code is being redefined from 6R Continuation of Medicaid for No Longer Disabled Children-Appeal Status. It was never activated.

B.1.9 MEDICALLY NEEDY-LTC

NOTE: These aid codes should be used for all individuals whose eligibility is determined in accordance with Sections 50203 and 50605, Title 22, CCR, regardless of whether or not there is share of cost involvement.

Long Term Care (LTC) is inpatient medical care that lasts for more than the month of admission and is expected to last for at least one full calendar month after the month of admission. However, LTC includes a disabled or presumptively disabled premature newborn who is born in a facility and remains an inpatient for the remainder of the month beginning with the month of birth rather than in the following month.

13 AGED-LTC Aid to the Aged-Long-Term Care Status(FFP) -- Persons 65 of age or older who are medically needy and in long-term care status.

23 BLIND-LTC Aid to the Blind-Long-Term Care Status (FFP) -- Persons who meet the federal criteria for blindness, are medically needy, and are in long-term care status.

55 UNDOCUMENTED ALIENS-LTC Aid to Undocumented Aliens in LTC not Permanently Residing Under Color of Law (PRUCOL) -- LTC services: State-only funds; Emergency and pregnancy related services: State and federal funds. Beneficiaries will remain in this aid code even if they leave LTC. Restricted services: LTC services (no FFP); Pregnancy-related or emergency services (no FFP for routine prenatal care).

63 DISABLED-LTC Aid to the Disabled-Long-Term Care Status (FFP) -- Persons who meet the federal criteria for disability, are medically need, and are in long-term care status.

B.1.9 MEDICALLY INDIGENT

04 AAP/AAC-NON-FEDERAL Adoption Assistance Program/Aid for Adoption of Children (non-FFP) With or Without a Cash Grant -- See Aid Code 03 for definition of AAP under "BENEFICIARY AID CODES (CASH GRANT-PUBLIC ASSISTANCE)". The Aid for Adoption of Children cases are eligible for financial assistance through the Adoption Assistance Program, providing an Aid for the Adoption of Children Agreement was executed prior to October1, 1982. (See Section 30674, Division 2, Title 22, CCR.)

45 CHILDREN SUPPORTED BY PUBLIC FUNDS Children Supported in Whole or in Part by Public Funds(FFP) -- Children whose needs are met in whole or in part by public funds other than AFDC-FC. No share of cost. See Aid Codes 40 and 42 under "BENEFICIARY AID CODES (CASH GRANT-PUBLIC ASSISTANCE)" (See Section 50251, Title 22, CCR and Medi-Cal Procedures Manual 8C.)

4K EMERGENCY ASSISTANCE (EA) FOR PROBATION CASES Probation Cases as a result of Emergency Assistance Foster Care Placement (50% FFP) -- Persons must be under the age of 21 who are placed in foster care due to probation. The EA program includes juvenile assessment centers,

residential treatment facilities, EA foster care for wards and after care. The EA services are available for eligible families for a period of six months, or until the emergency is over, whichever is less.

5K EMERGENCY ASSISTANCE (EA) FOR CHILD WELFARE SERVICES Child Welfare Service Cases Placed in Emergency Assistance Foster Care (50%FFP) -- Persons must be under the age of 21 who are placed in foster care. The EA program includes shelter care and EA foster care for dependents and voluntary placements. The EA services are available for eligible families for a period of six months, or until the emergency is over, whichever is less.

81 MI-ADULTS AID PAID PENDING Medically Indigent (MI)Adult-Aid Paid Pending (APP) for persons over 21 but under 65, with or without Share of Cost (SOC)(Non-FFP).

@ **82 MI-PERSON Medically Indigent Person Under 21-No Share of Cost (FFP)** -- Persons under 21 years of age (married or not married) who meet the eligibility requirements of medically indigent. No share of cost required of beneficiaries. (See Section 50251, Title 22, CCR.)(8) As of August 1, 1995 covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.

@ **83 MI-PERSON-SOC Medically Indigent Person Under 21-Share of Cost (FFP)** -- Persons under 21 who meet the eligibility requirements of medically indigent. Share of cost is required of beneficiaries. (See Section 50251, Title 22, CCR.)(8)

86 MI-PREGNANT Medically Indigent-Confirmed Pregnancy-21 Years or Older-No Share of Cost (FFP) -- Persons age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent. No share of cost required of beneficiaries. (See Section 50251, Title 22, CCR.)

87 MI-PREGNANT-SOC Medically Indigent-Confirmed Pregnancy-21 Years or Older-Share of cost (FFP) -- Persons age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for the 185%/200% programs or the Medically Needy programs. (See Section 50251, Title 22, CCR.)

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8 @ These aid codes can be used for a person under 21 years of age in long-term care (LTC) status. However, an LTC indicator CANNOT be used with Aid Code 82 on the Medi-Cal Eligibility System (MEDS). An indicator CAN be used with Aid Code 83 but should not be used when the individual must meet a share of cost using the MC 177 process.

B.1.10 MEDICALLY INDIGENT-LONG TERM CARE

53 MI-LTC-STATE ONLY Medically Indigent-Long Term Care-Age 21 or Older and Under 65 Years-With or Without a Share of Cost (Non-FFP) --Persons over 21 and under 65 years of age who are residing in a skilled nursing facility (SNF) or an intermediate care facility (ICF) and meet all other eligibility requirements of medically indigent, with or without a Share of Cost. Limited to LTC Services only.(See Section 50251, Title 22, CCR and Medi-Cal Eligibility Procedures Manual 19C.) STATE-ONLY. NO FFP.

B.1.11 REFUGEE/ENTRANT MEDICAL ASSISTANCE -100 % FEDERAL FUNDS

02 RMA-EMA (NO SOC) Refugee Medical Assistance/Entrant Medical Assistance -- Refugees and entrants who are not otherwise eligible for Medi-Cal under federally funded AFDC, SSI/SSP, MN, or Medically Indigent Child Programs may be eligible for Medi-Cal through the special federal programs of Refugee Medical Assistance (RMA) or Entrant Medical Assistance (EMA) for 8 months. Also covers up to four months of transitional RMA/EMA. FFP is available under the Refugee Resettlement program or

Cuban/Haitian Entrant Program, not Title XIX. Share of Cost may be required. See Section 50527, TITLE 22, CCR.) No FFP for age 21+.

B.1.12 MEDI-CAL SPECIAL TREATMENT

As of the June 1990 Month of Eligibility, there will only be aid codes 71 and 73 in the Medi-Cal Special Treatment Pro grams. Aid code 72 (Medi-Cal Dialysis Supplement Program) were added to aid code 71 (Medi-Cal Dialysis Only Program) and aid code 74 (Medi-Cal TPN Supplement Program) were added to aid code 73 (Medi-Cal TPN Only Program). This decision was based on statistics that indicate a very small number of beneficiaries in aid codes 72 and 74. The services provided for these two aid codes are virtually the same, the cards are identical limited service cards, and all services are non-FFP.(9)

71 DP/DSP Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (non-FFP) -- Persons of any age who are eligible only for dialysis and related services and person of any age who are eligible under the Medically Needy or Medically Indigent Programs and who also meet the specific eligibility requirements contained in Section 50264, Title 22, CCR and Article 17 of the Medi-Cal Eligibility Procedures Manual.

73 TPN/TPN SUPPLEMENT (TOTAL PARENTERAL NUTRITION) MediCal TPN Only Program/Medical TPN Supplement Program (non-FFP) -- Persons of any age who are eligible for parental hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs and who also meet the requirements contained in Section 50264,Title 22, CCR and Article 17 of the Medi-Cal Eligibility Procedures Manual.
No FFP.

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9 Restricted Medi-Cal card(s) are issued for these aid codes.

B.1.13 OBRA/IRCA WITH OR WITHOUT SHARE OF COST

Restricted or full-scope Medi-Cal benefits are extended to previously ineligible aliens, effective on or after October 1, 1988. This program was mandated by the Federal Omnibus Budget Reconciliation Act of 1986 (OBRA) and the Immigration Reform and Control Act of 1986 (IRCA). IRCA created a legalization program under the status of certain aliens unlawfully residing in the United State may be adjusted over time to permanent resident status. In granting these aliens amnesty, the law specifies that their participation in certain assistance programs be restricted to five years. OBRA applies to other aliens such as undocumented aliens and temporary visitors. (Also see poverty level program under "BENEFICIARY AID CODES (POVERTY LEVEL PROGRAMS - NO SHARE OF COST)"

Starting in fall of 1998, the name "OBRA undocumented Alien' terminology is being moved away from and there is new Federal terminology, which is "not qualified alien". These aliens are ineligible for Medicaid because they do not meet the citizenship or immigrant status requirements but would otherwise be eligible. In this case, the Feds allow Federal Financial Participation only for emergency services.

NOTE: For "not qualified aliens", there is no FFP for non-emergency routine prenatal and postpartum care defined as HCPCS codes Z1032-Z1038, Z6200-Z6210, Z6300-Z6308, Z6400-Z6414, and Z6500.

& 51 PRE-1982 AMNESTY ALIENS: FULL BENEFITS IRCA Aliens -Full Medi-Cal benefits (50% Title XIX FFP, 50% SLIAG funds) -- The Immigration Reform and Control Act of 1986 (IRCA)provides for State Legalization Impact Assistance Grant (SLIAG) to reimburse 50% of state costs for providing benefits to otherwise eligible amnesty aliens (pre-1982 legalization), who are ABD (Aged, Blind or Disabled) or children under 18.

& 52 PRE-1982 AMNESTY ALIENS: RESTRICTED BENEFITS IRCAAliens-Restricted Medi-Cal Services (50% Title XIX FFP, 50% SLIAG funds) -- IRCA provides for emergency and pregnancy-related Medi-Cal benefits to eligible amnesty aliens (pre-1982 legalization), who are not ABD (Aged, Blind or Disabled) or children under 18.

& 56 AMNESTY AGRICULTURAL WORKERS (SAWS AND RAWS):FULLBENEFITS IRCA Aliens - Full Medi-Cal benefits (50% Title XIX FFP, 50% SLIAG funds) -- IRCA provides for State Legalization Impact Assistance Grant(SLIAG) to reimburse 50% of state costs for providing benefits to Medi-Cal services to eligible Special Agricultural Workers (SAWs) or Replenishment Agricultural Worker (RAWs) (if addition workers are required). This aid code applies to aliens granted amnesty under IRCA who are Aged, Blind, Disabled (ABD)or children under 18.

& 57 AMNESTY AGRICULTURAL WORKERS (SAWS AND RAWS):RESTRICTED BENEFITS IRCA Aliens - Restricted Medi-Cal Benefits (50% Title XIX FFP, 50% SLIAG funds) -- IRCA provides for State Legalization Impact Assistance Grant (SLIAG) to reimburse 50% of state costs for providing emergency for eligible Special Agricultural Worker (SAW) or Replenishment Agricultural Worker (RAW) aliens who are not Aged, Blind, Disabled (ABD) or children under 18.

58 OBRA ALIENS: RESTRICTED BENEFITS Undocumented and Non immigrant Aliens - Restricted Medi-Cal benefits (50% Title XIX FFP for emergency services, 100% State General Fund for Pregnancy-Related Services) -- OBRA of 1986 allows emergency services including emergency labor and delivery, and dialysis services to Medi-Cal eligible undocumented and nonimmigrant aliens. These aliens are also eligible for state-only non-emergency pregnancy-related services. (Only one card is issued.) No FFP for routine prenatal care.

5F OBRA ALIENS:RESTRICTED TO PREGNANCY AND EMERGENCY SERVICES Covers undocumented and non immigrant aliens who do not have proof of permanent resident alien, PRUCOL, or amnesty alien status, but who are otherwise eligible for Medi-Cal. This code was developed to identify OBRA alien pregnant women who were formerly identified by aid code 58. This aid code is effective October 1, 1994. As with aid code 58, recipients with code 5F (undocumented aliens and certain temporary visitor aliens) are eligible for emergency and pregnancy-related services only. They may or may not have a Share of Cost. If they meet certain requirements, aid code 5F recipients who have an SOC may also receive zero-SOC pregnancy-related services, including labor, delivery, and 60-day postpartum services, under aid code 48 (Income Disregard Program). No FFP for routine prenatal care.

5G OBRA UNDOCUMENTED ALIENS/NONIMMIGRANT ALIENS-EMERGENCY SERVICES ONLY Covers undocumented and non-immigrant aliens who are not qualified aliens, nonimmigrant aliens under INA, or aliens paroled into the United States for less than a year under Section 212 (d) (5) of the INA (formerly under Aid Code 58)--Emergency services only (including emergency labor and delivery).

5H INCOME DISREGARD PROGRAM AND ASSET WAIVER PROVISION (PREGNANT) Pregnant OBRA Undocumented/Nonimmigrant Aliens who are not qualified aliens, nonimmigrant aliens under INA, or aliens paroled into the United States for less than a year under Section 212 (d) (5) of the INA (formerly under Aid Code 48)—Emergency services only (including emergency labor and delivery).

5M OBRA NON-IMMIGRANT/UNDOCUMENTED PREGNANT WOMEN (FORMERLY 7CS) Pregnant OBRAUndocumented/Non-immigrant Aliens who are eligible for restricted scope MediCal benefits (emergency care, including labor and delivery) without a share of cost. State-only funded immunizations with respect to immunizable diseases and testing and treatment of symptoms of communicable diseases, whether or not the symptoms are caused by a communicable disease, will continue to be covered benefits under Medi-Cal as a non-emergency visit when there is a primary diagnosis of pregnancy. coverage begins following a diagnosis of pregnancy through the 60-day postpartum period. New aid code 5M does not include any other state-only funded non-emergency pregnancy-related services. Global pregnancy billing will not be permitted. The eligibility messages will

read: "MEDI-CAL ELIGIBLE FOR EMERGENCY SERVICES WITH NO SHARE OF COST. "or "MEDI-CAL ELIGIBLE FOR EMERGENCY SERVICES WITH A SHARE OF COST of DOLLARS."

5N OBRA NON-IMMIGRANT/UNDOCUMENTED PREGNANT WOMEN (FORMERLY 5FS) Pregnant OBRA Undocumented/Non-immigrant Aliens who are eligible for restricted scope Medi-Cal benefits (emergency care, including labor and delivery) without a share of cost. State-only funded immunizations with respect to immunizable diseases and testing and treatment of symptoms of communicable diseases, whether or not the symptoms are caused by a communicable disease, will continue to be covered benefits under Medi-Cal as a non-emergency visit when there is a primary diagnosis of pregnancy. Coverage begins following a diagnosis of pregnancy through the 60-day postpartum period. New aid code 5N does not include any other state-only funded non-emergency pregnancy-related services. Global pregnancy billing will not be permitted. The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY SERVICES WITH NO SHARE OF COST."

NOTE: & This aid code expired December 31, 1994.

B.1.14 COUNTY MEDICAL SERVICES PROGRAM(CMSP)

NOTE: These aid codes are used by those counties that have exercised their option of contracting back with the State Department of Health Services for CMSP administrative services. In addition, non-CMSP counties may use these aid codes to report food stamp issuance for their medically indigent population. The CMSP program went into effect on January 1, 1983 and transferred the responsibility of providing health care services to medically indigent adults (MIAs), age 21 through 64 years, residing within each county from Medi-Cal to the counties. Counties with a population of less than 300,000 have the option of contracting back with the State Department of Health Services. The CMSP annually negotiates contracts to care for MIAs who are eligible in the contract counties under aid codes 50, 84, 85, 88, 89 and 8F.

Benefits NOT covered under CMSP contract are pregnancy-related services, Long term Care, adult day health, chiropractic, psychology, acupuncture, non-emergency medical transportation and all services not covered by Medi-Cal.

THERE IS NO MEDI-CAL CARD ISSUED FOR THESE AID CODES. These aid codes will never be seen on the regular Paid Claims files. There is a separate CMSP Paid Claims files.

For more information, please see Section 50521, Title 22,
CCR.

+50 MI-RESTRICTED NO SOC Persons who have undetermined immigration status. Limited to emergency services only. Also used for out-of-county persons for emergency services only.

+84 MI-A NO SOC Medically Indigent-Adults-Age 21 and over but Under 65 years-No Share of Cost(NON-FFP) -- Persons, age 21 and under 65 years of age, who meet the eligibility requirements of medically indigent. No share of cost required of the beneficiaries.

+85 MI-A-SOC Medically Indigent-Adults-Age 21 and over but Under 65 years-Share of Cost(Non-FFP) -- Persons, age 21 and under65 years of age, who meet the eligibility requirements of medically indigent. Share of cost required of the beneficiaries.

+88 MI-A-DISABLED PENDING NO SOC Medically Indigent-Adults Age 21 and over but under 65 Years-Disability Pending (Non-FFP) -- Persons, age 21 and under 65 years of age, who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application. No share of cost required of the beneficiaries.

+89 MI-A-DISABLED PENDING SOC Medically Indigent-Adults Age 21 and over but under 65 Years-Disability Pending-Share of Cost -- Persons, age 21 and under 65 years of age, who meet the

who meet the eligibility requirements of medically indigent and have a pending Medi-Cal disability application. Share of cost is required of the beneficiaries.

+8F CMSP COMPANION AID CODE SOC/NO SOC Covers persons eligible for certain benefits under the Medi-Cal Program and other benefits under the CMSP. 8F is used in conjunction with Medi-Cal aid codes 52, 53, and 57 to facilitate the payment of claims for covered benefits. 8F will appear as a special aid code and will entitle the eligible client to full-scope CMSP coverage for those services not covered by Medi-Cal.

B.1.15 PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

In 1986 the federal government introduced several options for pregnant women including that of Presumptive Eligibility (PE). This option allows the qualified provider to make a determination of presumptive eligibility for outpatient prenatal care services based on preliminary income information. The pregnant woman would have to file a Medi-Cal or Aid to Families with Dependent Care (AFDC) application at the county by the end of the month following the month of her PE determination. She remains eligible for PE until a Medi-Cal Only or AFDC determination is made. If she does not file the Medi-Cal or AFDC application, her presumptive eligibility would continue until the end of the second month. See "DATA ELEMENT:SOCIAL SECURITY NUMBER" for claim information about PE processing.

7F PRESUMPTIVE ELIGIBILITY (PREGNANCY VERIFICATION) Presumptive Eligibility (PE) for Pregnant Women-Pregnancy Verification and Related Office Visit (FFP). This option allows the qualified provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. There ARE age limits for eligibility. The women must be of childbearing age. This aid code is identified as a FEDERAL Program for women whose income is at or below 200% Federal Poverty Level (FPL). 7F is for pregnancy test, initial visit, and services associated with the initial visit. Person place in 7F have pregnancy test results that are negative. The provider must report her eligibility to DHS in order to bill for the visit. The patient may apply for Medi-Cal at the County Welfare Department even if she is not eligible for PE. This aid code became effective November 1993 Month of Eligibility (MOE).

7G PRESUMPTIVE ELIGIBILITY (AMBULATORY PRENATAL CARE SERVICES) Presumptive Eligibility for Pregnant Women-Ambulatory Prenatal Care Services (FFP). This does not have a share of cost. This option allows the qualified provider to make a determination of PE for outpatient prenatal care services based on preliminary income information. The pregnant woman would have to file a Medi-Cal or AFCD application at the county by the end of the month following the month of her PE determination. She remains eligible for PE until a Medi-Cal Only or AFDC determination is made. If she does not file the Medi-Cal or AFCD application, her PE would continue until the end of the second month. This aid code is limited to one period of eligibility per pregnancy. This aid code is identified as a FEDERAL Program for women whose income is at or below 200% Federal Poverty Level (FPL). This aid code became effective November 1993 Month of Eligibility (MOE). Aid Code 7G does NOT cover full-scope Medi-Cal. VALID ONLY FOR AMBULATORY PRENATAL CARE SERVICES.

B.1.16 TUBERCULOSIS PROGRAM

7H TUBERCULOSIS PROGRAM NO SOC. Medi-Cal Tuberculosis (TB) Program. Covers individuals who are TB-infected for TB-related outpatient services only. The program went into effect October 1, 1994.

B.1.17 MINOR CONSENT SERVICES

When a minor turns 21 years of age, they are no longer eligible and must apply for full-scope Medi-Cal or be linked through some other category. Eligibility for minor consent is re-evaluated monthly. These aid codes are not subject to out-of-state nonfederal foster care rules and can be used for three-months of retroactive Medi-Cal eligibility. When a share of cost is applied to these aid codes it cannot be met by a long-term care claim. These aid codes became effective on August 25, 1997 after the September MEDS Renewal process.

It appears that MEDS had a problem with cases that had been set to use the new Minor Consent aid codes. At the same time the case is added with a pseudo SSN and the MC aid code the restricted service code is established. Unfortunately, this code was not being erased from the next month's restriction code field if the MC eligibility was not reestablished. Those codes kept rolling even when the person became age 21 or changed aid code. Before the MC aid codes were installed the counties could fix the restriction codes, but not after the MC aid codes were installed in MEDS. This problem was determined in September 1999.

A check was installed in MEDS to make sure that if the aid code was not a minor consent code, and the restricted service codes were for minor consent, then the restricted service codes were not moved to the next eligibility period. This was done in September 1999.

+7M MINOR CONSENT SERVICES AGED 12-20 WITHOUT COUNSELING Minor Consent Services (non-FFP), restricted to minors who are at least 12 years of age, limited to sexually transmitted diseases, drug and alcohol abuse, pregnancy and pregnancy-related, family planning, and sexual assault services. This aid code may have a share of cost (SCO). The eligibility message for 7M are: "Recipient limited to services related to sexually transmitted diseases, sexual assault services, drug and alcohol abuse, and family planning with no share of cost." or "Recipient limited to services related to sexually transmitted diseases, sexual assault services, drug and alcohol abuse, and family planning with a share of cost of dollars." THIS AID CODE IS NOT TO BE USED FOR OUTPATIENT MENTAL HEALTH SERVICES.

+7N MINOR CONSENT SERVICES FOR PREGANCY Minor Consent Services (FFP), for pregnant minors and limited to pregnancy, postpartum, and family planning. This aid code does not have a share of cost (SCO). The eligibility message for 7N is: "Recipient limited to services related to pregnancy, postpartum, and family planning with no share of cost (SCO)."

+7P MINOR CONSENT SERVICES AGED 12-20 WITH COUNSELING Minor Consent Services (non-FFP), restricted to minors who are at least 12 years of age, limited to sexually transmitted diseases, drug and alcohol abuse, pregnancy and pregnancy-related, family planning, and sexual assault services. AND OUTPATIENT MENTAL HEALTH TREATMENT AND COUNSELING. This aid code may have a share of cost (SCO). The eligibility message for 7P are: "Recipient limited to services related to sexually transmitted diseases, sexual assault services, drug and alcohol abuse, family planning, and outpatient mental health with no share of cost." or "Recipient limited to services related to sexually transmitted diseases, sexual assault services, drug and alcohol abuse, family planning, and outpatient mental health with a share of cost of dollars."

+7R MINOR CONSENT SERVICES UNDER AGE 12 Minor Consent Services (non-FFP), restricted to minors under age 12, pregnancy and pregnancy-related, family planning, and sexual assault services. THIS AID CODE IS NOT TO BE USED FOR OUTPATIENT MENTAL HEALTHS ERVICES OR DRUG AND ALCOHOL ABUSE. This aid code may have a share of cost (SCO). The eligibility message for 7R are: "Recipient limited to services related to family planning and sexual assault with no share of cost." Or "Recipient limited to services related to sexually family planning and sexual assault with a share of cost of dollars."

B.1.18 SERVICES ONLY - NO MEDI-CAL CARDS ISSUED

THERE IS NOT MEDI-CAL CARD ISSUED FOR THESE AID CODES.

These aid codes will never be seen on the Paid Claims files, except for 9A, which has its own 35-file made of just those claims for Breast Cancer Early Detection Program by EDS.

+11 AGED-SO (OPTIONAL) Aid to the Aged-Services Only --Persons age 65 years or older who do not receive a cash grant, but are receiving social services as income eligibles with or without regard to income.

+21 BLIND-SO (OPTIONAL) Aid to the Blind-Services Only --Persons who meet the federal criteria for blindness and do not receive a cash grant, but are receiving social services as income eligible with or without regard to income.

+31 AFDC-FG-SO (OPTIONAL) Aid to the Families with Dependent Children-Family Group-Services care placement without such assistance. See aid code 30 under "BENEFICIARY AID CODES (CASH GRANT-PUBLIC ASSISTANCE)" for the definition of AFDC-FG. Families who do not receive a cash grant, but are receiving social services as income eligible with or without regard to income.

+41 AFDC-FC-SO (OPTIONAL) Aid to the Families with Dependent Children-(Optional) Foster Care-Services Only -- Families in the Foster Care Program who do not receive a cash grant, but are receiving social services as income eligible with or without regard to income.

+61 DISABLED-SO (OPTIONAL) Aid to the Disabled-Services Only -- Persons who meet the federal criteria for disability who do not receive a cash grant, but are receiving social services as income eligible with or without regard to income.

9A BREAST CANCER EARLY DETECTION PROGRAM (BCEDP) The Breast Cancer Act of 1993, which levies a two-cent per pack tax on cigarettes, took effect January 1, 1994. Forty-five percent of the revenue is allocated to the University of California for breast cancer research, five percent to the Department of Health Services for expanded breast cancer surveillance within the California Cancer Registry, and 50 percent to the Department of Health Services for a statewide breast cancer screening and early detection program known as the Breast Cancer Early Detection Program (BCEDP). BCEDP services are reimbursable for dates of service on or after July 1, 1994. BCEDP offers benefits to uninsured and under insured women whose household income is at or below 200 percent of the Federal poverty level. The goal of BCEDP is to reduce the breast cancer mortality rate in this population of California women. In addition to offering screening and diagnostic services, the program is designed to facilitate annual recall of women with normal or benign breast conditions and provide follow-up services for women with possible or confirmed diagnoses of breast cancer. Please note that BCEDP and Medi-Cal are separate programs, but BCEDP is using the Medi-Cal billing process. The claims are extracted out and sent to DHS in a separate Paid Claims file. Women 40 years old or older are eligible for an annual screening consisting of a clinical breast exam. All women at least 50 years old may receive an annual screening mammogram. Women 40-49 with a history of breast cancer of a first-degree relative (mother, sister or daughter) who had breast cancer also qualify for an annual screening mammogram. Women 40 years old or older may obtain diagnostic services as necessary.

B.1.19 FOOD STAMPS ONLY-NO MEDI-CAL CARDS ISSUED

THERE IS NOT MEDI-CAL CARD ISSUED FOR THESE AID CODES. This aid code will never be seen on the Paid Claims files.

+09 F/S Food Stamp Program -- Participants are not public welfare recipients, but need a case number to receive food stamps.

B.1.20 PERSONAL RESPONSIBILITY & WORK OPPORTUNITY

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Public Law 104-93) established a new mandatory coverage group at Section 1931(b) of the Social Security Act (FFP). Section 1931 requires Medi-Cal be provided to low income families who meet the requirements of the Aid to Families with Dependant Children (AFDC) State Plan in effect on July 16, 1996.

3N MANDATORY COVERAGE Families treated as receiving AFDC(as in effect on July 16, 1996) that would become ineligible for such assistance solely because of earnings, hours of employment, or loss of earned income disregards are entitled to up to 12 months of exten2ed benefits. Recipients covered by aid code 3N will receive full scope Medi-Cal benefits with no share of cost. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITHNO SHARE OF COST." This aid code should be effective January 1, 1998.

NO LONGER DISABLED CHILDREN (PRWORA/NLDC) PROGRAM

All these aid codes are valid for the Local Education Agency (LEA) Medi-Cal Billing Option program and the Child Health Disability Prevention (CHDP) program - inclusive for baby on mom's ID.

6P CONTINUATION OF MEDICAID FOR NO LONGER DISABLED CHILDREN Medi-Cal Policy Division has requested the implementation of new aid code 6P. This new aid code is required in order to comply with Section 4913 of the Balanced Budget Act of 1997: Continuation of Medicaid for No Longer Disabled Children. These are children under age 18 who lost Supplemental Security July 1, 1997 due to the Personal Responsibility and Work Opportunity Reconciliation Act which provides stricter definition of disability for children. Recipients covered by aid code 6P will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code is effective March 1, 1998.

6N CONTINUATION OF MEDICAID FOR NO LONGER DISABLED CHILDREN OFF SSI-APPEAL This code is being added to identify all other former SSI disabled recipients (adults and children not in aid code 6R) who are appealing their cessation of SSI disability and who are currently in aid code 64. Recipients covered by aid code 6P will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code is effective March 1, 1998.

CALWORKS LEGAL IMMIGRANT CODES

All these aid codes are valid for the Local Education Agency (LEA) Medi-Cal Billing Option program and the Child Health Disability Prevention (CHDP) program - inclusive for baby on mom's ID.

3E CALWORKS LEGAL IMMIGRANT - FG Recipients in the Family Group covered by this code will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code should be effective March 1, 1998.

3L CALWORKS LEGAL IMMIGRANT - FG (NO SOC) Recipients in the Family Group covered by this code will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code should be effective March 1, 1998.

3M CALWORKS LEGAL IMMIGRANT - U (NO SOC) Recipients who have a Unemployed parent who are covered by this code will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read:

"RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code should be effective March 1, 1998.

3U CALWORKS LEGAL IMMIGRANT - U (NO SOC) Recipients who have a Unemployed parent who are covered by this code will receive full scope Medi-Cal benefits with no share of cost. There will not be three months retroactive Medi-Cal eligibility for this aid code. The eligibility message will read: "RECIPIENT MEDI-CAL ELIGIBLE WITH NO SHARE OF COST." This aid code should be effective March 1, 1998.

B.1.21 HEALTHY FAMILIES PROGRAM

On October 2, 1997 Governor Wilson signed new legislation (AB 217, AB 1126, AB 1572 and SB 903) which created the Healthy Family (HF) Program, a comprehensive subsidized private health insurance program for uninsured children up to 200 percent of the federal poverty level. This new program will be administered by the Managed Risk Medical Insurance Board (MRMIB). Governor Wilson also proposed several changes to existing programs to complement HF. HF will use federal funds (65 percent) and state funds (35 percent) to cover up to 580,000 uninsured children of lower income working Californians who are ineligible for Medi-Cal. The program will be contracting with health care plans to provide comprehensive medical, dental, and vision services to enrolled children. EDS will do the claims processing. Implementation was July 1, 1998 and there was no retroactive eligibility.

9H HEALTHY FAMILIES To qualify for participation, families will need to meet the following basic requirements. 1) The family's income must be between 100 and 200 percent of the Federal Poverty Level (FPL). 2) The family must not be otherwise eligible for full scope no share of cost (SOC) Medi-Cal. 3) The family must not have been covered by a public, private, or employer-sponsored insurance policy for the three months prior to enrollment. 4) Eligibility starts at greater than or equal once year. Ineligibility is equal to or greater than 19 years. When and individual reaches the age of 19, he/she is no longer eligible for HF. 5) HF limitations are one enrollment per year unless there is an extenuating circumstance. There is no share of cost. The eligibility message will read, prior to December 1998: "HEALTHY FAMILY PARTICIPANT, CALL 1-800-880-5305 FOR ELIGIBILITY INFORMATION." After December 1998, the message will carry the health enrollment plan information from the Health Insurance System (HIS) database. This aid code will be effective July 1, 1998.

7X HEALTHY FAMILIES BRIDGE BENEFITS - NO SOC This aid code will provide one additional calendar month of health care benefits without a share of cost to any child who meets the criteria of the Healthy Families Bridge Benefits Program. This one-month "bridge" will provide the child with an opportunity to apply for the Healthy Families Program. Three-month retroactivity not applicable. There is no share of cost. The eligibility message will read, "Recipient Medi-Cal Eligible with No Share Of Cost." This aid code will be effective December 1, 1998.Under the Healthy Families Bridge Benefits Program, one additional calendar month of health care benefits without a SOC may be provided to any child who meets all the following requirements:

(1) He or she has been receiving, but is no longer eligible for, full-scope Medi-Cal Benefits without a SOC.

(2) He or She is eligible for full-scope Medi-Cal Benefits with a SOC.

(3) He or she is at least one or under 19 years of age at the time he or she is no longer eligible for full-scope Medi-Cal Benefits without a SOC.

(4) He or she has family income at or below 200 percent of the federal poverty level.

(5) He or she is not otherwise excluded under the definition of targeted low-income child under subsections(b)(1)(B)(ii),(b)(1)(C), and (b)(2) of Section 2110 of the Social Security Act.

The one calendar month of benefits under aid code 7X will begin the first day of the month following the last day of the receipt of benefits without a SOC and will be identical to the scope of benefits that the child was receiving under the Medi-Cal Program without SOC.

The one calendar month of health care benefits provided under aid code 7X will only be made available through a MediCal provider or under a Medi-Cal managed care arrangement or contract. A child currently enrolled in a Managed Care Plan will remain in that plan during the bridging month.

B.1.22 ABANDONED BABY PROGRAM

Senate Bill 1368 "Safe Arms for Newborns" requires that newborns who have been voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act will receive full-scope Medi-Cal benefits with no Share of Cost
(SOC).

2A ABANDONED BABY PROGRAM Aid code 2A provides full scope Medi-Cal benefits without SOC to qualified children under three months old. The eligibility message will read: Recipient Medi-Cal Eligible with no SOC". For Managed Care purposes, this aid code will be considered voluntary. It is valid for Child Health Disability Prevention (CHDP) program. The code is effective as of January 1, 2001, but not installed into MEDS until August 2001 Month of Eligibility.

B.1.23 FEDERAL POVERTY LEVEL

The State budget authorized a Federal Poverty Level Program (FPL) for qualified aged and disable individuals and couples. This new Program increases the income limit for qualified individuals and couples so that approximately 52,280 will no longer have a share of cost. This became effective as of January 1, 2000.

1H FEDERAL POVERY LEVEL PROGRAM - AGED (FPL-AGED) Aid code H provides full scope Medi-Cal benefits without SOC to qualified aged individuals and couples. (FFP) The eligibility message will read Recipient Medi-Cal Eligible with no SOC". For Managed Care purposes, this aid code will be considered voluntary. It is not valid for Child Health Disability Prevention (CHDP) program or Local Education Agency Medi-Cal Billing Program.

6H FEDERAL POVERY LEVEL PROGRAM - DISABLED (FPL-AGED) Aid code 6H provides full scope Medi-Cal benefits without SOC to qualified disabled individuals and couples. (FFP) The eligibility message will read: Recipient Medi-Cal Eligible with no SOC". For Managed Care purposes, this aid code will be considered voluntary. It is valid for Child Health Disability Prevention (CHDP) program and Local Education Agency Medi-Cal Billing Program.

1U FEDERAL POVERY LEVEL PROGRAM - AGED (RESTRICTIVE FPL-AGED) Aid code 1U restricted Medi-Cal benefits without SOC to qualified aged individuals and couples. (FFP) The eligibility message will read: “MEDI-CAL ELIGIBLE FOR EMERGENCY AND PREGNANCY RELATED SERVICES WITH NO SHARE OF COST." It is not valid for Child Health Disability Prevention (CHDP) program or Local Education Agency Medi-Cal Billing Program.

6U FEDERAL POVERY LEVEL PROGRAM - DISABLED (RESTRICTIVE FPL-DISABLED) Aid code 6U restricted Medi-Cal benefits without SOC to qualified disabled individuals and couples. (FFP) The eligibility message will read: "MEDI-CAL ELIGIBLE FOR EMERGENCY AND PREGNANCY RELATED SERVICES WITH NO SHARE OF COST." It is valid for Child Health Disability Prevention (CHDP) program and Local Education Agency Medi-Cal Billing Program.

B.1.24 MISCELLANEOUS

SPECIAL INDICATORS: These indicators which appear in the aid code portion of the county ID Number help Medi-Cal identify the following:

IE (INELIGIBLE) A person who is ineligible for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the Share of Cost (SOC) for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.

RR (RESPONSIBLE RELATIVE) A Responsible Relative (RR) is allowed to use medical expenses to meet the Share of Cost (SOC) for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Master Family Budget Unit (MFBU or MBU). The individual may be eligible for Medi-Cal benefits in another MFBU where the person is not identified as RR.

B.2 BENEFICIARY AID CODES BY PROGRAM

Public Assistance:	
Aged	10, 16, 18
Blind	20, 26, 28, 6A
Disabled	36, 60, 66, 68, 6C
Families	06, 30, 32, 33, 35, 38, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3P, 3R, 3U, 40, 42, 43, 46, 4C, 4F, 4G, 77, 78
SSI Appeal/NLDC	6N, 6P
Medically Needy:	
Aged	13, 14, 17
Blind	23, 24, 27
Disabled	63, 64, 65, 67, 6G, 6H, 6U, 6V, 6W, 6X, 6Y, 8G
Families	34, 37, 39, 3N, 3T, 3V, 54, 59, 5T, 5W, 5X, 5Y 7J, 7K
Medically Indigent:	
Child	03, 04, 2A, 45, 4A, 4K, 4M, 5K, 82, 83
Adult	53, 81, 86, 87
Refugees:	01, 0A, 02, 08
Special Treatment:	71, 73
60-Day Postpartum:	76
Presumptive Eligibility:	7F, 7G
QMB:	80
QDWI/SLBI/QI:	8A, 8C, 8D, 8K (no Medi-Cal cards issued)
IRCA:	51, 52, 56, 57
OBRA: MN/MI Not Qualified Alien	55, 58, 5F

100% Poverty:	7A, 7C, 8R, 8T
133% Poverty:	72, 74, 8N, 8P
Income Disregard Program formerly 185% Program:	44, 47, 48, 49, 69
Asset Waiver Program formerly 200% Program:	07, 70, 75, 79
Tuberculosis:	7H
Minor Consent:	7M, 7N, 7P, 7R
Non Medi-Cal Family P.A.C.T. program (State-only Family Planning Program):	8H (FFP effective with 12/1/1999 service dates)
Non Medi-Cal Healthy Families:	9H
Non Medi-Cal One-month Healthy Families Bridge:	7X
CMSP:	50, 84, 85, 88, 89, 8F

NOTE: For "Not Qualified Aliens", there is no FFP for non-emergency routine prenatal and postpartum care as defined as HCPCS Z1032-Z1038, Z6200-Z6210, Z6300-Z6308, Z6400-Z6414,and Z6500.

B.3 BENEFICIARY AID CODES DISCONTINUED DEFINITIONS

Discontinued definitions of recycled Medi-Cal Aid Codes:

06 Emergency Assistance-Unemployed Parent (discontinued1/31/94)
43 Emergency Assistance-Abused Children (discontinued 1/31/94)
46 AFDC Foster Care--20 Percent SSA disregard (discontinued 1/31/94)
+50 Aid to the Potentially Self-supporting Blind-Cash Grant (no FFP) (discontinued 3/86)
51 Pre-1982 Amnesty Aliens (ABD or under 18) Full Medi-Cal Benefits (discontinued 12/31/94)
#52 Pre-1982 Amnesty Aliens (not ABD, not under 18) Restricted Medi-Cal (discontinued 12/31/94)
56 SAW/RAW Amnesty Aliens (ABD or under 18) Full Medi-Cal Benefits (discontinued 12/31/94)
#57 SAW/RAW Amnesty Aliens (not ABD, not under 18) Restricted Benefits (discontinued 12/31/94)
77 Refugee Demonstration Project-Family Group (discontinued 1/31/94)
78 Refugee Demonstration Project-Unemployed (discontinued 1/31/94)
+ &@84 Medically Indigent (MI) Adult-No Share of Cost (SOC) (discontinued 1/83)
+ &@85 Medically Indigent (MI) Adult-Share of Cost (SOC) (discontinued 1/83)
+ &@88 Medically Indigent (MI) Adult-Disability Pending-No Share of Cost (SOC) (discontinued 1/83)
+ &@89 Medically Indigent (MI)-Disability Pending-Share of Cost (SOC) (discontinued 1/83)

Key to the symbols used:

- FFP based on age

+	No FFP
=	FFP based on services
*	Optional
&	No Medi-Cal card(s) issued for this aid code
#	Restricted Medi-Cal card(s) issued for this aid code
@	CMSP ID card(s) issued for this aid code
$	On MEDS in the Special Program Segment

B.4 BENEFICIARY AID CODES PREVIOUS DEFINITIONS

Previous definitions of recycled Medi-Cal Aid Codes that are currently used with new definitions and that were redefined in 1981 or later (the discontinued date refers to either the date noted in an All County Welfare Directors letter or the date the program itself was discontinued):

+07 Refugee Cash Assistance (no FFP) (discontinued 3/86)
32 AFDC-Family Group-Money Management (discontinued 3/86)
33 AFDC-Unemployed Parent-Money Management (discontinued 3/86)
36 AFDC-Title II Disregard (discontinued 7/86)
38 AFDC-child Not in School or Training (discontinued 10/81)
39 AFDC-4 month continuing Medi-Cal without SOC-AFDC cash discontinued due to increased earnings (discontinued 7/90); note the new meaning was effective 4/90 which resulted in double meaning for this aid code from 4/90 through 6/90)
44 AFDC-Boarding Homes and Institutions-no SOC (discontinued 8/86)
47 AFCD-Boarding Homes and Institutions-SOC (discontinued 1/86)
55 AFDC-4 month continuing Medi-Cal without SOC-AFDC cash discontinued due to the expiration of the $30 plus 1/3 disregard after 4/82 and prior to 10/1/84 (discontinued 7/85)
56 Aid to the Potentially Self-supporting Blind-Title II Disregard (no FFP) (discontinued 3/86)
58 Aid to the Potentially Self-IHSS (no FFP) (discontinued 3/86)
59 AFDC-4 month continuing Medi-Cal without SOC-AFDC cash discontinued due to the expiration of the $30 plus 1/3 disregard after 10/84 (discontinued 12/90) which resulted in double meaning for this aid code from 10/90 through 11/90)
+72 Renal Dialysis-Supplement (no FFP) (discontinued 4/90)
74 Total Parenteral Nutrition-Supplement (no FFP)(discontinued 4/90)

Key to the symbols used:

-	FFP based on age
+	No FFP
=	FFP based on services
*	Optional
&	No Medi-Cal card(s) issued for this aid code
#	Restricted Medi-Cal card(s) issued for this aid code
@	CMSP ID card(s) issued for this aid code
$	On MEDS in the Special Program Segment

APPENDIX C. COMPOUND DRUG SEGMENT

A compound drug claim record (effective with SDN 06043) normally has one, and only one, main - type 'M' - segment as the first detail segment followed by 0 to 40 compound drug segments.

The first segment must always be a main 'M' segment. If a compound drug segment is present it must always be the second and subsequent segment.

Compound drug claim layout general overview

- Header
- Main Segment (1)
- Compound segments (0-40 or 0-25)

Claims processed by EDS will have 0 to 25 segments. Other data sources may provide up to 40.

When there are compound drug segments the NDC reported in the main segment must be ‘0’ (A single zero). This is a change per SDN 02024.

The NCPDP standards allow for two types of reporting of compound drugs.

1) All of the ingredients used in the compound drug are reported.
2) Only the most expensive ingredient in the compound is reported.

EDS will use reporting type 1, but will truncate any submission to 25. The actual number of ingredients in the original submission is recorded in the field F35B-CMPND-ACTUAL-NBR-INGR. The record submitted by EDS should have the most expensive ingredients in the 25 that are reported. This is a procedural recommendation, however, not an edit.

Other data sources may use reporting type 1 and provide up to 40 'C' segments.

In the event a data source is using reporting type 2 there will be only one 'C' segment for the compound drug.

The actual number of 'C' segments present on the claim is recorded in the field F35B-COMPOUND-DRUG-NBR-INGRED.

The total number of segments for any compound drug claim with one or more compound drug segments must equal the field F35B-COMPOUND-DRUG-NBR-INGRED + 1.

A compound drug claim record cannot have a segment count of zero, with no detail segments, as the information that the drug is a compound is located on the main segment. Without a main segment it is impossible to know a claim is for a compound drug.

A compound drug may, however, have no compound drug segments. In that case the NDC number on the main segment will be for the compound drug. Using this method a drug claim record may have multiple main type segments that are flagged as "compound drug". But if there are multiple main type segments there can be no compound drug segments. In that case in each of the segments the fields F35B-COMPOUND-DRUG-ATTACHMENT and F35B-COMPOUND-DRUG-NBR-INGRED must be zero. That condition could occur on drug claims prior to SDN 02024 or on drug claims from sources other than EDS, the main Medi-Cal Fiscal Intermediary.

C.1 NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The following information is include for reference purposes.

Definitions

C.1.1 COMPOUND INGREDIENT COMPONENT COUNTER NUMBER (447-EC):

Definition: A count of each ingredient (both active and inactive) in the compound mixture submitted. The Compound Ingredient Counter Number is incremented for each ingredient submitted.
Purpose: Compound counter number associates each ingredient and NDC for reporting, billing, reimbursement and DUR.

C.1.2 COMPOUND INGREDIENT METRIC DECIMAL QUANTITY (448-ED):

Definition: The quantity in metric decimal format of the product included in the compound mixture.
Purpose: Data in this field reports the metric decimal quantity of the product used in the compound mixture and facilitates the calculation of the reimbursement amount for this ingredient.

C.1.3 COMPOUND INGREDIENT DRUG COST (449-EE):

Definition: The ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in field 448-ED.
Purpose: Facilitates the calculation of reimbursement for this ingredient.

C.1.4 COMPOUND DOSAGE FORM DESCRIPTION CODE (450-EF):

Definition: The dosage form of the complete compound mixture. The data in this field is reported one time following all iterations of fields 447-EC, 448-ED, and 449-EE.
Purpose: When used in combination with field 451-EG, provides a complete description of the compound prescription dispensed.

C.1.5 COMPOUND DISPENSING UNIT FORM INDICATOR (451-EG):

Definition: The total compound metric decimal quantity expressed as Each, Grams, or Milliliters.
Purpose: When used in combination with field 450-EF, provides a complete description of the compound prescription dispensed.
Example: Describes the units form of the entire compound, such as 10 each, 30 grams, or 1000 milliliters.

C.1.6 COMPOUND ROUTE OF ADMINISTRATION CODE (452-EH):

Definition: represents the route of administration of the complete compound mixture.
Purpose: The data in this field is used primarily for on-line real-time drug use review in order to avoid unnecessary processing time and screening by the claims processor. This field can be used to selectively apply DUR modules to compounds submitted on-line. For example, in general, topical preparations do not result in drug-drug interactions; thereby the claims processor can bypass this DUR module.

C.1.7 PRESCRIPTION CLARIFICATION CODE (420-DK) VALUE 8:

Process Compound for Approved Ingredients.
Purpose: If one or more ingredients are not covered, the claim should be rejected. However, the pharmacist may decide to accept payment excluding the non-covered ingredient(s). A value “08” is resubmitted on a rejected compound prescription when the pharmacist decides to accept payment for all other ingredients, except those not covered by the plan.

C.1.8 DUR CONFLICT/REASON FOR SERVICE CODE:

- This code identifies the type of utilization conflict that was detected during ORDUR, or the reason for the pharmacist’s professional service.

C.1.9 CLINICAL SIGNIFICANCE CODE

- Indicates the severity of a potential conflict. This field reflects the severity that the originating database has assigned to a potential therapeutic problem.

C.1.10 OTHER PHARMACY INDICATOR:

- Indicates the source of the previous prescription that forms the basis for the conflict with the present prescription.

C.1.11 PREVIOUS DATE OF FILL:

- Indicates the date of fill for the previous prescription that forms the basis for the conflict with the present prescription.

C.1.12 QUANTITY OF PREVIOUS FILL:

- Indicates the quantity dispensed of the previous prescription that forms the basis for the conflict with the present prescription.

C.1.13 DATABASE INDICATOR:

- Identifies the source of the clinical data used to detect conflicts.

C.1.14 OTHER PRESCRIBER INDICATOR:

- Compares the prescriber of the current prescription to the prescriber of the previously filled and conflicting prescription.

C.1.15 COMPOUND ROUTE OF ADMINISTRATION CODE (452-EH):

- This field has been added to facilitate DUR processing on select prescriptions. The data in this field is used primarily for On-line Real-Time Drug Use Review in order to avoid unnecessary processing and screening by claims processors. By use of this field, plan administrators may selectively apply DUR screening to compounds submitted on-line. For example, topical preparations generally do not result in drug-drug interactions; therefore, claims processors can deselect claims that carry a topical route of administration from DUR evaluation.

C.1.15 PRESCRIPTION CLARIFICATION CODE (420-DK):

This field allows providers to accept payment for compound prescriptions when one or more ingredients are not covered by the patient's plan. Some benefit plans may deny payment of certain ingredients contained in compound prescriptions. Processors should reject the entire claim with the denial message indicating which ingredients are not covered. Providers will then decide whether to dispense the prescription with partial payment or not fill the prescription based on non-covered information provided by the claims processor. Providers may resubmit rejected claims with a Prescription Clarification Code indicating acceptance of sponsor-determined payment, excluding non-covered items.

Providers submitting claims for compound prescriptions in the 4.0 variable format may submit up to 99 ingredients. To avoid a possible 2KB buffer limit, we recommend an electronic compound transaction be limited to a single prescription with no more than 25 ingredients. Data elements that allow capture of accurate information about the ingredients, cost, dosage form and applicability for drug use review of the final compound include:

C.1.16 COMPOUND INGREDIENT COMPONENT COUNTER NUMBER FIELD 447-EC:

C.1.17 COMPOUND INGREDIENT METRIC DECIMAL QUANTITY FIELD 448-ED:

C.1.18 COMPOUND INGREDIENT DRUG COST FIELD 449-EE:

C.1.19 COMPOUND DOSAGE FORM DESCRIPTION CODE (FINAL MIXTURE) FIELD 450-EF
Values:
1 = Capsule
2 = Ointment
3 = Cream
4 = Suppository
5 = Powder
6 = Emulsion
7 = Liquid
10 = Tablet
11 = Solution
12 = Suspension
13 = Lotion
14 = Shampoo
15 = Elixir
16 = Syrup
17 = Lozenge
18 = Enema

C.1.20 COMPOUND DISPENSING UNIT FORM INDICATOR FIELD 451-EG
Values:
1 = Each
2 = Grams
3 = Milliliters

C.1.21 COMPOUND ROUTE OF ADMINISTRATION CODE FIELD 452-EH
Values:

1 Buccal	12 Other/Miscellaneous
2 Dental	13 Otic
3 Inhalation	14 Perfusion
4 Injection	15 Rectal
5 Intraperitoneal	16 Sublingual
6 Irrigation	17 Topical
7 Mouth/Throat	18 Transdermal
8 Mucous Membrane	19 Translingual
9 Nasal	20 Urethral
10 Ophthalmic	21 Vaginal
11 Oral	22 Enteral

C.1.22 PRESCRIPTION CLARIFICATION CODE VALUE: 8

Process Compound for Approved Ingredients Field 420-DK

Reject Code Field 511-FB
Values:
EC = M/I Compound Ingredient Component Counter Number
ED = M/I Compound Ingredient Metric Decimal Quantity

EE = M/I Compound Ingredient Drug Cost
EF = M/I Compound Dosage Form Description Code
EG = M/I Compound Dispensing Unit Form Indicator
EH = M/I Compound Route of Administration Code

C.1.23 INGREDIENT DATA AREA:

- Fields 407, 423, 436, 437, 447-449 pertain to each compound ingredient. Note: These fields will be repeated for each ingredient. They are defined below in the order they will appear in the transaction for a single ingredient. Each field is preceded by its field identifier, and followed by a field separator. Additionally, fields 407, 423, 436 and 437 may also occur in the main body of the transaction.

Field #	Field Name
447-EC	Compound Ingredient Counter #
407-D7	NDC
423-DN	Basis of Cost Determination
436-E1	Alternate Product Type (Optional)
437-E2	Alternate Product Code (Optional)
448-ED	Compound Ingredient Metric Decimal Quantity
449-EE	Compound Ingredient Drug Cost

Compound Trailing Information Data Area:
Fields 450-452 pertain to the compound trailing information and they apply to the entire compound. Each field is preceded by its field identifier and is followed by a field separator. The transaction ends with field 452-EH.

Field #	Field Name
450-EF	Compound Dosage Form Description Code
451-EG	Compound Dispensing Unit Form Indicator
452-EH	Compound Route of Administration Code

C.1.23 FIELD FORMAT VALUES:

FIELD #	FIELD NAMES	FORMAT	LENGTH	COBOL PIC
407-D7	NDC NUMBER	N	11	9(11)
423-DN	BASIS OF COST DETERMINATION	A/N	2	X(2)
436-E1	ALTERNATE PRODUCT TYPE (OPTIONAL)	A/N	1	X
437-E2	ALTERNATE PRODUCT CODE (OPTIONAL)	A/N	13	X(13)
447-EC	COMPOUND INGREDIENT COMPONENT COUNTER #	N	2	99
448-ED	COMPOUND INGREDIENT METRIC DECIMAL QUANTITY	N	8	9(5)V999
449-EE	COMPOUND INGREDIENT DRUG COST D		8	S9(6)V99
450-EF	COMPOUND DOSAGE FORM DESCRIPTION CODE	A/N	2	XX
451-EG	COMPOUND DISPENSING UNIT FORM INDICATOR	N	1	9
452-EH	COMPOUND ROUTE OF ADMINISTRATION CODE	N	2	99

APPENDIX F. CLAIM COUNTS BY PLAN CODES

These counts are for February 1997:

PLAN CODE	Name	Count
0	CDS Dental-Medi-Cal	325,518
0	CDS Dental-Special	123
0	CDS Dental-Root Crown	0
0	CDS Dental-IRCA	16,214
1	DSS PCSP	250,814
1	DDS WAIVER	42,006
4	SBHI	46,127
4	HPSM	97,187
5	EPSDT	Not enough time to get a count
6	DMH	6,082
8	Medi-Cal Short/Doyle	443,101
9	EDS Medi-Cal	7,969,606
9	EDS BCEDP	10,879
9	EDS DMH Inpatient	1,775
9	EDS CHDP	93,561
9	EDS CCS	1,606,161 (April 97)
9	EDS GHPP	2,085
9	EDS CMSP	Not available

The MEDSTAT system uses most of the claims for MIS/DSS.

These counts are for June 1998:

PLAN CODE	Name	Count
0	CDS Dental-Medi-Cal	365,710
0	CDS Dental-Special	92
0	CDS Dental-Root Crown	1
0	CDS Dental-IRCA	16,594
1	DSS PCSP	290,873
1	DDS WAIVER	41,299
2	Managed Care	1,000,000 Approximately
4	SBHI	54,209
4	HPSM	83,646
4	Solano	61,169
5	EPSDT	Not enough time to get a count
6	DMH	4,691
8	Medi-Cal Short/Doyle	670,831
9	EDS Medi-Cal	8,349,190
9	EDS BCEDP	13,615
9	EDS DMH Inpatient	5,102
9	EDS CHDP	83,328
9	EDS CCS	2,740,677
9	EDS GHPP	1,551
9	EDS CMSP	89,805

APPENDIX G. PROVIDER TYPE CODES

Sometime in 1999, the Provider Type field will be expanded to three characters. This is also true of the Category of Service.

DN Dentist for Encounter data files only
001 Adult Day Care Centers
002 Assistive device and medical equipment
003 Audiologists
004 Blood banks
005 Certified nurse midwife
006 Chiropractors
007 Certified pediatric nurse practitioner and certified family Nurse practitioner
008 Christian Science practitioners
009 Clinical laboratories
010 Group certified pediatric nurse practitioner and certified Family nurse practitioner
011 Fabricating optical laboratory
012 Dispensing opticians
013 Hearing aid dispensers
014 Home Health Agencies
015 Community hospital outpatient departments
016 Community hospital inpatient
017 Long Term Care
018 Certified Nurse anesthetists
019 Occupational Therapists
020 Optometrists
021 Orthotists
022 Physicians group
023 Optometric group
024 Pharmacies/pharmacist
025 Physical therapists
026 Physicians
027 Podiatrists
028 Portable X-ray laboratory
029 Prosthetics
030 Ground medical transportation
031 Psychologists
032 Certified acupuncturist
033 Genetic disease testing
034 LCSW Crossover Provider Only (before 11/98 34 was Rural Health Clinics)
035 Rural Health Clinics and Federally Qualified Health Centers (FQHCs)
037 Speech therapists
038 Air ambulance transportation services
039 Certified hospice service per AB 4249
040 Free clinics
041 Community clinics
042 Chronic dialysis clinics
043 Multi-specialty clinics
044 Surgical clinics
045 Exempt from licensure clinics
046 Rehabilitation clinics
047 Employer/Employee clinic
048 County clinics not associated with hospital
049 Birthing centers-Primary Care Clinic
050 Clinic-otherwise undesignated

051 Outpatient heroin detoxification center
052 Alternative Birth Centers-Specialty Clinics
053 Breast Cancer Early Detection Program
054 Expanded Access to Primary Care.
055 Local education agency
056 Respiratory Care Practitioner
057 EPSDT Supplemental Services Provider
058 Health Access Program
059 Congregate Living Health Facilities with Type A licensure
060 County hospital inpatient
061 County hospital outpatient
062 Group Respiratory Care Practitioner
063 County hospital - LTC
064 Community hospital - LTC
065 Pediatric Subacute Care-LTC
072 Mental Health Inpatient
073 AIDS waiver provider
074 Multi-Purpose Senior Services
075 Indian Health Services/Tribal Health Plan for "638" clinics
080 California children's service/Genetically Handicapped Person Program-Non-institutional
081 California children's service/Genetically Handicapped Person Program-Institutional
082 Licensed Midwife
090 Out of state

APPENDIX H. EDS CATEGORY OF SERVICE (COS)

In the summer of 1999, the Category of Service field was expanded to three characters. This is also true of the Provider Type. The new codes that are 2 characters will just have a zero added to the pre-existing codes. The next group will start with a 1, such as 100, when all the old 2 character codes are depleted.

Revised 3/15/00

001 Physician services
002 Inpatient hospital services
003 Medicare Crossover Provider Only (for LCSWs, IDTF)
004 Mental Health Inpatient services
Transitional Care Services - Freestanding Nursing Facility Level B/Distinct Part Skilled Nursing Facility Level B
Transitional Care Services - General Acute Care Hospital (GACH)
007 Ground Medical Transportation/Emergency (MTE) Services
EPSDT Supplemental Services-On-site Investigation to Detect the Source of Lead Contamination
009 Hospital outpatient department services
010 Use of facilities
Family P.A.C.T. (Planning Access Care & Treatment) Certified Providers
012 TeenSMART Demonstration Project
013 Expanded Clinic Access Demonstration Project
EPSDT Supplemental Services-Individual Outpatient Drug Free Counseling for Alcohol and Other Drug (AOD) Problems rendered by Outpatient Drug Free Clinics Only
015 Newborn Hearing Screening
Los Angeles County Waiver Facilities Early Discharge Follow Up Visit
018 Mental Health services
019 Multipurpose Senior Services Program (MSSP) Waiver Services
020 Renal homotransplantation
021 Chronic dialysis services
022 Rehabilitation center outpatient services
023 Directly Observed Therapy (DOT) services (for the TB program)
024 Hospice services per AB 4249
025 Health Families
Nursing Facility Services Level A (ICF)-Developmentally disabled NF-A/DD)
027 Nursing Facility Services Level A (ICF) (NF-A)
028 Nursing Facility Services Level A (SNF) (NF-B)
029 Pediatric Subacute Care Services (SNF) (DP/FS NF-B)
030 Pediatric Subacute Rehabilitation Therapy Services Supplement
Ventilator Wearing Services
031 Portable X-Ray services
032 Clinical Laboratory-CLIA Waived Tests
033 Clinical Laboratory-CLIA Physicians Performed Microscopy (PPM)
034 Laboratory and Pathology services
035 Radiology/Nuclear Medicine services
036 Acupuncture services
037 Certified Nurse Midwife
038 Nurse Anesthetist services
Medical supplies(includes incontinent medical supplies before SDN9014 done)

040 Optometry services
041 Chiropractic services
042 Psychology services
043 Podiatry
044 Skilled Nursing services
045 Physical Therapy
046 Occupational therapy
047 Speech Pathology services
048 Audiological services
049 Non-physician Medical Practitioner services
050 Genetic Counseling services
051 Christian Science practitioner services
052 Home Health Agency services
053 Expanded Alpha Feto-Protein Screening services
054 Prosthetic and Orthotic asterisk procedures
055 NARD/HSA Certified Prosthetic and Orthotic services
057 Lenses and frames
058 EPSDT Supplemental Services
059 Durable Medical Equipment
060 Pharmaceutical services(incl. incontinent medical supplies before SDN9014)
061 Eye appliances
062 Prosthetic Appliances
063 Orthotic Appliances
064 Blood and Blood derivatives
065 Hearing Aids
066 Human Milk
067 Certified Pediatric Nurse Practitioner services
068 Certified Family Nurse Practitioner services
069 Ground Medical Transportation services
070 Air Ambulance Transportation services
071 Congregate Living Health Facilities with Type A licensure
072 Breast Cancer Early Detection Program services
Note: Based on OIL #195-97, this COS is used on the Provider Master File for informational purposes only. The provider's Medi-Cal COS is used in claims processing to determine eligibility to render services.)
073 Alternative Birthing Center services (Specialty Clinic)
074 Surgical Clinic Medicine services
075 Local Education Agency services
076 Expanded Access to Primary Care services
077 Facility Fee--Birthing Services
078 Birthing Center services
079 P.L. 95-210 Rural Health Clinic and Federally Qualified Health Center services
080 Outpatient Clinic services
081 Adult Health Care services
082 Outpatient Heroin Detoxification services
083 Home and Community Based services
084 Surgical services
085 Home Nursing services
086 Respiratory Care Practitioner Services
087 Psoriasis Day Care
088 Surgical Clinic services
089 Hyperbaric Oxygen Therapy, Chamber Charge
090 Out of state provider services

091 Medicine services
092 Comprehensive Prenatal Care services
093 LEA Targeted Case Management (Low)
L.A. County Waiver Facilities OB-Comprehensive Prenatal Services
Targeted Case Management Service for a low cost LEA (TCM) Provider
Targeted Case Management Service for a medium cost LEA
TCM) Provider
096 AIDS Waiver services
097 LEA Targeted Case Management (High)
098 Miscellaneous
099 CCS/GHPP services
100 Laboratory Test Excluded from CLIA Edits
101 Licensed Midwife

APPENDIX I. COMPARISON OF PROVIDER TYPE AND CATEGORY OF SERVICE CODES

PSD sends a copy of this information with its Operating Instruction Letters (OILs) attachments. The name of the actual listing is "MEDI-CAL VERSION ENCLOSURE A". The third and fourth column headings on the OIL attachment says "DE 206" and "Other Services". Their English names are listed here. From revised 10/14/98 enclosure, lots of changes were made because EDS is running out of 2-character numeric Provider Type codes. A number of the old codes were deleted since they had been set up by CSC and not used or were assigned but never installed. (OIL #342-98).

Revised using the 7/13/99 Medi-Cal version in March 2000.

Provider Type	Description of Service	Category of Service	Other Categories
01	ADULT DAY CARE CENTERS		81
02	ASSISTIVE DEVICE AND SICK ROOM/ DURABLE MEDICAL EQUIPMENT		59, 39, 61 - 63, 65
03	AUDIOLOGISTS		48, 15, 47, 65
04	BLOOD BANKS		64,66
05	CERTIFIED NURSE MIDWIFE		37,11 - 13, 32, 33, 72, 92
06	DOCTOR OF CHIROPRACTIC		41
07	CERTIFIED PEDIATRIC NURSE AND CERTIFIED NURSE FAMILY PRACTITIONER		67, 68,11 - 13, 32, 33, 72, 92
08	CHRSITIAN SCIENCE PRACTITONER		51
09	CLINICAL LABORATORIES		34 and/or 35
10	GROUP CERTIFIED PEDIATRIC NURSE PRACTITIONER AND CERTIFIED NURSE FAMILY PRACTITIONER		67, 68 ,11 - 13, 32, 33, 72, 92
11	FABRICATING OPTICAL LABORATORY		57
12	DISPENSING OPTICIANS		61
13	HEARING AID DISPENSERS		65, 48
14	HOME HEALTH AGENCIES		52, 59, 83
15	COMMUNITY HOSPITAL--OUTPATIENT DEPARTMENT		09, 08, 11 - 13, 18, 21, 22, 32, 33, 44, 69, 72, 82, 87, 92,
16	COMMUNITY HOSPITAL--INPATIENT		02 or 06,18, 20
17	LONG TERM CARE		05, 26 - 28
18	NURSE ANESTHETISTS		38, 32,33
19	OCCUPATIONAL THERAPISTS		46
20	OPTOMETRISTS		40, 61
21	ORTHOTISTS		63, 39, 59
22	PHYSICIAN GROUP		01, 11 - 13, 15, 32, 33, 50 59, 72, 82, 92
23	OPTOMETRIC GROUPS		40, 61
24	PHARMACIES/PHARACIST		60,55, 59, 62, 63
25	PHYSICAL THERAPISTS		45
26	PHYSICIANS (M.D.)		01, 11 - 13, 15, 32, 33, 50, 59, 72, 82, 92
27	PODIATRISTS (D.P.M.)		43, 32, 33, 59, 63
28	PORTABLE X-RAY LABRATORY		31, 35
29	PROSTHETISTS		62, 39, 59, 63
30	GROUND MEDICAL TRANSPORT		69
31	PSYCHOLOGISTS		42
32	CERTIFIED ACUPUNCTURISTS		36

33	GENETIC DISEASE TESTING FUND	53
34	MEDICARE CROSSOVER PROV. ONLY	03
35	P.L.95-210 RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)	79
37	SPEECH THERAPISTS	47, 48
38	AIR AMBULANCE TRANSPORTION SERVICES	70
39	CERTIFIED HOSPICE SERVICE PER AB 4249	24
40	FREE CLINICS	80, 08, 10 – 13, 32, 33, 38, 44, 72,82, 92
41	COMMUNITY CLINICS	80, 08, 10 - 13, 23, 32, 33 38, 44, 72, 77, 82, 92
42	CHRONIC DIALYSIS CLINICS	21, 32 - 34, 59, 72, 82, 92
43	MULTISPECIALTY CLINICS	80, 08, 11-13,15, 21, 22, 33, 44, 72, 82, 88
44	SURGERAL CLINICS	88, 08, 11 - 13, 32, 33, 72
45	EXEMPT FROM LICENSURE CLINICS	80, 08, 10 - 13, 23, 32, 33, 44, 72, 82, 92
46	REHABILITATION CLINICS	22, 15, 18, 44, 59, 72, 82, 84, 91
47	EMPLOYER/EMPLOYEE CLINICS	80, 08, 32, 33, 44, 72, 82
48	COUNTY CLINICS NOT ASSOCIATED WITH HOSPITAL	80, 23, 08, 10-13, 15, 16, 32, 33, 38, 44, 72, 82, 92, 94
49	BIRTHING CENTERS-PRIMARY CARE CLINIC	78
50	CLINIC - OTHERWISE UNDESIGNATED	08, 72
51	OUTPATIENT HEROIN DETOX CENTERS	82
52	ALTERNATIVE BIRTH CENTERS-SPECIALTY CLINICS	73, 11-13, 32, 33
53	BREAST CANCER EARLY DETECTION PROGRAM	80, 72
54	EXPANDED ACCESS TO PRIMARY CARE	76
55	LOCAL EDUCATION AGENCIES	75, 93, 95, 97
56	RESPIRATORY CARE PRACTITIONER	86
57	EPSDT SUPPLEMENTAL PROVIDER	58, 08
58	HEALTH ACCESS PROGRAM	11, 25, 80, 12, 13
59	CONGREGATE LIVING HEALTH FACILITIES, TYPE A LICENSURE	71
60	COUNTY HOSPITAL INPATIENT	02 or 06, 20
61	COUNTY HOSPITAL OUTPATIENT	09, 23, 08, 11-13, 15, 16, 21, 22, 32, 33, 44, 69, 72, 82, 87, 92, 94
62	GROUP RESPIRATORY CARE PRACTITNER	86
65	PEDIATRIC SUBACUTE CARE LONG TERM CARE	29, 30
66	REGISTERED NURSES AS INDEPENDENT PROVIDERS	83
72	MENTAL HEALTH INPATIENT	04
73	AIDS WAIVER PROVIDER	96
74	MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)	19
75	INDIAN HEALTH SERVICES/TRIBAL HEALTH PLAN FOR "638" CLINICS	79

80	CALIFORNIA CHILDREN'S SERVICE/ GENETICALLY HANDICAPPED PERSON PERSON NON-INSTITUTIONAL	99
81	CALIFORNIA CHILDREN'S SERVICE/ GENETICALLY HANDICAPPED PERSON PERSON INSTITUTIONAL	99
82	LICENSED MIDWIFE (LMW)	101
84	INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) CROSOVER PROVIDER ONLY	03
90	OUT-OF-STATE	90, 32, 33

APPENDIX J. PHYSICIAN SPECIALTY CODES

01 General Practice
02 General Surgery
03 Allergy
04 Otology, Laryngology, Rhinology
05 Anesthesiology
06 Cardiovascular Disease (M.D. only)
07 Dermatology
08 Family Practice
09 Gynecology (D.O. only)
10 Gastroenterology (M.D. only)
11 Aviation (M.D. only)
12 Manipulative Therapy (D.O. only)
13 Neurology (M.D. only)
14 Neurological Surgery
15 Obstetrics (D.O. only)
16 OB-Gynecology (M.D. only)
17 Ophthalmology, Ototolaryngology, Rhinology(D.O.only)
18 Ophthalmology
19 Dentists (DMD and DDS)
20 Orthopedic Surgery
21 Pathologic Anatomy: Clinical Pathology (D.O. only)
22 Pathology (M.D. only)
23 Peripheral Vascular Disease or Surgery (D.O. only)
24 Plastic Surgery
25 Physical Medicine and Rehabilitation
26 Psychiatry (child)
27 Psychiatry Neurology (D.O. only)
28 Proctology (colon and rectal)
29 Pulmonary Diseases (M.D. only)
30 Radiology
31 Roentgenology, Radiology (M.D. only)
32 Radiation Therapy (D.O. only)
33 Thoracic Surgery
34 Urology and Urological Surgery
35 Pediatric Cardiology (M.D. only)
36 Psychiatry
38 Geriatrics
39 Preventive (M.D. only)
40 Pediatrics
41 Internal Medicine
42 Nuclear Medicine
43 Pediatric Allergy
44 Public Health
45 Nephrology
46 Hand Surgery
47 Miscellaneous
66 Emergency Medicine
67 Endocrinology
68 Hematology
70 Clinic (mixed specialty)
77 Infectious Disease
78 Neoplastic Diseases
79 Neurology-Child
83 Rheumatology

84 Surgery-Head and Neck
85 Surgery-Pediatric
89 Surgery-Traumatic
90 Pathology-Forensic
91 Pharmacology-Clinical
99 Unknown (on EDS claims)
99 Delta Dental Claims
Monterey Outpatient claims use this code for some
Reason For Plan Code 2, Vendor Code 27, Dental Encounter records only:

00 General Practitioner (included for Hygienists)
01 10 Oral Surgeon
15 Endodontist
20 Orthodontist
25 Certified Orthodontist
30 Pedodontist
40 Periodontist
50 Prosthodontist
60 Oral Pathologist
70 Public Health
80 Fulltime Faculty

APPENDIX K. VENDOR CODES

VENDOR CODE	PROVIDERS
01	Adult Day Health Care Center
02	Medicare Crossover Provider Only
03	CCS/GHPP Program
04	Genetic Disease Testing
05	Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric Nurse Practitioner
08	Certified Family NP
09	Respiratory Care Practitioner
10	Licensed Midwife Program
11	Fabricating Optical Lab
12	Optometric Group
13	Nurse Anesthetist
19	Portable X-ray Lab
20	Physician (M.D. or D.O.)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Physician Part Lav Srvc
26	Pharmacies
27	Dentist
28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist
35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-professional provider services)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Fac
49	Birthing Center
50	County Hospital - Acute Inpatient
51	County Hospital - Extended Care
52	County Hospital - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers (formerly State Hosp-Developmentally Disabled)
57	State Hospital-Mentally Disabled
58	County Hospital - Hemodialysis Center
59	County Hospital – Rehab Facility
60	Community Hospital - Acute Inpatient

61		Community Hospital - Extended Care
62		Community Hospital - Outpatient
63	**	Mental Health Inpatient Consolidation
64	**	Short-Doyle Community Mental Health-Hosp Services
68		Community Hospital - Renal Dialysis Center
69		Community Hospital - Rehab Facility
70	*	Acute Psychiatric Hospital
71		Home/Comm Based Service Waivers
72		Surgicenter
73		AIDS Waiver Services
74	**	Short-Doyle Community Mental Health-Clinic Svs
75		Organized Outpatient Clinic
76	**	DDS Waiver Services
77		Rural Health Clinics/FQHCs
78		Community Hemodialysis Center
79		Independent Rehabilitation Facility
80		Nursing Facility (formerly known as Skilled Nursing Facility)
81		MSSP Waiver Services
82		EPDST Supplemental Services
83		Pediatric Subacute Rehab/Weaning
84		Assist. Living Waiver Pilot Project (ALWPP)
89	**	Personal Care Services, DDS
90		Out of State
91		Outpatient Heroin Detoxification
92		Medi-Cal Targeted Case Management
93	**	DDS Targeted Case Management
94		CHDP Provider
95	**	Short-Doyle Community Mental Health-Rehabilitation Treatment)
All Other		All Other Providers

* Vendor Code 70 was assigned but never implemented.
** These are Medi-Cal services but files are separate from regular Medi-Cal claims files.

NOTE: Prior to 11/1/92, Vendor Code 07 meant Certified Nurse Practitioner for a pilot project for which there were very few claims. Vendor Code 49 was used by Redwood Health Foundation (Plan Code 3) from September 1973 through June 1989 when RHF went out of business. The code meant out-of-state/unassigned.

APPENDIX L. ROUTINE PRENATAL CARE CODES

These CPT-4 Procedure codes came from the DHS Pregnancy Monitoring System as of September 1998:

THESE CODES COVER DELIVERY, ANTEPARTUM AND POSTPARTUM FOR VAGINAL BIRTH CARE:

'59400' THRU '59410'
'59610' '59612' '59614'

THESE CODES COVER CESAREAN DELIVERY:

59500' THRU '59515'

THESE ARE ALL THE "MATERNITY CARE AND DELIVERY" CODES:

'59000' THRU '59899'

THESE ARE THE DELIVERY CODES:

CPT-VAGINAL-DELIVERY-ONLY	'59409' '59612'.
CPT-VAGINAL-INCL-POSTPART	'59410' '59614'.
CPT-VAGINAL-DELIVERY-GLOBAL	'59400' '59610'.
CPT-C-SECT-DELIVERY-ONLY	'59514' '59620'.
CPT-C-SECT-INCL-POSTPART	'59515' '59622'.
CPT-C-SECT-DELIVERY-GLOBAL	'59510' '59618'.

HCPCS Local Procedure Codes also came from the PMS system:

THESE CODES COVER DELIVERY, ANTEPARTUM AND POSTPARTUM CARE THAT MATCH CPT4 CODES '59400' - '59410' AND CODES '59610' '59612' '59614':

'Z1032' THRU 'Z1038'

THESE CODES COVER POSTPARTUM VISITS.

'Z1004' 'Z1012' 'Z1026'

THESE CODES ARE CLINIC/BIRTHING CENTERS DELIVERY CODES:

'Z1002'
'Z1006'
'Z1010'
'Z1014'
'Z1024'

THIS CODE IS FOR A BIRTHING ROOM:

‘Z7516’

APPENDIX M. PROVIDER NAMING/NUMBER SYSTEM

M.1 CURRENT PROVIDER NUMBER NAMING ACRONYMS

This provider information was enhanced by the Provider Enrollment Section. A special thanks to Mike Lynskey for all his assistance and research during October and November of 1991. The provider type was added to this documentation in February 1993. Updated 3/00.

On EDSNET, their provider status codes are 1 = active, 2 = not active, 3 = pending, and 4 = deceased.

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
AC	032	CERTIFIED ACUPUNCTURISTS
ABC	049	ALTERNATIVE BIRTHING CENTERS
ABS	041	ALTERNATIVE BIRTHING SERVICES
ADU	001	ADULT DAY CARE CENTERS
AU	003	AUDIOLOGISTS
AYD	073	AIDS PROVIDERS
BB004BLOOD BANKS		
BCP053BREAST CANCER PROGRAM		
CCS	046	CCS CERTIFIED REHAB CLINIC FOR MEDI-CAL ELIG CCS PATIENTS
CGP	080	PROVIDERS FOR THE CCS/GHPP PROGRAM =NON-INST.
CGP	081	PROVIDERS FOR THE CCS/GHPP PROGRAM =INSTITUT.
CDC	042	CHRONIC DIALYSIS CLINICS
CLN	041	COMMUNITY CLINICS
CLF	059	CONGREGATE LIVING HEALTH FACILITIES
CMM	041	COMMUNITY CLINICS
CNP	007	CERTIFIED NURSE PRACTITIONERS (Discontinued-new is NP)
CSP	008	CHRISTIAN SCIENCE PRACTICIANER
CSW	034	CLINICAL SOCIAL WORKER (LICENSED--LCSW)
CT	019	CERTIFIED OCCUPATIONAL THERAPISTS
DC	006	DOCTOR OF CHIROPRACTIC
DIAA	045	DIAGNOSTIC MAGNETIC IMAGING CTRS(enrolled as exempt)
DIAB	045	DIAGNOSTIC MAGNETIC IMAGING CTRS(enrolled as exempt)
DME	002	DURABLE MEDICAL EQUIPMENT
DX	012	DISPENSING OPTICIANS
EAP	054	EXPANDED ACCESS TO PRIMARY CARE CLINIC
EMP	047	EMPLOYER/EMPLOYEE CLINIC
EPS	034	EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
EPSL	034	EPSDT ONSITE INVESTIGATIONS TO DETECT THE SOURCE OF LEAD
EXE	045	EXEMP FROM LICENSURE CLINICS

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
FHC	035	FEDERALLY QUALIFIED HEALTH CTRS(enrol'd as rural h.)
GDTF	033	GENETIC DISEASE TESTING FUND
G***	Any	"G" INDICATES A GROUP OF THE TYPE ASSOC. WITH PREFIX
G***	Ind.	OF PROV TYPE; A GROUP OF AUDIOLOGISTS WILL BE "GAU"
GNP	010	GROUP NURSE PRACTITIONERS (PEDIATRIC & FAMILY SERV.)
GPS	031	PSYCHOLOGISTS GROUP
GR	022	PHYSICIAN GROUP
GRE	026	PODIATRIC GROUP
GRR	022	PHYSICIAN GROUP WITH A REGIONAL CENTER(DEPT DEV.SER)
GRR**	Any	REGIONAL CENTER GROUP,WITH ADDED LETTERS TO INDICATE Type; A GROUP OF AUDIOLOGISTS WILL BE "GRRAU"
GRT	056	
GRX	098	MISCELLANEOUS FOR CROSSOVER PAYMENTS
GSD	023	OPTOMETRY GROUPS
HA	013	HEARING AID DISPENSERS
HAP	058	FAMILY PLANNING
HDC	051	OUTPATIENT HEROIN DETOX CENTERS
HHA	014	HOME HEALTH AGENCIES
HPC	039	HOSPICE PROVIDERS
HSC	016	COMMUNITY HOSPITAL INPATIENT (CONTRACTED)
HSD	016&060	SPECIAL "SHELL" NUMBER FOR "DISPROPORTINATE (can't bill
HSD	016&060	SHARE" PAYMENTS TO ELIGIBLE IN-PATIENT HOSPITALS x-overs)
HSM		MENTAL HEALTH HOSPITAL for hospital inpatient only
HSP0	016	COMMUNITY HOSPITAL--INPATIENT (NON-CONTRACTED) Some are MENTAL HEALTH CONSOLODATION.
HSP1	016	COMMUNITY HOSPITAL--INPATIENT (non active now)
HSP2	016	COMMUNITY HOSPITAL--INPATIENT - OUT OF STATE
HSP3	016	COMMUNITY HOSPITAL--INPATIENT (NON-CONTRACTED)
HSM3	072	MENTAL HEALTH CONSOLODATION
HSM4	015	COMMUNITY HOSPITAL OUTPATIENT MOBILE VANS
HSP5	--	NEVER HAVE USED THIS PREFIX
HSP6	016	COMMUNITY HOSPITAL--INPATIENT - OUT OF STATE
HSP7-9	--	THESE PREFIXES NEVER USED
HST	016&060	INPATIENT HOSPITALS-TRANSITIONAL CARE (can't bill x-overs)
HSW	060	INPATIENT HOSPITALS-L.A. COUNTY WAIVER
HCX	016&060	HOSPITAL CONSTRUCTION FUNDS - USED ONLY FOR AR PMTS.
LAB	009	CLINICAL LABORATORIES
LAB7	009	CLINICAL LABORATORIES-BUILT FROM THE CLIA NUMBER
LAW	048	L.A. WAIVER COUNTY CLINICS
LMW	082	LICENSED MIDWIFE
LTC	017	LONG TERM CARE FACILITIES
LTC3	017	RURAL HEALTH SWING BEDS
LTC4	065	LONG TERM CARE FACILITIES FOR PEDIATRAIC SUBACUTE CARE
LTC7	017	SUB-ACUTE (Adult) LONG TERM CARE FACILITIES

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
LTM	017	LTC FACILITIES - ONLY TITLE 19-EFF. AFTER OBRA 10-90
LTP	065	LTC PEDIATRIC SUBACUTE
LTT	017	LTC FACILITIES - TRANSITIONAL CARE
LTX	017	DISTINCT PART LTC FACILITIES
MIA	ANY	A SPECIAL PROVIDER TYPE, FOR COUNTY BILLING OF MIAs
MIC	060	LIKE THE MIAs ABOVE, BUT FOR COUNTY CONTRACT FACIL.
MSS	074	MULTIPURPOSE SENIOR SERVICES PROGRAM
MTA000	030	MEDICAL TRANSPORT-AIR- OLD, NO REMAINING ACTIVE
MTA0055	38	MEDICAL TRANSPORT-NEW EXCLUSIVE AIR TRANSPORT
MTE	030	MEDICAL TRANSPORT-GROUND, EMERGENCY
MTN	030	MEDICAL TRANSPORT-GROUND, NON-EMERGENCY
NMW	005	CERTIFIED NURSE MIDWIFE
NP	007	NURSE PRACTITIONERS (PEDIATRIC & FAMILY SERV.)
PA-PS	031	PSYCHOLOGISTS
PU-PZ	031	PSYCHOLOGISTS
PHA	024	PHARMACIES-PHARMISTISTS
PHB-C	024	PHARMACIES-HOSPITALS
PHD-F	024	PHARMACIES
PHX	024	PHARMACIES-OUT OF STATE
PIA	011	PRISON INDUSTRIES FABRICATING OPTICAL LAB
PT	025	PHYSICAL THERAPISTS
PSY	031	PSYCHOLOGISTS
PTX	031	PSYCHOLOGISTS
REH	046	REHABILITATION CLINICS
RHC	034	RURAL HEALTH MEDICAL CLINICS (no longer used)
RHM	035	RURAL HEALTH MEDICAL CLINICS
RN	018	NURSE ANESTHETISTS
RPE	037	REQUIRED PROFESSIONAL EXPERIENCE (for intern SP)
RT	056	RESPIRATORY CARE PRACTITIONER
SD	020	OPTOMETRISTS
SP	037	SPEECH THERAPISTS
SS	055	SCHOOL-LINKED SERVICES / LOCAL EDUCATION AGENCIES
SUR	044	SURGERY CLINICS
THP	075	TRIBAL HEALTH PLAN
TMT	030	OUT OF COUNTY MEDICAL TRANSPORTATION (12 providers)
TPY	026	OUT OF COUNTY PHYSICIANS
X	MANY	AN X IS ADDED TO THE NUMBER WHICH WOULD BE GENERATED FOR IN-STATE PROVIDERS. THE PROVIDER TYPE AND CATEGORY OF SERVICES ARE THE SAME AS FOR IN-STATE PROVIDERS - EXCEPT FOR ORTHOTIC & PROSTHETIC WHICH USES "X" IN THE PROVIDER NUMBER-NOTE EXAMPLES BELOW. X CAN ALSO MEAN BORDER as in across the border.

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
XB	027	PROSTHETISTS (in-state)
XBB	004	OUT OF STATE BLOOD BANK
XC	027	PROVIDER IS BOTH PROSTHETIC AND ORTHOTHOTIC
XDC	006	OUT OF STATE DOCTORS OF CHIROPACTICS
XDME	002	OUT OF STATE DURABLE MEDICAL EQUIPMENT
XHSP3	016	OUT OF STATE HOSPITALS - INPATIENT
XHSP4	015	OUT OF STATE HOSPITALS - OUTPATIENT
XPY	026	OUT OF STATE PHYSICIANS
XRO	028	OUT OF STATE PORTABLE X-RAY
XTHP	035	BORDER TRIBAL HEALTH PLAN
00A	026	PHYSICIANS (M.D.)
000A	026	PHYSICIANS (M.D.)
00AX	026	PHYSICIANS (OSTEOPATHS)
00C	026	PHYSICIANS (M.D.)
000C	026	PHYSICIANS (M.D.)
00G	026	PHYSICIANS (M.D.)
000G	026	PHYSICIANS (M.D.)
000E	027	PODIATRISTS (D.P.M.)
00F	026	FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT
000F	026	FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT
0000F	026	FOREIGN PHYSICIANS IN USA ON SPECIAL PERMIT

M.2 OLD PROVIDER NUMBER NAMING ACRONYMS

Some of these numbers still exist from earlier times. Most were created under the "BLUES"/MIO system from the 1970s. Some now contain as few as one provider.

ACCRONYM	PROVIDER TYPE	NAME OF PROVIDER TYPE
ACX	032	CERTIFIED ACCUPUNTURISTS (only two remaining)
DDX	012	DISPENSING OPTICIANS (only one remaining)
DIA	042	CHRONIC DIALYSIS CENTER (only one remaining)
DS	--	DENTAL DOCTORS (no longer used in the EDS system)
EMP	047	EMPLOYER/EMPLOYEE CLINICS (not used at this time)
FSS	MANY	NO ACTIVE PROVIDERS REMAINING
FS0	MANY	OUT OF STATE (BORDER) PROVIDERS - MOSTLY PHYSICIANS
FS0-4	MANY	(70 physicians; 3 ambulance; 2 labs; 1 pharmacy)
GR	MANY	VARIOUS OTHER GROUPS - OLD NUMBERS ISSUED BY "BLUES"
GRX	098	NO ACTIVE PROVIDERS REMAINING
HAD	013	HEARING AID DEVICES (only 15 remaining)
RUR	061	COUNTY HOSP.-OUTPATIENT (only one still remaining)
SNF	024	PHARMACIES - NEVER ANY PROVIDERS, ONLY TEST FILES
USA	MANY	OUT OF STATE MISC. PROVIDERS (few remaining active)
YYY	022	MEDICAL GROUPS
ZZR0	016	COMMUNITY HOSPITALS - INPATIENT
ZZR1	Mix	COMMUNITY CLINIC AND HOSPITAL MIX
ZZR2	015	COMMUNITY HOSPITALS - OUTPATIENT - OUT OF STATE
ZZR3	016	NO ACTIVE PROVIDERS REMAINING
ZZR5	060	COUNTY HOSPITALS (No remaining active providers)
ZZR52	090	OUT OF COUNTRY INPATIENT HOSPITALS (No active)
ZZR55	017	LONG TERM CARE FACILITIES-(Only 27 active providers)
ZZR56	016	COMMUNITY INPATIENT HOSPITALS (No active)
ZZR6-9	MIX	NO ACTIVE PROVIDERS REMAINING
ZZT0	017	LONG TERM CARE FACILITIES
ZZT1-9	MIX	LTC, HOSPTIALS, OUT OF STATE, ETC.
ZZW	060	L.A. WAIVER PROVIDERS
ZZX	061	NO ACTIVE PROVIDERS REMAINING
ZZZA-D	MIX	NO ACTIVE PROVIDERS REMAINING
ZZZP	022&926	CALIFORNIA UNIVERSITIES DEPARTMENTS AND PHYSICIANS
ZZZ1-9	MANY	MIX OF PHY. GROUPS, INDIV. PHY., MED TRANS.,& OTHERS

BLUE CROSS AND BLUE SHIELD HISTORICAL PERSPECTIVE

BLUE CROSS enrolled hospitals ONLY, and only in Northern California, and utilized the same number (ZZR0) for both in and out patient services. At the transfer, this was kept as the inpatient code and caused the creation of a new number for outpatient codes (HSP4), with the ZZR numeric added BLUE SHIELD enrolled hospitals Southern California ONLY, and all other provider types statewide. Blue Shield utilized both inpatient as well as outpatient provider numbers and
both were kept (ZZT3=inpatient and ZZT4=outpatient). Blue Shield indiscriminately utilized ZZZ for all other provider types. USA was utilized for out-of-state.

APPENDIX N. INPATIENT ACCOMMODATION CODES

N.1 CHFCA HOSPITAL INPATIENT ACCOMMODATION CODES

The California Health Facilities Chart of Accounts (CHFCA) were used to summarize the charges for each Cost Center. All Inpatient Hospital claims must include ancillary charges. Although contracting facilities will be paid for ancillary services on claims for Administrative Days, ancillary charges must still be shown for total charges. These codes were replaced by UB-82s on January 1, 1992.

Contracting All Inclusive Rates	Contracting Per Case Rate	Non-Contracting Rate	Description
3010	3019	3010	MEDICAL/SURGICAL INTENSIVE CARE
3020	3029	3020	CORONARY CARE
3030	3039	3030	DEFINITIVE OBSERVATION
3040	3049	3040	PEDIATRIC INTENSIVE CARE
3050	3059	3050	PSYCHIATRIC ISOLATION
3060	3069	3060	OTHER INTENSIVE CARE UNIT
3063	3069	3060	INTENSIVE CARE HEART TRANSPLANT
3064	3069	3060	INTENSIVE CARE LIVER TRANSPLANT
3065	3069	3060	INTENSIVE CARE BONE MARROW TRANSPLANT
3066	3069	3060	INTENSIVE CARE KIDNEY TRANSPLANT
3070	3079	3070	BURN CARE
3080	3089	3080	MEDICAL/SURGICAL ACUTE
3090	3099	3090	NEONATAL INTENSIVE CARE
3111	3119	3111	LITHOTRIPSY
3120	3129	3120	PEDIATRIC ACCUTE
3140	3149	3140	PSYCHIATRIC ACUTE
3150	3159	3150	PSYCHIATRIC, ADOLESCENT & PEDIATRIC CARE
3160	3169	3160	OBSTETRICS ACUTE
3170	3179	3170	NURSERY ACUTE
3180	3189	3180	OTHER ACUTE UNITS
3202			MEDICARE CERTIFIED DISTINCT PART SNF
3203	3203	3203	ADMINSTRATIVE DAYS
3340	3349	3340	REHABILITATION
3360	3369	3360	OTHER DAILY HOSPITAL SERVICE
3980		3980	DISPROPORTIONATE SHARE
* 3998			COMMON DAY CODE, MOTHER AND BABY(IES)

NOTE:* 3998 is a combination code for use with mother and baby(ies) common days of inpatient stay only. A separate nursery charge or obstetrics charge is not allowable. If no common days, codes 3160 and 3170 are used.

CHFCA HOSPITAL INPATIENT ANCILLARY CODES

Ancillary Codes	Description
4010	LABOR AND DELIVERY
4020	SURGERY AND RECOVERY
4040	ANESTHESIOLOGY
4050	CENTRAL SERVICES AND SUPPLIES
* 4060	LABORATORIES - CLINICAL
4070	LABORATORIES - PATHOLOGICAL
4080	LABORATORIES - PULMONARY FUNCTION
4090	LABORATORIES - OTHER
4100	BLOOD BANK
4110	ELECTROCARDIOGRAPHY
4120	ELECTROMYOGRAPHY
4130	ELECTROENCEPHALOGRAPHY
* 4140	RADIOLOGY - DIAGNOSTIC
* 4150	RADIOLOGY - THERAPEUTIC
* 4160	NUCLEAR MEDICINE
* 4170	PHARMACY
* 4171	PHARMACY - DISCHARGE MEDICATIONS **
4180	INHALATION THERAPY
4190	DIALYSIS
* 4200	PHYSICAL THERAPY
* 4210	OCCUPATIONAL THERAPY
* 4220	OTHER PHYSICAL MEDICINE
4230	EMEREGENCY ROOM
4250	PSYCHIATRIC EMERGENCY ROOM
4410	OTHER ANCILLARY SERVICES
4420	COMPUTERIZED TOMOGRAPHIC SCANNER
4440	CARDIAC CATHERIZATION LABORATORY

* Administrative Days - use code 3203. Only asterisked(*) Ancillary Codes are payable with code 3203.

Blood Gas Studies need to use code 4080.

** The quantities furnished as discharge medications shall not exceed a 10-day supply. When the amount of this change exceeds $50.00, the provider must attach a list of the medications, including the name of the drugs, quantities dispensed, dosage prescribed and charges per prescription. Discharge medications are to be billed using the non-contract inpatient provider number for Medicare claims ONLY.

UB-92 HOSPITAL INPATIENT ACCOMMODATION CODES (CONT.)

Starting January 1, 1992, CHFCA hospital inpatient codes will be replaced by UB-82s. The UB-82s Must be used to summarize the charges for each Cost Center. As of the fall of 1994 the UB-82s were renamed UB-92s.

Listed below is the conversion scheme as of December 9, 1991. The leading '0' or '00' or '1' or '10' has been dropped from the UB-82 codes for easier reading. See "DATA ELEMENT:PROCEDURE CODE or DRUG TYPE" for the format of the UB-92s.

Providers for their accounting systems use the OSHPD codes.

UB-92 codes are numbered 100 or higher. State-only codes are numbered lower than 100.

ACCOM CODE	OLD CHFC CODE	N E W U B 8 2 C O D E CONTRACTING ALL INCLUSIVE	NON-CONTRACTING	DESCRIPTION OF CARE
1. 08	3010	200	200	INTENSIVE CARE, GENERAL
		201	201	INTENSIVE CARE, SURGICAL
		202	202	INTENSIVE CARE, MEDICAL
		208	208	INTENSIVE CARE, TRAUMA
2. 04	3020	210	210	CORONARY CARE, GENERAL
		211	211	CORONARY CARE, MYOCARDIAL INFARCTION
		212	212	CORONARY CARE, PULMONARY CARE
		219	219	CORONARY CARE, OTHER
3. 02	3030	206	206	INTENSIVE CARE, POST ICU
		214	214	CORONARY CARE, POST CCU
4. 08	3040	203	203	INTENSIVE CARE, PEDIATRIC
5. 02	3050	204	204	INTENSIVE CARE, PSYCHIATRIC
6. 08	3060	209	209	INTENSIVE CARE, OTHER
7. 08	3063	86	-	INTENSIVE CARE, HEART TRANSPLANT
8. 08	3064	87	-	INTENSIVE CARE, LIVER TRANSPLANT
9. 08	3065	88	-	INTENSIVE CARE, BONE MARROW TRANSPLT
10. 08	3066	89	89	INTENSIVE CARE, KIDNEY TRANSPLANT
11. 08	3070	207	207	INTENSIVE CARE, BURN CARE IN LICENSED BURN CENTER BEDS

& These codes have been defined as Medi-Cal benefits in order to provide an accommodation code to meet the needs of small hospitals - those with limited be capacity in ICU or CCU. Code 200 must ONLY be used to represent Medical (202) or Surgical (210) Intensive Care. If other services are available, they must be billed with specifically designated code, for example, Pediatic ICU = code 203. Code 210 must ONLY be used to represent Coronary Care: Myocardial Infarction (211), Pulmonary Care (212) or Other (219). It may NOT be used for Coronary Care, POS CCU (214).

UB-92 HOSPITAL INPATIENT ACCOMMODATION CODES

ACCOM CODE	OLD CHFC CODE	NEW UB82 CODE CONTRACTING ALL INCLUSIVE	NEW UB82 CODE NON-CONTRACTING	DESCRIPTION OF CARE
12.	02	3080	111	ROOM AND BOARD - PRIVATE, MEDICAL/SURGICAL/GYNECOLOGICAL
		117	117	ROOM AND BOARD - PRIVATE, ONCOLOGY
		121	121	ROOM AND BOARD - SEMI-PRIVATE 2 BED, MEDICAL/SURGICAL/GYNECOLOGICAL
		127	127	ROOM AND BOARD - SEMI-PRIVATE 2 BED, ONCOLOGY
		131	131	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED, MEDICAL/SURGICAL/GYNECOLGICAL
		137	137	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED, ONCOLOGY
		151	151	ROOM AND BOARD – WARD (MEDICAL OR GENERAL), MEDICAL/SURGICAL/GYN
		157	157	ROOM AND BOARD - WARD (MEDICAL OR GENERAL), ONCOLOGY
13.	08	3090	175	175	NURSERY, NEONATAL INTENSIVE CARE
14.	08	3111	90	90	LITHOTRIPSY
15.	08	3119	91	-	LITHOTRIPSY (PER DISCHARGE RATE)
16.	02	3120	113	113	ROOM AND BOARD - PRIVATE, PEDIATRIC
		123	123	ROOM AND BOARD - SEMI-PRIVATE 2 BED, PEDIATRIC
		133	133	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED,PEDIATRIC
		153	153	ROOM AND BOARD - WARD (MEDICAL OR GENERAL), PEDIATRIC
17.	02	3140	114	114	ROOM AND BOARD - PRIVATE, PSYCIATRIC
		124	124	ROOM AND BOARD - SEMI-PRIVATE 2 BED, PYSCHIATRIC
		134	134	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED, PSYCHIATRIC
		154	154	ROOM AND BOARD - WARD (MEDICAL OR GENERAL), PSYCHIATRIC
18.	02	3150	97	97	PSYCHIATRIC ACUTE (ADOLESCENT AND CHILD)
19.	02	3160	112	112	ROOM AND BOARD - PRIVATE, OBSTETRIC

			122	122	ROOM AND BOARD - SEMI-PRIVATE 2 BED, OBSTETRIC
			132	132	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED, OBSTETRIC
			152	152	ROOM AND BOARD - WARD (MEDICAL OR GENERAL), OBSTETRIC
20.	02	3169	92	-	OBSTETRICS ACUTE(PER DISCHARGE RATE)
21.	05	3170	171	171	NURSERY, NEWBORN
22.	02	3180	80	80	OTHER ACUTE CARE UNITS
23.	07	3203	98	98	ADMINISTRATIVE DAYS

* NS - None Specified

N.2 UB-92 HOSPITAL INPATIENT ACCOMMODATION CODES AFTER CONVERSION

	ACCOM CODE	NEW UB92 CODE: CONTRACTING ALL INCLUSIVE	NEW UB92 CODE: NON-CONTRACTING	DESCRIPTION OF CARE
24.	02	3340	118	ROOM AND BOARD - PRIVATE, REHABILITATION
			128	ROOM AND BOARD - SEMI-PRIVATE 2 BED, REHABILITATION
			138	ROOM AND BOARD - SEMI-PRIVATE 3 OR 4 BED, REHABILITATION
			158	ROOM AND BOARD - WARD (MEDICAL OR GENERAL, REHABILITATION
25.	02	3360	81	OTHER DAILY HOSPITAL SERVICES
26.	02	3980	99	DISPROPORTIONATE SHARE
27.	02	3998	96 -	COMMON DAY CODE, MOTHER & BABY(IES) (Discontinued, Effective February 1, 1997)
28.	08	083 (START 3/96)		LUNG TRANSPLANT (SINGLE OR DOUBLE): INTENSIVE CARE
29.	08	084 (START 3/96)		HEART-LUNG TRANSPLANT: INTENSIVE CAR
30.	02	075 /		TRANSITIONAL CARE, MEDICAL
31.	02	076 /		TRANSITIONAL CARE, REHABILITATION
32.	07	077 *** / (START 1/1/96)		TRANSITIONAL CARE, REHABILITATION-LEAVE OF ABSENCE
33.	07	078 \		TRANSITIONAL CARE, MEDICAL-ADMINISTRATIVE DAYS
34.	07	079 \		TRANSITIONAL CARE, REHABILITATION-ADMINISTRATIVE DAYS
35.	08	085	Started 12/96	NURSERY ACUTE WITHOUT ASSOCIATED DELIVERY
36.	02	094	Started 12/96	NURSERY NEWBORN, INELIGIBLE MOTHER
37.	08	095	Started 12/96	NURSERY ACUTE WITH ASSOCAITED DELIVERY
38.	02	171	Started 12/96	NURSERY, NEWBORN (Well Baby)

*** This code will be reimbursed at the established rate, minus the raw food cost of $3.95. 5/96. $4.25 as of 12/96.

UB-92 HOSPITAL INPATIENT ANCILLARY CODES

ANCILLARY CODES

12/20/91

CHFC Codes to UB-82 Codes Conversion

	ACCOM CODE	CHFC CODE	UB-82 CODE	DESCRIPTION
1.	A1	4010	720	LABOR ROOM/DELIVERY, GENERAL
			721	LABOR ROOM/DELIVERY, LABOR
			724	LABOR ROOM/DELIVERY, BIRTHING CENTER (UNLICENSED BEDS)
			729	LABOR ROOM/DELIVERY, OTHER
2.	A1	4020	360	OPERATING ROOM SERVICES, GENERAL
			361	OPERATING ROOM SERVICES, MINOR SURGERY
			362	OPERATING ROOM SERVICES, ORGAN TRANSPLANT OTHER THAN KIDNEY
			367	OPERATING ROOM SERVICES, KIDNEY TRANSPLANT
			369	OPERATING ROOM SERVICES, OTHER OPERATING ROOM SERVICES
			710	RECOVERY ROOM, GENERAL
3.	A2	4040	370	ANESTHESIA, GENERAL
			371	ANESTHESIA, INCIDENT TO RADIOLOGY
			372	ANESTHESIA, INCIDENT TO OTHER DIAGNOSIS SERVICES
			374	ANESTHESIA, MINOR SURGERY
			379	ANESTHESIA, OTHER
4.	J1	4050	270	MEDICAL/SURGICAL SUPPLIES AND DEVICES, GENERAL
			271	MEDICAL/SURGICAL SUPPLIES AND DEVICES, NON-STERILE SUPPLY
			272	MEDICAL/SURGICAL SUPPLIES AND DEVICES, STERILE SUPPLY
			274	MEDICAL/SURGICAL SUPPLIES AND DEVICES, PROSTHETIC/ORTHOTIC
			275	MEDICAL/SURGICAL SUPPLIES AND DEVICES, PACEMAKER
			276	MEDICAL/SURGICAL SUPPLIES AND DEVICES, INTRAOCULAR LENS
			278	MEDICAL/SURGICAL SUPPLIES AND DEVICES, OTHER INPLANTS
			279	MEDICAL/SURGICAL SUPPLIES AND DEVICES, OTHER SUPPLIES/DEVICES
			290	DURABLE MEDICAL EQUIIPMENT (DME), (OTHER THAN RENAL EQUIPMENT), GENERAL
			291	DURABLE MEDICAL EQUIIPMENT (DME), (OTHER THAN RENAL EQUIPMENT), RENTAL
			292	DURABLE MEDICAL EQUIIPMENT (DME), (OTHER THAN RENAL EQUIPMENT), PURCHASE OF NEW DME
			293	DURABLE MEDICAL EQUIIPMENT (DME), (OTHER THAN RENAL EQUIPMENT), PURCHASE OF USED DME
			299	DURABLE MEDICAL EQUIIPMENT (DME), (OTHER THAN RENAL EQUIPMENT), OTHER EQUIPMENT

621 MEDICAL/SURGICAL SUPPLIES AND DEVICES, INCIDENT TO RADIOLOGY
622 MEDICAL/SURGICAL SUPPLIES AND DEVICES, INCIDENT TO OTHER DIAGNOSTIC SERVICES

UB-92 HOSPITAL INPATIENT ANCILLARY CODES

ANCILLARY CODES

12/20/91

CHFC Codes to UB-82 Codes Conversion

	ACCOM CODE	CHFC CODE	UB-82 CODE	DESCRIPTION
5.	F1	4060	300	LABORATORY, (LAB) GENERAL
			301	LABORATORY, CHEMISTRY
			302	LABORATORY, IMMUNOLOGY
			304	LABORATORY, NON-ROUTINE DIALYSIS
			305	LABORATORY, HEMATOLOGY
			306	LABORATORY, BACTERIOLOGY AND MICROBIOLOGY
			307	LABORATORY, UROLOGY
6.	F1	4070	310	LABORATORY, PATHOLOGY, GENERAL
			311	LABORATORY, PATHOLOGY, CYTOLOGY
			314	LABORATORY, PATHOLOGY, BIOPSY
7.	F1	4080	460	PULMONARY FUNCTION, GENERAL
8.	F1	4090	DOES NOT CORRELATE TO ANY UB-82	
9.	B2	4100	380	BLOOD, GENERAL
			381	BLOOD, PACKED RED CELLS
			382	BLOOD, WHOLE BLOOD
			383	BLOOD, PLASMA
			384	BLOOD, PLATELETS
			385	BLOOD, LEUKOCYTES
			386	BLOOD, OTHER COMPONENTS
			387	BLOOD, OTHER DERIVATIVES (CRYOPRECIPITATES)
			389	BLOOD, OTHER
			390	BLOOD STORAGE AND PROCESSING, GENERAL
			391	BLOOD STORAGE AND PROCESSING, BLOOD ADMINISTRATION
10.	G1	4110	730	ELECTROCARDIOGRAM (EKG/ECG), GENERAL
			731	ELECTROCARDIOGRAM (EKG/ECG), HOLTER MONITOR
11.	G1	4120	922	OTHER DIAGNOSTIC SERVICES, ELECTROMYOGRAM
12.	G1	4130	740	ELECTROENCEPHALOGRAM (EEG), GENERAL
13.	D1	4140	320	RADIOLOGY, GENERAL
	D1		321	RADIOLOGY, ANGIOCARDIOGRAPHY
	D1		322	RADIOLOGY, ARTHROGRAPHY
	D1		323	RADIOLOGY, ARTERIOGRAPHY
	D1		324	RADIOLOGY, CHEST X-RAY
	D1		329	RADIOLOGY, OTHER
	* I1		401	OTHER IMAGING SERVICES, DIAGNOSTIC MAMOGRAPHY
	* I1		403	OTHER IMAGING SERVICES, SCREENING MAMOGRAPHY
	D1		610	MAGNETIC RESONANCE IMAGING, GENERAL
	D1		611	MAGNETIC RESONANCE IMAGING, BRAIN (INCLUDING BRAINSTEM)
	D1		612	MAGNETIC RESONANCE IMAGING, SPINAL CORD (INCLUDING SPINE)
	D1		619	MAGNETIC RESONANCE IMAGING, OTHER
14.	E3	4150	330	RADIOLOGY - THERAPEUTIC, GENERAL
			331	RADIOLOGY - THERAPEUTIC, CHEMOTHERAPY –

	INJECTED
332	RADIOLOGY - THERAPEUTIC, CHEMOTHERAPY - ORAL
333	RADIOLOGY - THERAPEUTIC, RADIATION THERAPY
335	RADIOLOGY - THERAPEUTIC, CHEMOTHERAPY, IV
339	RADIOLOGY - THERAPEUTIC, OTHER

* NOTE: These accommodation codes were added for the new UB-82 conversion in 1992.

UB-92 HOSPITAL INPATIENT ANCILLARY CODES

ANCILLARY CODES 12/20/91
CHFC Codes to UB-82 Codes Conversion

	ACCOM CODE	CHFC CODE	UB-82 CODE	DESCRIPTION
15.	E2	4160	340	NUCLEAR MEDICINE, GENERAL
			341	NUCLEAR MEDICINE, DIAGNOSTIC
			342	NUCLEAR MEDICINE, THERAPEUTIC
			349	NUCLEAR MEDICINE, OTHER
16.	C1	4170	250	PHARMACY, GENERAL
			251	PHARMACY, GENERIC DRUGS
			252	PHARMACY, NON-GENERIC DRUGS
			254	PHARMACY, DRUGS INCIDENTAL TO OTHER PROCEDURES
			255	PHARMACY, DRUGS INCIDENTAL TO RADIOLOGY
			257	PHARMACY, NON-PRESCRIPTION
			258	PHARMACY, IV SOLUTION
			259	PHARMACY, OTHER
			630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL
17.	C2	4171	253	PHARMACY, TAKE HOME DRUGS
18.	L1	4180	410	RESPIRATORY SERVICES, GENERAL
			412	RESPIRATORY SERVICES, INHALATION SERVICES
			419	RESPIRATORY SERVICES, OTHER
19.	N1	4190	800	INPATIENT RENAL DIALYSIS, GENERAL
			801	INPATIENT RENAL DIALYSIS, HEMODIALYSIS
			802	INPATIENT RENAL DIALYSIS, PERIONEAL (NON-CAPD)
			803	INPATIENT RENAL DIALYSIS, CONT. AMULATORY PERITONEAL DIALYSIS (CAPD)
			803	INPATIENT RENAL DIALYSIS, CONT. CYCLING PERITONEAL DIALYSIS (CCPD)
			809	INPATIENT RENAL DIALYSIS, OTHER
20.	K1	4200	420	PHYSICAL THERAPY, GENERAL
21.	K2	4210	430	OCCUPATIONAL THERAPY, OTHER
			439	OCCUPATIONAL THERAPY, GENERAL
22.	P1	4220	93	OTHER PHYSICAL MEDICINE
			440	SPEECH/LANGUAGE PATHOLOGY, OTHER
			449	SPEECH/LANGUAGE PATHOLOGY, GENERAL
			470	AUDIOLOGY, GENERAL
			471	AUDIOLOGY, DIAGNOSIC
			472	AUDIOLOGY, TREATMENT
			479	AUDIOLOGY, OTHER

23.	*R1	4230	450	EMERGENCY ROOM, GENERAL
24.	*R1	4250	82	PSYCHIATRIC EMERGENCY ROOM
25.	P1	4410	413	RESPIRATORY SERVICES, HYPERBARIC OXYGEN THERAPY
			750	GASTRO-INTESTINAL SERVICES, GENERAL
			790	LITHOTRIPSY, GENERAL
26.	E1	4420	350	COMPUTED TOMOGRAPHIC SCAN, GENERAL
			351	COMPUTED TOMOGRAPHIC SCAN, HEAD
			352	COMPUTED TOMOGRAPHIC SCAN, BODY
			359	COMPUTED TOMOGRAPHIC SCAN, OTHER
27.	H1	4440	481	CARDIOLOGY, CARDIAC CATHETERIZATION

* NOTE: These accommodation codes were added for the new UB-82 conversion in 1992.

UB-92 HOSPITAL INPATIENT ANCILLARY CODES

ANCILLARY CODES

12/20/91

CHFC Codes to UB-82 Codes Conversion

	ACCOM CODE	CHFC CODE	UB-82 CODE	DESCRIPTION
28.	*I1	-	400	OTHER IMAGING SERVICES, GENERAL
29.	*I1	-	402	OTHER IMAGING SERVICES, ULTRASOUND
30.	*I1	-	409	OTHER IMAGING SERVICES, OTHER
31.	*H1	-	489	CARDIOLOGY, OTHER

* NOTE: These accommodation codes were added for the new UB-82 conversion in 1992.

THIS TABLE WAS DELEVOPED USING EDS' INPATIENT/OUTPATIENT PROVIDER MANUAL PAGES 300-108-1 THROUGH 300-109-10, DATED DECEMBER 1991.

APPENDIX O. L.A. WAIVER CODES – INPATIENT/OUTPATIENT

If a L.A.Waiver code ends in a '9', then it is a contracted hospital per case code. Also all L.A. Waiver provider numbers start with 'HSW' or 'ZZW'.

The L.A.Waiver reflect all-inclusive rates and are defined as follows:

	INPATIENT ACCOMMODATION	CODES
	Disproportionate Share	0001
*	Trauma Transitional Care Unit	0002
*	Physician Referral Unit (Medical)	0003
*	Physician Referral Unit (Surgical)	0004
	Liver	0007
	Intensive Medical	0008
	Acute Medical	0009
*	A.I.D.S.	0010
	Surgical	0011
	Chest Medicine	0012
	Communicable Disease	0013
	Clinic Study Center	0014
	Surgical - Level I	0016
	Surgical - Level II	0017
	Surgical - Level III	0018
	Surgical - Level IV	0019
	Surgical - Level V	0020
	Surgical - Level VI	0021
	Surgical - Level VII	0022
*	Pediatric Intensive Special Care	0023
	Surgical - Level VIII	0024
	Pediatrics	0025
	Surgical - Level IX	0026
	Surgical - Level X	0027
	Pediatric Intermediate Care (for Olive View Medical Care Center only prov# HSW30040G)	0027
*	Surgical - Level XI	0028
*	Surgical - Level XII	0029
	Intensive Care	0030
	Burn ICU	0031
	Nursery-Newborn (ineligible mother)	0032
*	Surgical - Level XIII	0033
*	Surgical - Level XIV	0034
*	Psychiatric	0035
*	Surgical - Level XV	0036

* NOTE:These L.A. Waiver codes were dropped after the Medi-Cal Operations Division reviewed the claims. EDS has end dated/zero priced these codes with an effective date of service of January 1, 1993.

O.1 L.A. WAIVER CODES - INPATIENT

INPATIENT ACCOMMODATION	CODES
* Surgical - Level XVI	0037
* Surgical - Level XVII	0038
* Surgical - Level XVIII	0039
* Surgical - Level XV	0036
* Surgical - Level XVI	0037
* Surgical - Level XVII	0038
* Surgical - Level XVIII	0039
Ortho-Neuro Acute (Rehab Unit)	0040
Normal Birthing Center (NBC) Mother	0041
Normal Birthing Center (NBC) Nursery	0042
Observation Inpatient	0043
OB Mother	0044
* Surgical - Level XIX	0045
OB Nursery	0046
OB Special Care Nursery (delivery in hosp.)	0047
* Cadaver Kidney Harvest	0048
* Surgical - Level XX	0049
Transitional Living	0050
* Live Donor Kidney	0051
* Cadaver Kidney Acquisition	0053
* Jail	0055
* ICU-Level 2	0058
* ICU-Level 3	0059
* Definitive Observation Unit	0060
* Weekend Therapeutic	0061
* Cadaver Organ Harvest	0070
* Special Intensive Care	0081
* Lowest Acute Rate	0095
OB Duplicate Days (OB/Nursery Common Day)	0098
Neonatal Intensive Care Unit	0099
Skilled Nursing:	
* Skilled Nursing Long-Term Care	0015
Skilled Nursing Administrative Days- Routine	0052
* Skilled Nursing Long-Term Care	0065
Skilled Nursing Administrative Days- Heavy Care (also see Inpatient Services)	0095
* Subacute Administrative Days- With Ventilator	0096
* Subacute Administrative Days- Without Ventilator	0097

- NOTE:These L.A. Waiver codes were dropped after the Medi-Cal Operations Division reviewed the claims. EDS has end dated/zero priced these codes with an effective date of service of January 1, 1993.
-

O.2 L.A. WAIVER CODES - OUTPATIENT CODES

TRANSITIONAL INPATIENT ACCOMMODATION	CODES
Transitional Care-Medical Services	0075
Transitional Care-Rehab Services	0076
Transitional Care-Rehab Patient-Leave of Absence	0077
Administrative Day-Medical Services	0078
Administrative Day-Rehab Services	0079

GENERAL OUTPATIENT SERVICES	CODES
Level of Care:	
** All-Inclusive Visit-Level 1 - 3	0060
** All-Inclusive Visit-Level 4 - 5	0061
** All-Inclusive Visit-Level 6 - 10	0062
** All-Inclusive Visit-Level 11 - 13	0063
** All-Inclusive Visit-Level 14 - 15	0064
** All-Inclusive Visit-Level 16 - 18	0066
** All-Inclusive Visit-Level 19 - 20	0067
** All-Inclusive Visit-Level 21 - 23	0068
** All-Inclusive Visit-Level 24 - 35	0069

Note:0060 is also an Inpatient Services code.

0062, 0063, and 0066-0069 also represent various levels of outpatient surgery.

SPECIAL OUTPATIENT SERVICES	CODES
Other Outpatient Services:	
Outpatient Surgery:	
For Rancho Los Amigos Medical Center	
* Level I	0068
* Levels II - XIII	0069
For Olive View Medical Center	
* Level I	0062
* Levels II - III	0063
* Levels IV - V	0066
* Levels VI	0067
* Levels VII - VIII	0068
* Levels IX - XX	0069
* Outpatient Surgery	0071

** NOTE: While doing research on L.A. Waiver outpatient claims, these codes were found on the RFF035-file. The all have 5 numeric with a leading zero and then the 4 digit code.

L.A. WAIVER CODES - OUTPATIENT SERVICES

	GENERAL OUTPATIENT SERVICES	CODES
**	Special Services	0070
**	Outpatient Surgery	0071
**	Observation Outpatient	0072
	Hyperbaric Chamber:	
**	Brief	0083
**	Limited	0084
*	Intermediate	0085
*	Extended	0086

	SPECIAL OUTPATIENT SERVICES	CODES
	Psychiatric Outpatient Clinic	
*	Collateral	0005
*	Individual	0006
**	Assessment	0087
*	Medication	0088
*	Group Therapy	0089
**	Intensive	0090
*	Habilitative	0091
**	Community Clients	0092
*	Community Outreach	0093
*	Case Management - Support *	0094
**	Psychiatric Emergency Room	0056
**	Psychiatric Consultation	0057
	HOME HEALTH SERVICES	
**	Skilled Nursing	0073
**	Physical Therapy	0074
*	Occupational Therapy	0075
*	Speech Therapy	0076
*	Home Health Aide	0077
*	Initial Case Evaluation	0078
*	Case Re-evaluation	0079
**	Physician	0080
**	Medical Social Services	0082

** NOTE: While doing research on L.A. Waiver outpatient claims, these codes were found on the RFF035-file. The all have 5 numeric with a leading zero and then the 4-digit code.

L.A. WAIVER CODES - OUTPATIENT SERVICES

Effective April 1989 L.A. Waiver facilities providing comprehensive Prenatal Services were given a new provider number for billing for those services. They also have to use CPT-4 procedure codes like other providers do! These facilities have Vendor Code 75 (organized outpatient clinic) instead of Vendor Code 52 (county hospital-outpatient). The Disproportionate Share code became effective October
1989 retroactive to services rendered on or after July 1, 1988. See Inpatient/Outpatient Bulletin #170, October 1989 for use of this code.

APPENDIX P. DELTA DENTAL CODES

P.1 DELTA PROCEDURE CODES

This scheme of dental codes is good until June 1993 month of payment. Starting July 1993 month of payment, these dental codes were replaced with HCPCS procedure codes. There were numerous old dental codes. Listed here are only the main groupings and the services related.

DENTAL CODES	DENTAL SERVICES
010-160	Visits - Diagnosis
210-299	Oral Surgery
300-399	Drugs
400-449	Anesthesia
450-499	Periodontics
500-549	Endodontics
550-599	Orthodonitic Services
600-679	Restorative Dentistry
680-699	Prosthetics
700-799	Dentures, Stayplates
800-812	Space Maintainers
832	Space Maintainers
900-916	Fractures, Dislocations
950-998	Maxillofacial Services
All Other	All Other Services

P.2 DELTA TOOTH IDENTIFICATION CODES

CODE	DESCRIPTION
Ab-Tb	Primary Teeth
01-34	Permanent Teeth
66	Service which does not involve a specific tooth, i.e. a prophylaxis
U	Upper
UR	Upper Right
L	Lower
LR	Lower Right
UL	Upper Left
LL	Lower Left

APPENDIX Q. SHORT-DOYLE/MEDI-CAL CODES

Q.1 SD/MC PROCEDURE CODES

Short-Doyle/Medi-Cal claims are for mental health services and alcohol and drug services. Department of Mental Health (DMH) and the Department of Drug and Alcohol Program (ADP) contract with Department of Health Services to do their claims processing. They are processed by program MFR151 to convert the 350-character record into a single segment paid claim after the MSD system adjudicates the claims.

Four-digit codes came into effect beginning with the April 1992 month of payment. The first character is either a 0 or a 5. A 5 means that record is from a case management claim (Mode of Service code = '50'). A 0 means all non-case management claims. The second digit is the first character of the MSD system's Service Function code. They are listed further down. The last two digits reflect the Program Code
with is '01' for Mental Health; '10' for Alcohol Services;' '20' for Drug Services (formerly '05'); and '25' for Prenatal Services. And starting with the July 1999 claims, the last character of the Service Function code is moved into the fifth/last character of the procedure code. Before the fifth/last character of the procedure code was a space.

The codes and/or definitions went into effect beginning with the July 1992 month of service due to the implementation of the Mental Health Rehabilitation Option. The codes were defined as follows:

0001 - Mental Health-Case Management
0101 - Mental Health-Collateral, Assessment, Individual Therapy, or Group Therapy (combines former codes of 0101, 0301, 0401, and 0501)
0201 - Mental Health-Crisis Stabilization-Emergency room, Crisis Stabilization, Psychiatric Health Facility
0220 - Drug Services-Methadone Maintenance
0225 - Prenatal Services-Methadone Maintenance
0301 - Same as 0101 (optional code)
0310 - Alcohol Services-Day Care Habilitative
0320 - Drug Services-Day Care Habilitative
0325 - Prenatal Services-Day Care Habilitative
0401 - Same as 0101 (optional code)
0425 - Prenatal Services-Residential Care
0501 - Same as 0101 (optional code)
0520 - Drug Services-Naltrexone Treatment
0525 - Prenatal Services-Naltrexone Treatment
0601 - Mental Health-Medication Support
0701 - Mental Health-Crisis Intervention
0801 - Mental Health-Day Treatment Intensive
0810 - Alcohol Services-Drug Free Treatment
0820 - Drug Services-Drug Free Treatment
0825 - Prenatal Services-Drug Free Treatment
0901 - Mental Health-Day Treatment Rehabilitative
5101 - Mental Health-Case Management/Brokerage

Q.2 SD/MC PROCEDURE CODES (OLD CODES)

One-digit codes were in effect though the March 1992 month of payment. The codes were defined as follows:

1 - Collateral Services
2 - Methadone Maintenance or Drug Free Treatment
3 - Assessment
4 - Individual Therapy
5 - Group Therapy
6 - Medication
7 - Crisis Intervention
8 - Day Care Intensive
9 - Day Care Habilitative

Q.3 SD/MC MODE OF SERVICE (ACCOMMODATION CODES)

On Short-Doyle/Medi-Cal claims, the Mode of Service Code is the equivalent of the accommodation code. So, therefore, it is moved into the accommodation code in the paid claims segment. ADP only uses Mode of Service of 12 and 17 since they offer no inpatient services. DMH uses all of the Modes of Service codes. They are defined as follows:

05 - Residential Rehabilitative Treatment
07 - Inpatient Hospital Services
08 - Psychiatric Hospital Inpatient (HIP)-Age under 21
09 - Psychiatric HIP-Age 65+
12 - Outpatient Hospital Services
17 - Clinic Services
18 - Non-Residential Rehabilitative Treatment
50 - Case Management (obsolete effective July 1993 month of service when it is identified by procedure code 0001)

Q.4 SD/MC SERVICE FUNCTION CODES

These codes were in effect though the March 1992 month of payment, but over time the ranges like the 20s for both ADP and DMH under Mode of Service 10 and the 80s for both departments have been split to mean new things. Unfortunately, we only carried the first one in the procedure code field until the July 1999 claims were processed. At that time, the last character of the Service Function code is moved into the last character of the 5-character procedure code. DMH requires all providers to bill with a Service Function code, but ADP does not always require it. The real production codes are defined as follows as of January 1999:

ADP uses this format when they send DHS their new Fiscal Year Rates. Rates will not be shown here, though. Mode of Service 12 or 18 does not help make a determination on rates for ADP.

Program Code 20 (Alcohol and Drug Services):

	DESCRIPTION	SERVICE FUNCTION	UNIT OF SERVICE
	Outpatient Methadone Maintenance	20 thru 22	Daily
@	LAAM Maintenance	23 thru 25	Daily
	NTP - Individual Counseling	26 thru 27	One 10 min. increment
	NTP - Group Counseling	28 thru 29	One 10 min. increment
	Day Care Habilitative	30 thru 39	Face-to-face Visit
%	Residential Care		Not Applicable
&	Naltrexone Treatment	50 thru 59	Face-to-face Visit
	Outpatient Drug Free Individual Counsel.	80 thru 84	Face-to-face / person
	Outpatient Drug Free Group Counseling	85 thru 89	Face-to-face / person

Program Code 25 (Perinatal Services):

	DESCRIPTION	SERVICE FUNCTION	UNIT OF SERVICE
	Outpatient Methadone Maintenance	20 thru 22	Daily
@	LAAM Maintenance		Not Applicable
	NTP - Individual Counseling	26 thru 27	One 10 min. increment
	NTP - Group Counseling	28 thru 29	One 10 min. increment
	Day Care Habilitative	30 thru 39	Face-to-face Visit
%	Residential Care	40 thru 49	Daily
&	Naltrexone Treatment		Not Applicable
	Outpatient Drug Free Individual Counsel.	80 thru 84	Face-to-face / person

Outpatient Drug Free Group Counseling	85 thru 89	Face-to-face / person

@ LAAM is not valid for Program Code 25 (Perinatal Services)
% Residential is not valid for Program Code 20
& NAL is not valid for Program Code 20
NTP = Narcotic Treatment Program

SD/MC SERVICE FUNCTION CODES (CONTINUED)

DMH uses this format when they send DHS their new Fiscal Year Rates. Rates will not be shown here, though.

	MODE OF SERVICE CODE	SERVICE FUNCTION CODE	TIME BASE
SERVICE FUNCTION			
A. 24 Hour Services			
Hospital Inpatient	07,08,09	10 thru 18	Client Day
Hospital Administrative Day	07,08,09	19	Client Day
Psychiatric Health Facility (PHF)	05	20 thru 29	Client Day
Adult Crisis Residential	05	40 thru 49	Client Day
Adult Residential	05	65 thru 79	Client Day
B. Day Services			
Crisis Stabilization	12,18		
Emergency Room		20 thru 24	Client Hour
Urgent Care		25 thru 29	Client Hour
Day Treatment Intensive			
Half Day		81 thru 84	Client 1/2 Day
Full Day		85 thru 89	Client Full Day
Day Rehabilitation			
Half Day		91 thru 94	Client 1/2 Day
Full Day		95 thru 99	Client Full Day
C. Outpatient Services	12,18		
Case Management, Brokerage		01 thru 09	

Collateral	Staff Minute 10 thru 18
Professional Inpatient Visit - Collateral	Staff Minute 19
Mental Health Services (MHS)	Staff Minute 30 thru 38
Professional Inpatient Visit - MHS	Staff Minute 39
Mental Health Services (MHS)	Staff Minute 40 thru 48
Professional Inpatient Visit - MHS	Staff Minute 49
Mental Health Services (MHS)	Staff Minute 50 thru 58
Professional Inpatient Visit - MHS	Staff Minute 59
Medication Support (MS)	Staff Minute 60 thru 68
Professional Inpatient Visit - MS	Staff Minute 69
Crisis Intervention (CI)	Staff Minute 70 thru 78
Professional Inpatient Visit - CI	Staff Minute 79

APPENDIX R. LONG TERM CARE (LTC) ACCOMMODATION CODES

NURSING FACILITIES (NF):

Level A (NF-A) (formerly Intermediate Care Facility {ICF})

21 ICF REGULAR - INPATIENT
22 ICF REGULAR - LEAVE DAYS
23 ICF REGULAR - LEAVE DAYS - DEVELOPMENTALLY DISABLED
31 REHABILATATION PROGRAM-MENTALLY DISORDERED-INPATIENT
32 REHABILATATION PROGRAM-MENTALLY DISORDERED-LEAVE DAYS
39 BED HOLD FOR TRANSFER TO TRANSITIONAL INPATIENT CARE

Level B (NF-B) (formerly Skilled Nursing Facility {SNF})

01 NF REGULAR - INPATIENT
02 NF REGULAR - LEAVE DAYS
03 NF REGULAR - LEAVE DAYS - DEV DISABLED
04 NF RURAL SWING BED PROGRAM - INPATIENT
05 NF RURAL SWING BED PROGRAM - LEAVE DAYS
09 BED HOLD FOR TRANSFER TO TRANSITIONAL INPATIENT CARE
11 NF SPECIAL TREATMENT PROGRAM-MENTALLY DISORDERED-INPATIENT
12 NF SPECIAL TREATMENT PROGRAM-MENTALLY DISORDERED-LEAVE DAYS

Transitional Inpatient Care:

06 HOSPITAL-BASED - MEDICAL - REGULAR SERVICE
08 HOSPITAL-BASED - MEDICAL - LEAVE DAYS - non-DD patient
07 HOSPITAL-BASED - REHABILATIVE - REGULAR SERVICE
09 HOSPITAL-BASED - REHAVILATIVE - LEAVE DAYS - non-DD patient
24 FREESTANDING NF - MEDICAL - REGULAR SERVICE
26 FREESTANDING NF - MEDICAL - LEAVE DAYS - non-DD patient
25 FREESTANDING NF - REHABILATIVE - REGULAR SERVICE
26 FREESTANDING NF - REHAVILATIVE - LEAVE DAYS - non-DD patient

Adult Subacute:

71 HOSPITAL-BASED - VENTILATOR DEPENDENT - INPATIENT
72 HOSPITAL-BASED - NON-VENTILATOR DEPENDENT - INPATIENT
73 HOSPITAL-BASED - VENTILATOR DEPENDENT - BED HOLD
74 HOSPITAL-BASED - NON-VENTILATOR DEPENDENT - BED HOLD
75 FREESTANDING NF - VENTILATOR DEPENDENT - INPATIENT
76 FREESTANDING NF - NON-VENTILATOR DEPENDENT - INPATIENT
77 FREESTANDING NF - VENTILATOR DEPENDENT - BED HOLD
78 FREESTANDING NF - NON-VENTILATOR DEPENDENT - BED HOLD
79 HOSPITAL-BASED - VENTILATOR DEPENDENT - LEAVE DAYS
80 HOSPITAL-BASED - NON-VENTILATOR DEPENDENT - LEAVE DAYS
81 FREESTANDING NF - VENTILATOR DEPENDENT - LEAVE DAYS
82 FREESTANDING NF - NON-VENTILATOR DEPENDENT - LEAVE DAYS

Pediatric Subacute in Nursing Facilities-Level B:

85 HOSPITAL DISTINCT-PART VENTILATOR DEPENDENT - REGULAR
86 HOSPITAL DISTINCT-PART NON-VENTILATOR DEPENDENT- REGULAR
87 HOSPITAL DISTINCT-PART VENTILATOR DEPENDENT - BED HOLD
88 HOSPITAL DISTINCT-PART NON-VENTILATOR DEPENDENT–BED HOLD
89 HOSPITAL DISTINCT-PART VENTILATOR DEPENDENT - LEAVE DAYS
89 HOSPITAL DISTINCT-PART NON-VENTILATOR DEPENDENT - LEAVE DAYS
91 FREESTANDING VENTILATOR DEPENDENT - REGULAR
92 FREESTANDING NON-VENTILATOR DEPENDENT - REGULAR
93 FREESTANDING VENTILATOR DEPENDENT - BED HOLD
94 FREESTANDING NON-VENTILATOR DEPENDENT - BED HOLD
95 FREESTANDING VENTILATOR DEPENDENT - LEAVE DAYS
96 FREESTANDING NON-VENTILATOR DEPENDENT - LEAVE DAYS

Pediatric Subacute Rehab Support or Ventilation Weaning

HOSPITAL-BASED - SUPPLEMENTAL REHABILITATION THERAPY SERVICE
84 HOSPITAL-BASED - VENTILATOR WEANING SERVICE
97 FREESTANDING NF - SUPPLEMENTAL REHABILITATION THERAPY SERVICE
98 FREESTANDING NF - VENTILATOR WEANING SERVICE

Pediatric Subacute Codes listed above are only found with Vendor Code 83. Units of service reported with these codes do not represent inpatient days.

INTERMEDIATE CARE FACILITIES (ICF):

41 ICF DEVELOPMENTALLY DISABILITY PROGRAM (DD) - INPATIENT
43 ICF DEVELOPMENTALLY DISABILITY PROGRAM (DD) - LEAVE DAYS
45 ICF/DD 60-99 BEDS WITH 1-59 DISTINCT PART BEDS-INPATIENT
48 ICF/DD 60-99 BEDS WITH 1-59 DISTINCT PART BEDS-LEAVEDAYS
51 ICF/DD 100 OR MORE BEDS WITH 60-99 DISTINCT PART BEDS – INPATIENT
52 ICF/DD 100 OR MORE BEDS WITH 60-99 DISTINCT PART BEDS – LEAVE DAYS
61 ICF/DD HABILITATIVE (DDH) (4-6 BEDS) - INPATIENT
62 ICF/DD-NURSING (DDN)(4-6 BEDS) - INPATIENT
63 ICF/DD HABILITATIVE (DDH) (4-6 BEDS) - LEAVE DAYS
64 ICF/DD-NURSING (DDN) (4-6 BEDS) - LEAVE DAYS
65 ICF/DD-HABILITATIVE (DDH) (7-15 BEDS) - INPATIENT
66 ICF/DD-NURSING (DDN) (7-15 BEDS) - INPATIENT
68 ICF/DD-HABILITATIVE (DDH) (7-15 BEDS) - LEAVE DAYS
69 ICF/DD-NURSING (DDN) (7-15 BEDS) - LEAVE DAYS

Department of Developmental Services uses Accommodation code of 99 frequently in their claims for HCPCS codes. The meaning is unknown.

APPENDIX S. MIO 2-DIGIT ACCOMMODATION AND ANCILLARY CODES

MIO Accommodation Services

01 = Private Room
02 = Semi-Private Room
03 = Ward
04 = Coronary case
05 = Nursery
06 = Long Term Care
07 = Extended Care or Administrative Days
08 = ICU/CCU
09 = Intermediate Care

Accommodation Services Hours Indicators

The Medi-Cal Inpatient/Outpatient Provider Manual explains why there is the possibility of the third digit of the accommodation code being an "H". The next two paragraphs are from that manual.

If an admission was medically necessary and appropriate as determined by the Medi-Cal consultant, and there was reasonable EXPECTATION that the patient would have remained at least overnight, the admission should be authorized as one day of care (even if the patient is discharged or dies later the same day). In this situation HOURLY billing is required for this partial day even though a full day of care has been authorized.

To bill accommodation codes on an hourly basis for non-contract hospitals: Enter the appropriate number of hours followed by the suffix "H" in the Units of Service box.

To indicate this on the Long Paid Claims file, EDS moves a "H" to the third digit of the accommodation code field.

1 = Hours in Lieu of Days
2 = Hours in Addition to Days
H = Hours in Lieu of Days
H = Hours in Addition to Days

MIO 2-DIGIT ACCOMMODATION AND ANCILLARY CODES CONTINUED

MIO Ancillary Services

A1 = Operating/Delivery Room
A2 = Anesthesia
A3 = Anesthesia Supplies
B1 = Blood Administration
B2 = Blood Bank
C1 = Inpatient Drugs
C2 = Take-Home Drugs
D1 = X-Ray Exams
E1 = Nuclear Medicine - Diagnostic
E2 = Nuclear Medicine - Therapeutic
E3 = Radiation Therapy
F1 = Laboratory Examinations
F2 = Blood Gases
G1 = EKG, EEG, EMG
* H1 = Cardiology
* I1 = Imaging Services
J1 = Medical - Surgical Supplies
K1 = Physical Therapy
K2 = Occupational Therapy
K3 = Speech Therapy
L1 = Inhalation Therapy (Exclude IPPB)
L2 = IPPB Treatments
M1 = Hospital Compensated Physician
N1 = Acute Hemodialysis
P1 = Other Physical Therapy
* R1 = Emergency Room

* NOTE: These codes were added for the new UB-82 conversion in 1992.

APPENDIX T DEVELOPMENTAL CENTER ACCOMMODATION CODES
(PLAN CODE 6)

NOTE: The old name for Developmental Centers was State Hospitals.

SERVICE	MEDI-CAL ACCOMMODATION CODE
Acute:	
Room Charge	10
Leave day	11
Ancillaries	12
Skilled Nursing:	
Room Charge	20
Leave day	21
Ancillaries	22
Intermediate Care:	
Room Charge	30
Leave day	31
Ancillaries	32

APPENDIX U. RURAL HEALTH BILLING PROCEDURE CODES

Rural Health Clinic (RHC) and Federally Qualified Health Clinic (FQHC) facilities use the following all-inclusive per visit codes:

Code	Description	Explanation	Program
01	Medi-Cal Per Visit Code	Requires medical justification for more than one visit per recipient per day.	RHC, FQHC
02	Crossover Claims	Require that the Medicare EOMB/RA be attached to the claim. A deductible is not included in the crossover reimbursement.	RHC, FQHC
03	Dental	Dental services	RHC, FQHC
04	Optometry	Optometry services	FQHC only
05	Implantable Contraceptive Kit (Norplant)	Use code 01 to bill for insertion or removal of the implantable contraceptive. Code 01 and 05 may be billed by the same provider for the same date of service. Attach a copy of the invoice to the paper claim, or enter the invoice number and price paid in the Remarks Record of the CMC claim.	RHC, FQHC
06	ADHC Regular Day of Service	Minimum four-hour day at the center excluding transportation time.	FQHC only
07	ADHC Initial Assessment Day	With subsequent attendance at the center. Limit of three assessment days. Same center may not bill for assessment days again within 12 months of the last day of service. If the participant transfers to another center, assessment days may be billed by the second center without the 12-month restriction.	FQHC only

Code	Description	Explanation	Program
08 only	ADHC Initial Assessment Day	Without subsequent attendance at the center. A statement explaining why the participant did not attend the center subsequent to assessment must be entered in the Remarks area of the claim. (same limitations as for code 07).	FQHC
09 only	ADHC Transition Day	Limit of five days per participant's lifetime. A statement that the Physician Authorization and Medical Information form is on file at the center must be entered in the Remarks area of the claim.	FQHC
10	EPSDT	All-inclusive, Per-Visit Code for Early and Periodic Screening diagnosis and Treatment (EPSDT) services.	RHC, FQHC, EPSDT
11	LCSW	Licensed Clinical Social Worker (LCSW). A mental health service rendered by a LCSW for beneficiaries of any age.	RHC, FQHC
12	Psychologist	A mental health service rendered by a psychologist for beneficiaries of any age.	RHC, FQHC
13	Psychiatrist	A mental health service rendered by a psychiatrist for beneficiaries of any age.	RHC, FQHC
14	Marriage, Family and Child Counselor (MFCC)	A mental health service rendered by a psychiatrist for beneficiaries under 21 years of age only.	RHC, FQHC
15	Acupuncture	An acupuncture service rendered for beneficiaries of any age.	RHC, FQHC
16	Chiropractic	An chiropractic service rendered for beneficiaries of any age.	RHC, FQHC

Code	Description	Explanation	Program
17	Heroin Detox-ification	A heroin detox service rendered in accordance with California Code of Regulations 51328 and 51533.	RHC, FQHC
18	Managed Care Differential Rate – Local Initiative (LI)	FQHC services covered by managed care rendered to beneficiaries enrolled in Medi-Cal managed care plans. This rate approximates the difference between payments received from the LI, expressed on a per visit basis, and the code "01" rate.	RHC, FQHC
19	Managed Care Differential Rate - Commercial Plan (CP1)	FQHC services covered by managed care rendered to beneficiaries enrolled in Medi-Cal managed care plans. This rate approximates the difference between payments received from the LI, expressed on a per visit basis, and the code "01" rate.	RHC, FQHC
20	Managed Care Differential Rate - Commercial Plan (CP2)	FQHC services covered by managed care rendered to beneficiaries enrolled in Medi-Cal managed care plans. This rate approximates the difference between payments received from a CP, expressed on a per visit basis, and the code "01" rate.	RHC, FQHC
21	Managed Care Differential Rate – Another managed care plan (e.g. PHP, PCCM, etc.)	FQHC services covered by managed care rendered to beneficiaries enrolled in Medi-Cal managed care plans. This rate approximates the difference between payments received from a managed care plan, expressed on a per visit basis, and the code "01" rate. (Codes 11-21 were added in October, 1997.)	RHC, FQHC

Code	Description	Explanation	Program
22	Managed Care per Visit Code (non-capitated Indian Health Clinic (IHC)	Indian Health Clinics services rendered to beneficiaries who are qualified to receive services from IHCs and are enrolled in Medi-Cal Managed Care Plans. (Two services per month due to MEDI limits.)	RHC, FQHC

(Code 22 was added in April, 1998 retroactively to 7/11/96 (OIL 124-98) and now has been deleted as of January 1, 2000 via OIL # 041-00.)

"Visit" Defined

"Visit" means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and a single location constitute a
single visit--except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Furthermore, if a patient is receiving only laboratory services or X-ray studies, such actions do not qualify as clinic visits. CPT-4 codes will not be necessary, since billing will be by "visit" as defined.

Health Care Plan (HCP) Recipients"
90

RHCs and FQHCs must bill the appropriate Health Care Plan (HCP) when rendering services the HCP recipients. EDS does not accept these claims unless the billed services are contractually excluded from the plan. Providers should contact the plan for plan specific information on prior authorization and billing.

APPENDIX V. APPROVED MODIFIERS

NOTE: The APPROVED MODIFIERS are from EDS' Medi-Cal Inpatient/Outpatient Provider Manual.

Modifier/ HCPCS Modifier	Description
Ophthalmologic modifiers used only with CPT-4 codes 92002, 92004, 92012, 92014, or 92310 through 92317:	
AP / 29	Determination of refractive state not performed or did not result in a prescription under current FTC rules
X1 / 01	Lens supplied by same provider; previous examination within past 24 months
X2 / 02	Prescription supplied for dispensing elsewhere; previous examination within past 24 months
X3 / 03	Insufficient correction for Medi-Cal coverage; previous examination within past 24 months
X4 / 04	Insufficient change for Medi-Cal coverage; previous examination within past 24 months
X5 / 09	Other
X6 / 11	Lens supplied by same provider; no previous examination within past 24 months
X7 / 12	Prescription supplied for dispensing elsewhere; no previous examination within past 24 months
X8 / 13	Insufficient correction for Medi-Cal coverage; no previous examination within past 24 months
X9 / 14	Insufficient change for Medi-Cal coverage; no previous examination within past 24 months

@Medi-Cal claims for orthodontic and/or prosthetic appliances may show either modifier X2/02 (purchase of a standard item) or modifier X3/03 (purchase of a custom made item).

APPROVED MODIFIERS

Modifier/ Description
HCPCS
Modifier

Other Modifiers:

21 / 21	Prolonged Evaluation and Management Services. (This modifier generally correlates to modifier 22, unusual services.)
22 / 22	Unusual Services (May be used with computerized tomography codes when additional slices are required or a more detailed evaluation is necessary.)
24 / 24	Unrelated Evaluation and Management (E & M) Service by the same physician during a postoperative period. (This definition for modifier 24 became effective with the January 1, 1992 implementation of E & M codes. The old modifier 24 was renumbered '28'.)
25 / 25	Significant, separately identifiable E & M Service by the same physician on the day of a procedure.
26 / 26	Professional Component (When physician submits a separate billing for certain procedures which have a technical component; laboratory, X-ray, etc.)
47 / 47	Anesthesia by surgeon. (Not to be used as a modifier for anesthesia codes.)
50 / 50	Bilateral procedure (added to 2 degrees or lesser procedure)
51 / 51	Multiple procedure (for second and each subsequent procedure)
52 / 52	Reduced Services (May be used with computerized tomography codes for a limited study or a follow-up study.)
53	Discontinued procedure (as of 7/1/97)
54 / 54	Surgical care only
55 / 55	Postoperative management only
62 / 62	Two surgeons (with separate skills)
66 / 66	Surgical Team
75 / 75	Concurrent Care, services rendered by more than one physician
76 / 76	Repeat procedure by same physician
77 / 77	Repeat procedure by another physician

APPROVED MODIFIERS

Modifier/ HCPCS Modifier	Description
78 / 78	Return to the operating room for a related procedure during the postoperative period
79 / 79	Unrelated procedure or service by the same physician during the postoperative period
80 / 80	Assistant surgeon
90 / 90	Reference (outside) laboratory when services is performed by a an outside laboratory, but billed by another provider. Only specified providers may use this modifier.
99 / 99	Multiple Modifiers. Used when two or more modifiers are necessary to completely delineate a service; the multiple modifiers used must be explained in the Remarks section of the claim form. (Also used in special circumstances as specified by DHS. For example, refer to Section 200-125, {Medical Services and Inpatient/Outpatient}).
AF / 33	Anesthesia complicated by total body hypothermia above 30 degrees
AG / 39	Emergency anesthesia (moribund patient or systemic disease)
AN / 83	Physician assistant on single service claim
AS / --	Physician Assistant serving as first assistant in surgery under an approved supervising physician
P1 / 30	Anesthesia services (normal, uncomplicated). (When essential to perform a radiology or pathology procedure.)
P3 / --	Anesthesia services (a patient with severe systemic disease)
P4 / 37	Anesthesia services (a patient with sever systemic disease that is a constant threat to life)
P5 / --	Anesthesia services (a moribund patient who is not expected to survive without the operation)
QW / --	CLIA Waived Test (limited to specific test kits from specific manufacturers from HCFA's "Waiver Test Categorization Test List")
TC / 27	Technical component
TM / --	Service rendered via telemedince (Starting 7/1/97)

APPROVED MODIFIERS

Modifier/ HCPCS Modifier	Description
Y1 / 01	Rental WITHOUT sales tax - Durable Medical Equipment - Hearing aids
Y2 / 02	Purchase, repair, mileage, WITHOUT sales tax (standard item) - Durable Medical Equipment - Prosthetic appliances - Orthotic appliances - Hearing aid and related items
Y3 / 03	Delivered, repair, mileage WITHOUT sales tax (custom item) - Prosthetic appliances - Orthotic appliances
Y4 / 04	Not delivered, custom made, WITHOUT sales tax - Prosthetic appliances - Orthotic appliances
Y5 / 05	Purchase less one month's rental WITHOUT sales tax - Durable Medical Equipment
Y6 / 06	Rental WITH sales tax - Durable Medical Equipment - Hearing aids
Y7 / 07	Purchase, repair, mileage, WITH sales tax (standard item) - Durable Medical Equipment - Orthotic appliances - Hearing aid and related items
Y8 / 08	Delivered, repair, mileage, WITH sales tax (custom item) - Orthotic appliances
Y9 / 09	Not delivered, custom made, WITH sales tax - Orthotic appliance (SMA 5560-5999)
YP / 10	Purchase less one month's rental WITH sales tax - Durable Medical Equipment
YQ / 84	Certified Nurse midwife service (when billed by a physician, organized outpatient clinic, or hospital outpatient department)
YR / 94	Certified Nurse midwife (multiple modifiers) (when billed by a physician, organized outpatient clinic, or hospital outpatient department)
YS / 91	Nurse practitioner service (replaces modifier 82)
YT / 92	Nurse practitioner service (multiple modifiers)

APPROVED MODIFIERS

Modifier/ HCPCS Modifier	Description
YU / 93	Physician assistant service (multiple modifiers)
YV / 85	AIDS Waiver
YW / 88	Required professional experience. (applies only to speech therapists and audiologists.)
YX / --	Indicates additional services beyond the 24-per-school-year limit for students with an IEP (Individualized Education Plan) or IFSP (Individualized Family Services Plan). Applies only to Local Educational Agency (LEA). This modifiers also used to indicate LEA services rendered to a recipient who is a member of a Medi-Cal managed care plan when the services are included in that student's IEP or IFSP
YZ / --	Indicates additional services beyond the 24-per-school-year limit for students with an Individual Health and Support Plan (IHSP). Applies only to Local Educational Agency (LEA).
Z1 / --	Additional air mileage in excess of 10 percent of standard airway mileage distances. (Reason for additional mileage flown must be documented on the claim or on an attachment.)
ZA / 31	Anesthesia procedures complicated by position or surgical field avoidance
ZB / 34	Anesthesia (emergency services, healthy patient)
ZC / 35	Anesthesia complicated by extracorporeal circulation
ZD / 38	Emergency anesthesia (systemic disease)
ZE / 40	Nurse anesthetist service; elective anesthesia: normal, healthy patient.
ZF / 48	Anesthesia supervision
ZG / 49	Multiple anesthesia modifiers
ZH / --	Nurse Anesthetist service; anesthesia special circumstances: unusual position/field avoidance.
ZI / --	Nurse Anesthetist service; anesthesia special circumstances: unusual position/field avoidance.

APPROVED MODIFIERS

Modifier/ HCPCS Modifier	Description
ZJ / --	Nurse Anesthetist service; anesthesia special circumstances: unusual position/field avoidance.
ZK / 70	Primary Surgeon (effective 9/83)
ZL / 57	Certifies that initial comprehensive office visit occurred within 16 weeks of the last menstrual period. Used with procedure code 59481 or only and restricted to comprehensive prenatal providers. (Reimbursed only once during pregnancy and with a service limitation of once in nine months.) Use of this modifier adds $50 to reimbursement. Available only to Comprehensive Prenatal Services Program (CPSP) providers.
ZM / 97	Supplies and drugs for surgical procedures without general anesthesia
ZN / 98	Supplies and drugs for surgical procedures with general anesthesia
ZO / --	Nurse Anesthetist service; anesthesia special circumstances: extracorporeal circulation.
ZP / --	Nurse Anesthetist service; elective anesthesia: patient with severe systemic disease that is a constant threat to life.
ZQ / --	Family planning counseling. Certifies that family planning counseling was provided during a routine non-family planning office visit. Limited to female recipients 15-44 years of age. Can be reimbursed once per recipient per provider in a 12-month period. Effective for services after January 1, 1997. A family planning diagnosis code is not required to bill this modifier. It does not apply to the State-Only Family Planning (SOFP) program. It is a Medi-Cal program benefit. (See provider manual Section 200-45, Family Planning Services, for detailed billing information.)
ZR / --	Nurse Anesthetist service; emergency anesthesia: patient with severe systemic disease that is a constant threat to life.
ZS / 28	Both Professional and technical component for radiology, pathology, and certain 90000 series medicine procedures. (Replaces modifier 24 as of April 1, 1992.)

APPROVED MODIFIERS

Modifier/ HCPCS Modifier	Description
ZT / --	Nurse Anesthetist service; emergency anesthesia: moribund patient who is not expected to survive without the operation.
ZU / 59	Exception modifier to 80 percent reimbursement (medical necessity requires common office procedure to be performed in outpatient setting)
ZV / 60	Exception modifier to 80 percent reimbursement (non-hospital compensated physician called from outside to render emergency service)
ZW / --	Early Discharge Follow Up Visit for mother and newborn within 48 hours of delivery. This modifier will not adjust the rate of reimbursement for the delivery, but show that the service was provided.
ZX / --	Nurse Anesthetist service; emergency or elective anesthesia: patent with severe systemic disease.
ZY / --	Nurse Anesthetist service; elective anesthesia: moribund patient who is not expected to survive without the operation.
-- / 23	Anesthesia services unusually needed
-- / 53	Primary emergency surgical procedure without follow-up
-- / 58	Asterisk procedure (surgical procedure and office visit billed as one charge)
-- / 61	Exception modifier to 80 percent reimbursement (total financial responsibility)
-- / 64	Co-surgeons (with similar skills)
-- / 68	Complication (requiring unusual follow-up)
-- / 82	Nurse practitioner on a single service claim
-- / 86	Certified nurse practitioner (independent provider)
-- / 95	Medi-Cal injection code

APPENDIX W. COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES

This page is for Electronic Data System's claims.

Plan Code	Claim Types	Type Of Service Code	Type Of Service Description	Procedure Indicator	Procedure Code Ranges	Accommodation code ranges
9	2	' '	- Inpat. Long Term Care	' '	' '	'01 ' - '78 '
9	2	A	- Inpatient Admittance	6	'3010 '-'3998 '	'01 ' - '09 '
9	2	B	- Inpatient Services	6	'4010 '-'4440 '	'A1 ' - 'R1 '
9	2	A	- Inpatient Admittance	1	'0080 '-'0219 '	'01 ' - '09 '
				1	'1080 '-'1219 '	'01 ' - '09 '
9	2	B	- Inpatient Services	1	'0082 ','0093 '	'A1 ' - 'R1 '
					'0250 '-'0999 '	'A1 ' - 'R1 '
9	2	' '	- LA Waiver Inpatient	7	'0001 '-'0099 '	' '
9	3	D	- RX (Drugs)	3	0000A-9999Z	
9	3	9	- Other SMA Codes	2	00001-09999	
9	1	'3'	- LA Waiver Outpatient	7	'00060'-'00071'	
9	1,4	1	- Anesthesia	2	00100-01999	
				4	10000-99999	
9	1,4	2	- Assistant Surgeons	2	00998-99999	
				4	10000-99999	
9	1,4	3	- Other CPT-4 Codes			
			Medicine	4	90000-99200	
			Medical Office appts	4	99201-99499	
			Laboratory	4	80000-89999	
			Radiology	4	70000-79999	
			Surgery	4	10000-69999	
			Other	2	00001-09999	
			LA Waiver Outpatient	7	00001-00099	

Note: For Mental Health Inpatient claims, the Provider Code always starts with HSM, has FI Provider type of '72', and has Category of Service of '04'.

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Code Ranges	Accommodation code ranges
9	1,4	5	- Radiology	4	70000-79999	
9	1,4	6	- Home Health-SMA	2	02600-02640	
		7	- Not In Use			
9	1,4	8	- Podiatry	4	10000-99999	
9	1,4	9	- Eye appliances	2	06400-06499	
		3	- Injections	4	00100-01999	
		9	- Other SMA Codes	2	00001-09999	
		9	- HCPCS level II	9	A0000-V9999	
		9	- HCPCS level III - Medicare	9	W0000-W9999	
				9	Y0000-Y9999	
		9	- HCPCS level III - Local codes	9	X0000-X9999	
				9	Z0000-Z9999	

NOTE: Most information was compiled by researching the claims themselves. The accuracy of the data is not guaranteed since it is impossible to research every claim.

COMPARISON OF PAID CLAIMS FIELDS FOR VARIOUS PLAN CODES (Cont.)

This page is for the other creators of claims.

Plan Code	Claim Types	Type Of Service Code	Description	Procedure Indicator	Procedure Code Ranges	Accommodation code ranges
0	5	4 -	Delta Dental	0	'001 '-'999 '@	
4	1,4	3 -	SBHI's Outpatient & Physician claims	2 4	'0000 '-'9999 ' 10000-99999	' ' ' '
4	2	3 -	SBHI's Inpatient Admit.	1	'0080 '-'0219 '	' '
4	2	3 -	SBHI's Inpatient Serv.	1	'0082 ','0093' '0250 '-'0999'	' ' ' '
4	3	D -	SBHI's RX (Drugs)	3	0000A-9999Z	
4	4	8 -	SBHI's Outpatient and Physician claims	4	10000-99999	' '
4	4	9 -	SBHI's Outpatient and Physician claims	2	'0000 '-'9999'	' '
4	1,4	1,3,5 -	HPSM's Outpatient & Physician claims	4	10000-99999	' '
4	1,4	3 -	HPSM's Outpatient & Physician claims	2 4	'0000 '-'9999 ' 10000-99999	' ' ' '
4	2	3 -	HPSM's Inpatient Admit.	1	'0080 '-'0219 '	' '

Plan Code	Claim Types	Type Of Service Code	Description	Indicator	Procedure Code Ranges	Accommodation code ranges
4	2	3 -	HPSM's Inpatient Serv.	1	'0082 ','0093' '0250 '-'0999'	' ' ' '
4	3	D -	HPSM's RX (Drugs)	3	0000A-9999Z	
5	6	' '-	EPSDT claims	2	'A001 ' (only)	' '
6	2	A -	DSS's Inpatient Admit.	' '	' '	'10 ' - '32 '
6	2	B -	DSS's HCPCS codes	5	00001-99999	'12 ' & '99 ' meanings unknown
8	1	' '-	SD/MC Outpatient	8	'1 '-'9 '	'07 ' - '09 ', '12 ', '17 ', and '50 '
8	2	' '-	SD/MC Inpatient	8	' '	'07 ' -'09 ', '12 ', '17 ', and '50 '

APPENDIX X. COMPARISON OF EDS' TYPE OF SERVICE CODES TO DHS'S FIELDS

COMPARISON OF EDS' TYPE OF SERVICE TO DHS'S PAID CLAIMS FIELDS FOR VARIOUS NON-INPATIENT LONG PAID CLAIM TYPES

EDS' PAID CLAIMS Type Of Service (TOS)			DHS's PAID CLAIMS Type of Service			
Code	Description	Claim Type	Code	Description	Procedure Indicator	Code Range
I	- Injections		3	- Injections (use Modifier 95)	4	10000-19999
			9	- HCPCS II and III	9	X5300-X7899
J	- Anesthesia	1,4	1	- Anesthesia	2	00100-01999
		(these codes dead as of 5/1/98)			4	10000-99999
K	- Surgery (Primary Surgeon)	1,4	3	- Other CPT-4 Codes	4	10000-69999
			9	- HCPCS II and III	9	Z1030-Z1212
					9 10	Z6200-Z6500
L	- Radiology	1,4	5	- Radiology	4	70000-79999
			3	- Other CPT-4 Codes	4	70000-79999
			9	- HCPCS II and III	9	A4647-A4648
					9 10	Z1700-Z1702
M	- Pathology/Clinical Laboratory	1,4	3	- Other CPT-4 Codes	4	80000-89999
			9	- HCPCS II and III	9	Z2000-Z2006
N	- Medicine	1,4	3	- Other CPT-4 Codes	4	90000-99999
			9	- HCPCS II and III	9	V2630-V2632
					9	X0800
					9 10	X9900-X9999
					9 10	Z0002-Z0314
					9	Z2008
					9	Z2730
					9 10	Z5218-Z5220

			9	Z5422-
			10	Z5436
			9	Z5499
O - Assistant Surgeon	1,4	2 - Assistant Surg.	2	00998-99999
			4	10000-
			5	99999

COMPARISON OF EDS' TYPE OF SERVICE TO DHS'S PAID CLAIMS FIELDS
FOR VARIOUS NON-INPATIENT LONG PAID CLAIM TYPES

EDS' PAID CLAIMS Type Of Service (TOS)		DHS's PAID CLAIMS Type Of Service		
Code Description	Claim Types	Code Description	Procedure Indicator	Code Ranges
P - Podiatry	1,4	8 - Podiatry	4	10000-99999
		9 - HCPCS II and III	9	A0001-Z9999
X - (MIO RX added to EDS Proc file)	3	D - RX (Drugs)	3	0000A-9999Z
1 - Medical personnel Types	1,4	6 - Home Health-SMA	2	02600-02640
		9 - HCPCS II and III	9	Z6900-Z6918
		7 - Not In Use		
1 - Allied Health		9 - Other SMA Codes	2	00001-09999
		9 - (AIDS codes only)	2	00581-00599
		9 - HCPCS II and III	9	A0001-Z9999
		9 - (AIDS codes only)	9	Z5000-Z5018
3 - Ophthalmology	1,4	9 - Other SMA Codes	2	06400-06499
		9 - HCPCS II and III	9	V2020-V2629
			9	V2700-V2977
			9	Z2900-Z3399

APPENDIX Y CCS/GHPP BACKGROUND INFORMATION

42.0 CCS/GHPP INDICATO
California Children's Services (CCS) provides medical and case management services to children with serious medical conditions from low-income families. Eligible conditions include birth defects, chronic diseases, genetic diseases, serious infectious diseases and severe trauma injuries. CCS is administered by county health departments or, for small counties, directly by the three State Children's Medical Services Branch (CMS) regional offices. There are approximately 140,000 children enrolled in the CCS program. About 75% of these children are from families with incomes of less than $40,000 or children with annual medical costs that exceed 20% of their families' income. Cost for services provided to this second group of children are shared equally by the State and the counties. The Genetically Handicapped Persons Program (GHPP) is administered on a statewide basis by the State CMS Branch. There are approximately 2,000 clients enrolled in GHPP. About half of these clients are eligible for Medi-Cal. Services provided to non-Medi-Cal eligible clients are paid for by the General Fund Patient eligibility, provider enrollment status and type of services rendered determine whether a provider bills under a non-Medi-Cal Provider number (prefix of CGP) or a Medi-Cal Provider number. The provider number identifies the funding source for the claim. Providers submit CCS and GHPP claims to the appropriate CCS or GHPP office. CCS and GHPP authorize services by entering a unique number in the TAR box and either stamping the claims as an indication of approval or attaching an authorization form to the claim. Claims passing this screening are forwarded to Electronic Data Systems Corporation (EDS) for adjudication. The TAR number must end with an '4' or '8' preceded by 10 zeroes (‘00000000004’, '00000000008'). The TAR number that ends with an '4' means that the services to the Medi-Cal eligible beneficiary under 21 years of age(with a CCS-eligible condition) are benefits of the Medi-Cal program. The TAR number that ends with an '8' means that the services to the Medi-Cal eligible beneficiary under 21 years of age (with a CCS- eligible condition) are benefits of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services as defined by the Medi-Cal program. There are also services for children under 21 years of age that are CCS-only or Medi-Cal beneficiaries receiving benefits not payable by the Medi-Cal program. The TAR control number consists of the child's two-digit county code of residence, a one-digit funding code, the child’s' seven-digit CCS number, and a '8'(30212437468). Claims bypass the Recipient ID field and the providers bill using a provider number beginning with the letters "CGP". These claims are paid from CCS program general funds and county appropriations. This background information is from OIL # 219-99 dated September 7, 1999 and OIL # 064-00 dated March 15, 2000.

APPENDIX Z HISTORY INFORMATION

2.0 Plan Code

02 Encounter Data started in summer of 1994
03 Redwood Health Foundations' (RHF) contract to create Long Paid Claims ended 6/89.)
04 Santa Barbara Health Initiative (SBHI) (Started getting claims 1/87)
04 SANTA CRUZ County Health Options (SCCHO) (set to begin 1/96)
04 NAPA County (began 3/98, then split from NAPA's file 11/98)
04 SOLANO County (began 1/96, had Napa claims in from 3-10/98)
04 CalOptima (Orange county) (began 12/98)
04 Health Plan of San Mateo (HPSM) (Started getting claims 12/87)
09 Computer Sciences Corporation (CSC) before 2/88

NOTE: + Solano included Napa county claims with the incorrect HCP code of 504,(which is Solano's HCP code) instead of 507, which is Napa's HCP code. This was from March 1998 through September 1998. This is supposed to be corrected with the October 98 payment data.

NOTE: * According to the MIS/DSS Project Office, CalOptima had a separate contract with someone to produce their 35-file file for inpatient/outpatient/medical claims. The contract expired at the end of August 2001. Therefore, effective with the August 2001 month of payment, DHS won't get a 35-file from CalOptima for those types of claims. Instead those types of claims will go through the encounter data route at EDS. That means our 35-files from Cal Optima, beginning with August 2001 month of payment, will contain only crossovers (all claim types) and drug claims. Bonnie Williams 10/19/01.

NOTE: ! In the 1970s all health, mental health, and social services were under one department. Before 1980, the groups became their own departments. In the old days the Department of Developmental Services was called Department of Mental Hygiene. Then the Developmental Centers were called State hospitals. Times change as do names, except Data Set Names. This files DSN has the word DMH in it but the file contains no Department of Mental Health claims. Per Howard Auble at DMH on 1/4/2000.

NOTE: A new Title XXI payment tape for all Healthy Family payments (excluding CHDP), including aid code 7X, is scheduled to be implemented by May, 1999, under SDN 8007B. Until SDN 8007B can be implemented, 7X will be reported on the Medi-Cal payment tape. DHS Accounting has agreed to transfer funds until the new payment tape is created. 11/98.

3.0 DHS CLAIM TYPE

DDS, when they create the paid claims for DHS only create inpatient claims. It appears that 95+% of all their October 1999 claims were for vendor code 56 and the other percentage was for vendor code 57. There were 6431 claims for that month of which 1964 claims were marked as an adjusted claim with adjustment indicator code of '1'.

4.0 INTERNAL CONTROL NUMBER

As of December 1997 EDS has made some modifications since it was discovered that some services were being paid for under the claim as there is only one place for aid code. Now we have the claims broken up by aid codes so that the right one that allowed the service is the one reflected on the claim. That results in a 2 or more claims whose header fields for the most part Is the same, but maybe the category of service has changed.

5.3 BENEFICIARY SERIAL NUMBER/MEDS ID/CIN

DHS historically also ran a cross-reference program to put the right serial number on a claim, but that will be discontinued sometime in 2002. As of 1988 a provider can bill with many variations of the 14 character Bene ID or just the CIN or MEDS ID.

8.0 ETHNICITY

Developmental Center's (Plan Code 6) Ethnicity Code before Feb 1992 MOP

	DDS Ethnicity Code	MEDS Code
White	1	1
Black	2	3
Hispanic	3	2
American Indian	4	5
Chinese	5	C
Japanese	6	J
Filipino	7	7
Asian Indian	E	N
Other Asian	8	8
Other Non-white	9	8
Samoan uses Arab	A	8
Unknown	0	8

10.0 PROVIDER ZIP CODE

EDS changed the last 4 characters from spaces to numeric values for the March 1993 file.

Not on Delta Dental claims until 1989. This item was phased in by Delta during 1988. Exact scheme of the phase is not known, but 1989 payment tapes were virtually complete.

11.0 PROVIDER NUMBER

An interesting variation occurred with OIL #253-90. The Department in conjunction with the California Medical Assistance Commission (CMAC), has signed a contract with the six (6) Los Angeles (L.A.) county hospitals which will allow these hospitals to bill the program for inpatient stays provided by a referred facility.

Under the contract, L.A. county hospitals will submit billings for the hospital in which the patient was referred.

These provider numbers will be utilized by L.A. County hospitals in order to bill the Medi-Cal program for services provided. Effective October 23, 1990 date of service.

NOTE: EPSDT, SBHI, HPSM, and EDS all use EDS' provider master file in their systems.

16.0 VENDOR CODE

Vendor Code is not from any claim source. It is a hold over from the old MIO days. It is put in the claims when they are made for DHS's use. Short Paid Claims only has this field and doesn't have room for FI's Provider Type and Category of Service, the Vendor Code is crucial for the programs that utilize this file.

VC 33 became effective for acupuncturist in June 1984;before that they were included in VC 75, organized outpatient clinic services.

Effective January 25, 1991 retro to April 1, 1990, Public Law (PL) 95-210 Rural Health Clinics (RHC)

became Federally Qualified Health Centers. Issued a new provider number beginning FHC. These facilities were and still are in vendor code 77 along with other types of RHCs.

Due to a change in Federal reporting requirements regarding Long Term care, the definitions of VC 47 and VC 80 were changed. EDS implemented the change on the paid claims file beginning with the July 1992 month of payment.

Prior to 11/1/92, VC 07 meant Certified Nurse Practitioner for a pilot project for which there were very few claims.

22.0 CHECK DATE

DDS claims contained low-values in this field many years ago, but as of March 2000, it appears that problem was corrected. When this was corrected is unknown.

24.0 C0-INSURANCE AMOUNT

Prior to AB251 (Statutes of 1981), this field reflected both the billed and paid coinsurance amounts for all claim types. After AB251, the coinsurance amount billed was not necessarily paid in full (or at all) for certain outpatient services.

31.0 DAYS-STAY

This field is usually equivalent to the length of stay; however, there have been problems. This field is calculated from data on the claim rather than billed by the provider and is subject to certain edits. The most recent problem resulted from this field being set to zero for certain county run facilities in Los Angeles. The problem occurred in Mid 1983.

37.0 FFP INDICATOR

This field was added as of June 2000, but DHS will be getting reruns on all claims from December 1999 to populate this field for Family P.A.C.T. (FPACT) claims. All claims with a Date of Service of December 1, 1999 or greater will have this indicator set. Claims with Date of Service prior to December 1, 1999 should have the FFP indicator set to 3.
As of June 2000, this will only be for claims with an aid code of 8H, Family P.A.C.T.(Planning Access Care & Treatment) and each segment detail of the claims should have the indicator set when the aid code is 8H.In the future, this will be done for other aid codes as well.

40.0 SOCIAL SECURITY NUMBER

This field should never contain the Client Index Number (CIN) or California Driver's License (CDL) number, but when looking at the March 2000 Encounter file, CINs were found in the SSN field! The Encounter file data dictionary dated December 18, 1995 states that their ID field can contain either an SSN or CIN. The MIS/DSS (Management Information System/Decision Support System) does load the CIN into a 9-character field after the Admit Source in the header, but it is not on other Paid Claims as of June 2000.

45.0 RESTRICTED SERVICE CODE

This is also known as the SURS indicator. This is required on EDS claims and comes from MEDS/FAME. It is the first two bytes of the restricted services code.

47.0 RECIPIENT PREPAID HEALTH PLANS(PHP) CODE

Staring at the end of the summer of 1998, SDN 6028B which is part of the Managed Care – 5 HCP Expansion project, has now defined 999 to represent other HCP codes that are not medical for the eligibility period when the service was rendered. The beneficiary may ha e dental or vision or some other HCP, but not one that is medical. Then a 999 is moved to this field

48.0 FI PROVIDER TYPE CODE

This field replaced the old 2 character FI Provider. They ran out of 2 character numeric definitions and opted to go with a 3-character field. All current definitions remains as they are now with a leading zero added on the left most character. So if the Provider Type was 05 it will became 005. The Category of Service also expanded to 3 characters at the same time.

49.0 CATEGORY OF SERVICE

In July of 1999, this field replaced the old 2 character FI Provider. They have almost run out of 2 character numeric definitions and have opted to go with a 3-character field. All current definitions will remain as they are now with a leading zero added on the left most character. So if the Category of Service was 05 it will became 005. The Provider Type also expanded to 3 characters at the same time.

As of the August 2000 file, there are no COS or FI providers that start with a '1'. So as of now both sets of fields have values in them.

OIL # 285-00 dated November 15, 2000 establishes the first 3 character COS, 101 for Licensed Midwife. No effective date as to when this new COS will be installed

50.0 PRIMARY DIAGNOSIS CODE (ICD)

Until the HCFA-1500 forms start in the summer of 1994, physicians were not required by law to enter the diagnosis code. EDS' physician claims receive their diagnosis code in house as EDS reads the claims for processing. EDS trains its staff to determine the diagnosis code where they enter it on the claim. Most other providers do their own coding.

EPSDT and DDS use spaces in this field. Starting with the January 2002 claims, EDS will be receiving both primary and secondary diagnosis codes for pharmacy claims. Practically all pharmacy claims are single line claims, so it has been decided to ask EDS to establish the header primary and secondary diagnosis codes by using the first detail's diagnosis codes.

Vic Walker, Senior Consulting Pharmacist for DHS, does have some comments on the codes:

"By the way, we ought to be cautious about how the pharmacy-submitted diagnoses are used. I have a lot more confidence in a diagnosis sent me by a physician or hospital than I do in one sent by a pharmacy. The pharmacy, by necessity, will be reporting the diagnosis secondhand, based on what the diagnostician (the physician) told them. There are a lot of reasons why that diagnosis might not be accurate. We might want to put a caution into the data dictionary regarding diagnoses on pharmacy claims."

So here is the caution in the data dictionary. (July 2001)

54.0 FI DISCHARGE/PATIENT STATUS CODE

Pre-UB92 valid values follow for hospital inpatient claims when the Claim Form Indicator is set to ' ':

00 = Still under care

01 = Admitted (Interim Bill)
02 = Expired
03 = Discharged to another acute hospital
04 = Discharged to home
05 = Discharged to a Long Term Care facility

60.0 CLIENT INDEX NUMBER --- ONLY ON MIS/DSS CLAIMS

This field was added as of December 1997 for MIS/DSS only.

The MIS/DSS (Management Information System/Decision Support System) loads the CIN into a this field, but it is not on other Paid Claims as of June 2000.

Starting with the May 20th 1999 cut off, California's Healthy Families Program was implemented in the Medi-Cal Short/Doyle system for the Department of Mental Health. Since SSNS are not required for billing, a new ID had to be developed. It was decided to use another pseudo BID number and it consists of the 2 digit county code, 9H (the HFP aid code) or 7X (the HFP bridge code), and '9' + Client Index Number (CIN). EDS claims do not have this requirement, so this format will never be seen on the claims they process.

65.0 CCN LINE NUMBER

As of December 1997 EdS has made some modifications. It was discovered that some services were being paid for under the wrong aid code that was on the claim as there is only one place for aid code. Now we have the claims broken up by aid codes so that the right one that allowed the service is the one reflected on the claim. That results in a 2 or more claims whose headers fields for the most part are the same, but maybe the category of service has changed. The COBOL program that does that is EDS' MFM320. Their program MFM325 then adds provider information. EDS calls the file out of MFM320 and MFM325, the RFF035 or 35-file.

72.0 PRIMARY CARE CASE MANAGEMENT (PCCM) INDICATOR.

Before the advent of BIC cards, this field was used to create red Medi-Cal cards for Prepaid Health Plan (PHP) and showed the beneficiary had limited coverage and must go to their PHP provider for all other services not listed on the card. Since then this information would appear when eligibility was checked using a Point Of Service (POS) device or other was eligibility was checked.

This field started to show the PCCM Indicator as of February 1990 on EDS created claims only.

Formerly, this field was called the Co-pay Status Code, but as of November 1985 the field became the PCCM indicator on EDS file. Co-pay Status showed the recipients co-pay status during Co-payment experiment from January 1, 1972 to June 30,
1973.

As of August 1991, there is a new Co-pay Indicator.

Before the advent of BIC cards, this field was used to create red Medi-Cal cards for Prepaid Health Plan (PHP) and showed the beneficiary had limited coverage and must go to their PHP provider for all other services not listed on the card. Since then this information would appear when eligibility was checked using a Point Of Service (POS) device or other was eligibility was checked

73.0 OTHER HEALTH CARE(OHC) COVERAGE CODE

Other Health Care Code-previously used

Pay and Chase OHC

M Two or more carriers
X Blue Shield
Y pseudo OHC post recovery code used for cost avoidance cases.
Z Blue Cross

Cost Avoidance OHC

B	Blue cross
D	prudential
E	Aetna
G	American General
H	Mutual of Omaha
I	Metropolitan Life
J	John Hancock Mutual Life
Q	Equicor/Equitable
S	Blue Shield
T	Travelers
U	Connecticut General (CIGNA)
W	Great Western Life Assurance
2	Provident Life and Accident
3	Principal Financial Group
4	Pacific Mutual Life Insurance
5	Alta Health Strategies Inc
6	AARP –Association of Retired Persons
7	Allstate Life Insurance
8	New York Life Insurance

If the recipient's Medi-Cal card is coded with one of the above codes, the provider must bill the other coverage (as well as Medicare, if applicable) before billing Medi-Cal. A copy of the coverage's Explanation Of Benefits (EOB) or denial letter must accompany the Medi-Cal claims to EDS.

This field, for EDS created claims before the February 1990, was defined as Co-pay Procedure, but was space filled and not useable.

Currently, the OHC code in the detail is on EDS created claims only. This field indicates that the recipient does have other health care coverage (OHC).
The field was added in August 1987 when EDS added it to their RFF034 and RFF035-files.
Please refer to the above Cost Avoidance OHC values .

This field is not used on DELTA, SD/MC, EPSDT, or DDS type claims. Other Coverage is any private health insurance plan or Policy under which a recipient is entitled to receive health care services. Other Coverage includes benefits available thought commercial insurance companies, prepaid health plans (PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans. Eligibility under Medicare is not considered Other Coverage; however, Medicare supplement policies are considered Other Coverage. The provider of medical services should refer recipients with PHP/HMO coverage to their plans for covered treatment, except in emergencies. Medi-Cal will not reimburse providers for plan covered services, including emergency services, if the recipient chooses to go elsewhere for treatment. There are three kinds of OHC codes, (1) cost avoidance, (2) Prepaid Health Plans/Health Maintenance Organizations

(PHP/HMO), and (3) pay-and-chase. When claims come in and the beneficiary's OHC code is a cost avoidance code, the claim is rejected. The provider must bill the insurance carrier first, before Medi-Cal is billed. If the insurance carrier does not pay for that service, the claims is reprocessed with the insurance carrier's rejection, so Medi-Cal will pay. If a pay-and-chase OHC claim comes in, the claim will be paid and the State of California through EDS starting in April 1991 will bill the insurance carriers directly.

NOTE: : "O", that's alpha 'oh', is used to override a cost avoidance code. This is called the Two-step Process at DHS's Third Party Liability (TPL) and is for the batch county transactions only. TPL has on-line update ability. The counties must make two transactions to change the OHC code. The first day a change transaction with an 'O'. Once changed to 'O', then OHC can be changed to 'N' if there is no active insurance segments for the month being changed on the Health Insurance System Database (HISDB). To change OHC from a cost avoidance code the change OHC code again is an 'O'. The next day, the new OHC code is entered. If no new code is entered the OHC code field is not updated. If an active insurance segment is found, the incoming OHC code will be reset to the existing OHC code of record or changed to an 'A' or 'N' depending on the value of the existing OHC. If no active insurance segments are found, the OHC will be set to an 'N'. Counties can change any OHC code to 'N' except Healthy Families code for Immediate Need transactions. Counties will not be able to remove a Healthy Families OHC code of '9'. Only a Healthy Families disenrollment transaction can change OHC from a '9' to an 'N'.

74.0 DHS PLACE OF SERVICE(POS)

The procedure code and/or vendor code is often a better way to determine place of service. Part B crossover claims got Place of Service '2' as a default prior to March 1994 month of payment because a place of service code was not available. Most crossover claims will have an actual place of service code available effective March 1994 month of payment; but if one is not available, the default will be '7' instead of '2'.

78.0 PROCEDURE INDICATOR

6 - California Health Facilities Commission Code (CHFC)(obsolete after 1/1/92)

79.0 PROCEDURE CODE

The Uniform Billing codes (UB-82s) were implemented in January 1992.Starting in the fall of 1994, the code name has been renamed to UB-92s.
See "UB-92 HOSPITAL INPATIENT ACCOMMODATION CODES" for the historical UB-82 codes and conversion scheme to HCFPA codes. It is necessary to use inpatient accommodation codes residing in the accommodation code field, "DATA ELEMENT:ACCOMMODATION CODE" 165 for EDS' LTC (Vendor codes 47 and 80) inpatient claims. This is also true for the Developmental Centers. See "Appendix T. DEVELOPMENTAL CENTER CODES (Plan Code 6)" for the Developmental Center codes.

SMA (Schedule of Maximum Allowances) codes were replaced by HCPCS Levels II and III codes in September of 1992. The codes are published in the Provider manual. The only other SMAs used are by Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC). See "Appendix U. RURAL HEALTH BILLING PROCEDURE CODES" for that list of codes.

The National Drug Codes are published in the Pharmacy manual. The first 5 characters are the company's number and the federal government assigns it. The company determines the next 6. Usually, but not always, the company assigns the first 4 characters as the description of the drug, such as aspirin, and then the next 2 characters are the package size. (Vic Walker, 6/2000.)

CPT-4 codes replaced RVS/CSN codes for claims for services delivered on or after November 1st, 1987. CPT-4 stands for Current Procedural Terminology Fourth Edition (CPT-4).The CPT codes are published yearly by the American Medical Association.(MediCal only code that resemble CPT-4 codes are published in the provider manuals.) See "DATA ELEMENT:PROCEDURE INDICATOR" for Procedure Indicator codes for RVS and CPT4 codes.

RVS/CSN codes are no longer used on claims for services delivered on or after November 1st, 1987. The codes were replaced by Current Procedural Terminology Fourth Edition(CPT-4). The RVS/CSN was published by the California Medical Association as either:

1. California Standard Nomenclature for Physician's Services; or

2. 1974 Revisions of the 1969 California Relative Values Studies.

California Health Facilities Commission (CHFC) codes were used by hospitals for inpatient billings for various levels of accommodation and related ancillaries. It is necessary to use inpatient accommodation codes residing in the accommodation code field, "DATA ELEMENT:ACCOMMODATION CODE" for EDS' LTC (Vendor codes 47 and 80) inpatient claims. This is also true for the Developmental Centers. See "Appendix T. DEVELOPMENTAL CENTER ACCOMMODATION CODES (Plan Code 6)" for the Developmental Centers codes.

NOTE: The CHFC codes have been replaced by Uniform Billing codes (UB-82s) in January 1992. Starting in the fall of 1994, the code name has been renamed to UB-92s.

See "UB-92HOSPITAL INPATIENT ACCOMMODATION CODES" for the historical UB-82 codes and conversion scheme to HCFPA codes. The Per Discharge Contract Hospital codes are not listed on the conversion scheme. At the time the conversion was in progress I was told not to include them since they may confuse people. If you wish to check out these codes, please refer to the Inpatient/Outpatient Provider Manual on pages 300-108-14 and -15.
See "Appendix N. INPATIENT ACCOMMODATION CODES" for CHFCA Accommodation and UB-82 procedure codes.

NOTE: L.A. Waiver: L.A. hospitals are exempt from using the standard procedure codes. They have their own unique set of codes. All hospital claims (inpatient and outpatient) will use the. A. Waiver codes. To find these claims use the first 3 characters of provider number. All L.A. Waiver provider numbers start with 'HSW' or 'ZZW'.

See "Appendix O. L.A. WAIVER CODES - INPATIENT" for L.A. Waiver procedure codes. HCPCS Levels II and III replaced SMA (Schedule of Maximum Allowances) codes in September of 1992. The codes are published in the Provider manual. The only other SMAs used are by Rural Health Clinics and Federally Qualified Health Centers (RHC/FQHC).

See "Appendix U. RURAL HEALTH BILLING PROCEDURE CODES" for that list of codes.

See "DATAELEMENT:PROCEDURE INDICATOR" for Procedure Indicator codes for SMA and HCPCS Levels II and III codes. HCPCS levels II and III replaced Delta Dental's California Dental Service (CDS) codes. The implementation date is July 1993 month of payment. The dentists will not bill with them, but Delta will convert them when they send DHS their paid claims files.

See "DATA ELEMENT:PROCEDURE INDICATOR" for Procedure Indicator codes for CDS codes.

EDS only Procedure code formats before March 1994

PROCEDURE INDICATOR	FORMAT
"- Long Term Care	5 spaces (use Accommodation code)

"- L.A. Wavier Long Term Care	5 spaces (use Accommodation code)
0 - CDS (Delta Dental) pre 7/93	3 Numeric characters and 2 spaces (replaced by HCPCS 7/93)
1 - UB-92 Inpatient after 1/92	'0' + 3 Numeric characters + 1 space
1 - UB-92 Inpatient after 1/92	'1' + 3 Numeric characters + 1 space
1 - 1964 RVS before the 1980s	4 Numeric characters and 1 space
2 - EPSDT	Always 'A001 '
2 - SMA for EDS for RHC/FQHC codes)	'0' and 4 numeric (replaced by HCPCS Levels II and III except
3 - Drug/Medical Supply Code	4 Numeric characters and 1 alpha (all drug codes & 9900A - 9999Z for medsupp.)
4 - CPT-4 (started 11/87)	5 Numeric characters
5 - 1974 RVS/CSN (CPTs replaced)	5 Numeric characters
6 - CHFC Primary Inpatient	'3' + 3 Numeric characters + 1 space before 1/92
6 - CHFC Secondary Inpatient	'4' + 3 Numeric characters + 1 space before 1/92
7 - L.A. Wavier	'00'+ 2 numeric characters & 1 space
8 - SD/MC Outpatient after 4/92	4 Numeric and 1 space (only on Plan Code 8 claims)
8 - SD/MC Inpatient	5 spaces (use Accommodation code) (only on Plan Code 8 claims)
9 - HCPCS Levels II and III	1 Alpha character and 4 numeric (started 10/92)

Before July, 1999 the last character was a space. Starting with July 1999 claims, the DHS program MFR151 that creates the standard DHS Long Paid Claims was modified to move the second character of the Service Function into the last character. Before 1992, all services were arrayed in groups of 10 starting with 0 and ending in 9; i.e. 20-29. This changed because it was easier to subdivide groups than add new ranges of tens. That means what service was being rendered was not fully known on the claim for many of the subdivided Service Functions range. July was chosen so that Fiscal Year claims would be consistent.

81.0 ACCOMMODATION CODE

It's also used by Short-Doyle/Medi-Cal to denote the mode of service code for hospital inpatient claims. "Appendix Q. SHORT-DOYLE/MEDI-CAL CODES".

Lastly, for hospital inpatient claims from EDS, the accommodation code is a converted code based currently on UB-92 accommodation or ancillary codes and previously on CHFC codes. The conversion takes place to simulate the hospital inpatient codes that a previous FI (MIO) used to provide.

See "Appendix N. INPATIENT ACCOMMODATION CODES" for HCFA Accommodation procedure codes with their matching Accommodation codes.

See "Appendix S. MIO 2-DIGIT ACCOMMODATION AND ANCILLARY CODES" for old MIO 2-digit Accommodation codes that are used by EDS' reformat program MFM320 to create the accommodation code field. The EDS program MFM320 looks at the HCFA accommodation codes and moves a value to the accommodation code field.

L.A. WAIVER claims do not always use the accommodation code field. Use the procedure code indicator '7' and the procedure code to determine the accommodation if the accommodation code is a space.

85.0 COPAY AMOUNT

Services Subject to Co-payment
Non-emergency Services Provided

in an Emergency Room. $5.00
A non-emergency service is defined as "any service not required for alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions that, if not immediately diagnosed and treated, would lead to disability or death." Such services provided in an emergency room are subject to co-payment.

Outpatient Service $1.00
Physician, optometric, chiropractic, psychology, speech therapy, audiology, acupuncture, occupational therapy, podiatric, surgical center, hospital or outpatient clinic, physical therapy.

Drug Prescriptions $1.00
Each drug prescription or refill.

Per federal law and regulation the following are Exceptions to Copay:

1) Persons age 18 or under.
2) Any woman during pregnancy and the postpartum period (through the end of the month in which the 60-day period following the termination of the pregnancy ends.)
3) Persons who are inpatients in a health facility (hospital,
4) Any child in AFDC-Foster care.
5) Any service for which the program's payments is $10.00 or less.
6) Any hospice patient.
7) Family planning services and supplies.

The co-pay amounts and regulations listed above are from 1982. 4/2000

87.0 PRESCRIBING/REFERRING PROVIDER NUMBER

With the implementation of OIL # 010-00 (in January 2000) and before SDN 7021 is implemented, EDS must now edit to make sure that there is a referring/prescribing/ordering provider number for selected provider claims. The Medical Review Branch of the DHS's Audits and Investigations Division and the Department of Justice's Bureau of Medi-Cal Fraud are impeded in their investigations by the failure of providers to disclose the referring/prescribing/ordering physician's Medi-Cal provider number/license when billing. These numbers are essential to pursuing investigations. EDS is instructed to implement an interim procedure to enforce existing policy; this requires providers to identify the referring/prescribing/ordering physician. This interim procedure will verify that the field for the referring/prescribing/ordering physician is not left blank on the Health Care Financing Administration (HCFA) 1500-claim form. When SDN 7021 is implemented it will edit this field for a valid provider number for specific provider types.

89.0 COPAY INDICATOR

Starting in the August 1991 claims file, the Copay Indicator field was added to the detail. EDS' program MFM320 moves the copay amount for LTC, drug and for L. A. Waiver claims and moves the copay indicator to the RFF035 copay indicator at the same time. 4/2000.

93.0 DETAIL OTHER COVERAGE AMOUNT

This field was added as of March 1994.
This field was originally called MEDICARE PAID AMOUNT-CALCULATED, but as of May 1994, it has been renamed to DETAIL OTHER COVERAGE AMOUNT. All the detail Other Coverage Amount paid are added to create the Header OTHER COVERAGE AMOUNT field.

94.0 ORIGINAL PLACE OF SERVICE

@N "N"o for Drug claims only. "N" meant the person was not in Long Term Care when they got the prescription.
@Y "Y"es for Drug claims only. "Y" meant the person was in Long Term Care when they got the prescription.

@ Note: These two codes are obsolete as of March 1995.

95.0 FIRST DATABANK SMART KEY

Field with number of bytes and example of codes as of 1993

Field(as of 1993)	Bytes	Number of Code
Generic Therapeutic Class (GTC) (GTC) broad classification; e.g. 20=Antiinfective	2	50
Specific Therapeutic Class (STC) Specific classification; e.g.0478=Tetracycline	4	500
Generic Name/ (HICL) Hierarchical Ingredient Code List identifies the specific Generic entity; e.g. 04003=Tetracycline HCI	5	5860
Drug Strength; (STR) e.g. 0600=250mg	4	2000
Dosage Form (DOSE) e.g. 500=capsule	3	200
Route of Administration (RT) e.g. 01=oral	2	23
Package Size (PS) e.g. 008=100each	3	30
Unit Dose/Unit of Use (UDUU) Identifies special packaging; 0 = doesn't have unit dose or use 1 = unit dose 2 = unit of use	1	3

98.0 DRUG DAYS SUPPLY

In July of 2000, somebody asked if this was reasonable data. Vic Walker, Senior Consulting Pharmacist for DHS, sent this reply:

We typically DON'T use the data, because we buy national utilization data from Scott Levin which contains DACON (daily consumption), and tend use that, in the hope that maybe it is more accurate. However, I've talked to Scott Levin about their DACON data, and they tell me they don't really do much

massaging of the data for reasonableness, etc, so I don't know that it's any better than ours.
The data is reported to us by pharmacies, so it's as accurate as they are. I think it's pretty accurate for tablets and capsules, very unreliable for Eye drops, creams and ointments, inhalers, etc

100.0 TOOTH SURFACE LOCATION

On GMC/Encounter (Geographic Managed Care) data, there is a 5-byte area used for denoting tooth surface, 1 byte for up to 5 occurrences per procedure code. According to dental managed care staff, this 5-byte Tooth Surface Location code must be passed to the RFF035-file which is the basis for providing data to MEDSTAT company for the MIS/DSS (Management Information System; Decision Support System), the relational database developed for DHS.

APPENDIX AA FI RELATED INFORMATION

3.0 DHS CLAIM TYPE

EDS, when they create the paid claims for DHS for our crossover claims, has to go through some checking to make our claims. All of the crossover claims have FI Claim Type 06 in their main claim type description, but they further identify which type of claim it is by using their claim types 01, 02, 03, 04, 05, and 07 to say if the claim is pharmacy, Long Term Care (LTC) inpatient, hospital inpatient, outpatient, medical/physician, or vision.

These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for short/long/RFF035 paid claims) for the facilities' convenience and would more appropriately be billed on the outpatient form.

DHS Claim Type	EDS Claim Type
1 = Outpatient	04 Outpatient
2 = Inpatient	02 Long Term Care 03 Hospital Inpatient
3 = Pharmacy	01 Pharmacy
4 = Medical/Physician	05 Medical 07 Vision
5 = Dental	not applicable
6 = EPSDT/CHDP	not applicable

4.0 INTERNAL CONTROL NUMBER

EDS' Roll number	Definition
01	on-line Claims Corrections
66	SPBU(01-09)
67,75	Physician Attachments Claim(KDE)
68	Tracer Special
69, 71-74	Claims Inquiry Forms (CIF) Systems Test
76	TAR Denied Date Recoupment
77	EPC Adjustment
78-79	Retro-Rate/Adjustment
80	RTD
81	Share Of Cost (SOC)
82-83	Crossover (KDE)
84	Crossover-C020 (KDE)
85-87	Medical Crossover
88	Claims Inquiry Forms (CIF) Crossover
89	Part B - Tape-to-Tape Crossover
90	CHDTP
91, 93	Unassigned

92	Part A - Tape-to-Tape Crossover
94	Treatment Authorization Request (TAR)
95-96	(CALifornia Point of Service)
97	CCS/GHPP
98-99	Appeals

6.0 BENEFICIARY NAME

Left justify field, consisting of any or all of the following:

Plan Code	Source	Format	
00	DELTA	LLLLLLLLLLLLLF	
01	DDS	Last name only	
01	DSS	Last name only	
02	Encounter	Free format-Last + ' ' + First for up	to 10 characters
04	LHPSM	Free format - Last + space + First	
04	SBHI	LLLLLLLLLFFFFFF	
04	Monterey first	Free format and most of the time and last name	there is no space between
05	EPSDT	Last name only	
06	DDS	Free format - Last + space + First	
08	S/D	Free format	
09	EDS	LLLLLLLLLLLLFFF	

Note: 'L' stands for a character of the last name and 'F' stands for a character of the first name.

7.0 SEX

Plan Code	Source	Format
00	DELTA	M, F
01	DDS	space
01	DSS	M, F
02	Encounter	M, F
01,02	MIO	1, 2
04	HPSM	M, F
04	SBHI	M, F
04	Monterey	M, F
05	EPSDT	1, 2
06	DDS	M, F
08	S/D	M, F
09	EDS	1, 2

1 or M – Male. 2 or F – Female.
Space – Not Reported

8.0 ETHNICITY (RACE)

Plan Code	Source	Format
00	DELTA	Not currently used
01	DDS	Not currently used
01	DSS	Not currently used
02	Encounter	Sometimes used/sometimes not
04	HPSM	Not currently used
04	SBHI	Not currently used
04	Monterey	Sometimes used/sometimes not
05	EPSDT	Lists ethnicity
06	DDS	Lists ethnicity, but different values until February 1992 when DHS started converting the codes.
08	S/D	Lists ethnicity
09	EDS	Lists ethnicity starting in November 1990.

10.0 PROVIDER ZIP CODE

Monterey county for the last four characters has a mixture of either all spaces, all zeros or the real four characters of the zip code.

11.0 PROVIDER NUMBER

Field Contents for Various Claims

Source	Position	Values
Dental Claims	Bytes 1-2	Zeroes
	Bytes 4-9	Numeric.
DDS	Bytes 1-9	Numeric.
DSS	Bytes 1-3	Zeroes
	Bytes 4-9	Alphanumeric
Short Doyle (SD/MC)	Bytes 1-5	Zeroes
	Bytes 6-7	Numeric
	Bytes 8-9	Alphanumeric

Encounter is a mixture. From Encounter Data Dictionary, it says that "If the service is provided by a Medi-Cal provider, then the Medi-Cal provider number must be used. If the clinic does not have a Medi-Cal provider number, the State clinic license number must be used. If the service is provided by a health facility, the Department of Health Services assigned facility number must be entered. When making entries in the field, enter the entire provider or license number, plan provider identifier number, tax identifier number, or national provider identification number, including all leading and trailing characters."

14.0 PROVIDER COUNTY

DSS and EPSDT claims have zeros or space sometimes besides real county codes. Encounter sometimes has zeros. Attempts to designate '99' for out-of-state providers have proven to be unsuccessful, but '99' is still used for out-of-state providers.

These codes are the same as Data Element : BENEFICIARY COUNTY for EDS, SBHI, HPSM, SD/MC, DDS claims.

15.0 PHYSICIAN SPECIALTY

Informal review generally indicates the data to be reasonable for EDS claims as they are the keeper of the main Provider Master File (PMF).

On Delta claims, a '99' indicates the claim was a fee-for- service billing. All other Delta claims will have spaces in
this field.
On Monterey claims, this field is used for non-physician claims also. It appears from comparing Vendor Code to the values in this field that there is a mix of codes. Some are true Physician specialty codes and the other codes are provider type. See "Appendix G. PROVIDER TYPE CODES" for a list of the provider type codes.

17.0 DHS DISCHARGE/PATIENT STATUS CODE

DHS Discharge EDS FI Patient Status Correlation

/Patient Status	Form UB-92	Not Form UB-92	
1	Transfer to another hospital	02	03,08,11
2	Transfer to long term care (prior to 4/1/96)	N/A	N/A
	Transfer to Transitional Inpatient Care (eff 4/1/96)	N/A	32
3	Transfer to long term care	03,04	05,13
4	Discharge-deceased	20	02,10
5	Discharged to home	01	04,09,12
6	Still a patient	30,31	00,01
7	Transfer to long term care (obsolete)	N/A	N/A
8	Leave of absence	N/A	06,07
9	Transfer to board and care (obsolete)	N/A	N/A

18.0 Surgery

If the claim is an EDS inpatient claim, the primary surgery code is check to see if it is greater than zero. If it is, the surgery code is set to an "S".

If the EDS claim is a medical claim, then a check is made for valid Physician/Medical/Vision surgery procedure code codes. The surgery code is set to "S" if it is any of these codes:

'00100' thru '01999'
'10000' thru '59480'
'59482' thru '59484'
'59488' thru '59599'
'59620' thru '69999'

If the EDS claim is an outpatient, then a check is made for valid surgery procedure code codes. The surgery code is set to "S" if it is any of these codes:

'10000' thru '59480'
'59482' thru '59484'
'59488' thru '59599'
'59620' thru '69999'

If the EDS claim is an Medicare crossover, claim type is checked to see if it is a outpatient, medical/physician or medical/vision claim (EDS claim type 04, 05, or 07). If it is, then the same group of procedure codes are checked as listed above for the outpatient claims to see if the surgery code is set to "S".

19.0 MEDICARE INDICATOR
EDS uses the roll number from the Internal Control Number to set the Medicare Indicator to '1'. If the roll number is between 82 and 90 or is 92, the claim is a Medicare claim. Also if the EDS inpatient type is 06, which means the claim is a Medicare Crossover, this indicator is set to '1'. See "DATA ELEMENT: INTERNAL CONTROL NUMBER" for placement of roll number.

20.0 ADMISSION DATE
This field is frequently unreliable on Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Long Term Care (LTC), and Medicare/ Medi-Cal inpatient claims since EDS and DDS can be very old dates or zeroes for ongoing cases. DDS, DSS, SD/MC and EPSDT do not use this field.

21.0 DISCHARGE DATE
May not be reliable for Medicare / Medi-Cal crossover claims. SD/MC and DDS leave spaces unless person is discharged. NOTE: EPSDT does not use this field.

22.0 CHECK DATE
On EDS processed claims it is the date that EDS sent the payment data to SCO. For EDS claims, EDS sends the State Controllers Office (SCO) a file listing those providers that need to have checks issued for services rendered. SCO then writes out checks for the providers or does an EFT (Electronic Fund Transfer). The EFTs are done 4 or 5 days after the checks are mailed. When EDS runs MFM320 to create our RFF035-file, they process all the claims that fall in the month that the SCO Warrants are mailed.

24.0 CO-INSURANCE AMOUNT
Encounter records always have zero in this field.
26.0 TOTAL MEDI-CAL PAID AMOUNT
Details show amount approved for payment before any adjustments for patient liability or other offsets. EDS uses the Medi-Cal Reimbursed amounts from each claim line to make the Total Medi-Cal Paid Amount field.

28.0 MEDICARE DEDUCTION CODE
This field is unreliable. On the October 2001 EDS file, out of 1000 records marked as Medicare claims, only 15 had a value of A and the rest were space filled. EPSDT claims have low-values in this field.

30.0 ADJUSTMENT INDICATOR
When EDS creates adjustment claims, it uses their claim disposition code to set the DHS Paid Claims adjustment code.

DHS Adjustment Code	EDS Claim Disposition Code Correlation
1 Positive supplemental	not applicable
2 Negative supplemental	not applicable
3 Refund to Medi-Cal (negative only)	6 (void), 7 (void to accounts receivable)
4 Positive side of void and reissue	2 (debit adjustment), 3 (retroactive debit adjustment), 4 (accounts receivable debit adjustment)
5 Negative side of void and reissue	5 (credit adjustment)
6 Cash disposition (obsolete)	
Space = not an adjustment	0 (original), 1 (Tape-to-tape crossover)

While EDS does not use adjustment codes of 1, 2, and 6, that does not mean the other claim processors do not use them. The other Plan Codes use DHS adjustment code values.

In October 1999, I was again asked about how to treat adjusted claims. This field is beyond me, but I knew who to ask so I forward the note on. On the next page is part of the originating note and the answers to the questions:
If I look at the Adjustment Indicator, I see that I can treat all claims with no reversals (space value) as they are. DHS values 4 and 5 are the classic reversals (void and re-issue). Can I treat DHS values of 3 (refund to MediCal) as simply a change in the MediCal paid amount, and not a reversal? If so, I can ignore these claims when I'm counting things, but must combine the paid amounts when I am looking at dollars. True?

On the other hand, can I always ignore the adjustment indicators of 4 and 5? How about adjustment indicators of 1 and 2: I presume I must combine them for costs. Since the adjustment indicator is contained in the header section of the record, I presume that it applies to the entire claim, including all of the details that follow the header. Is this true?

Appreciate any help you can provide!

Inquiring New User of the RFF035-file

Here are the answers:

Adjustment 3 (refund) basically voids out the original claim, so you would want to include them in the count of dollars as well as units or days. I believe these are mostly pharmacy claims that the beneficiary didn't pick up but the pharmacy had already billed for. I think there is a new ruling so that pharmacies are no longer permitted to bill until the prescription is Picked up.

If you ignore Adjustment 4 and 5, you would wind up with the incorrect dollar amount. A lot of these are retroactive adjustments to the original amount paid. So you would want to include them in the count of dollars and it would be fine to include them in counts of units or days since the original will be voided and the reissue will take its place.

Adj. 1 and 2 occur when the dollar amount is being adjusted either up or down and is used in lieu of Adj. 4 and 5. EDS doesn't use Adj. 1 and 2 but some of the county organized health systems (COHS) do. You would want to count these dollars but probably not the units or days. I haven't worked with these kinds of adjustments since EDS doesn't use them so I don't know for sure.

Yes, the Adj. Ind. applies to the whole claim. But be careful with those from COHS since they do things a little oddly due to their system limitations. You could find both positive and negative detail amounts on one of their adjustment claims, but the total of those details should add to the header amounts.

31.0 DAYS STAY

On EDS adjustment claims days stay can be negative, especially those for Vendor Code 47. EDS checks their claim disposition. If it is 5, 6, or 7, it is an adjustment claim, and the days stay field becomes a negative number.

Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units are not inpatient days. These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for paid claims) for the facilities' convenience and would more appropriately be billed on the outpatient claim form. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included.

SBHI, HPSM, and DDS originating files have admittance and discharge times. Thus, the days stay can be equal to the calculated "From" and "To" dates of service or it may be one day less.

DDS and Encounter may list zeros when the claim crosses months. On Encounter claims the discharge day is not counted unless the patient is 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, 2001, and was discharged alive on October 31, 2001, the days stay for this record would be 008. If the same patient dies instead of being discharged alive on October 31, the days stay would be 009.

32.0 HEADER OTHER COVERAGE AMOUNT

This field on EDS claims is created from '3rd Party AMT' on EDS' RFF034 file.

DDS, DSS and Encounter are zero filled.

33.0 ADJUSTMENT CCN

Delta Dental does not use this but uses the adjustment indicator to identify adjustment claims. See "DATA ELEMENT:ADJUSTMENT INDICATOR".

34.0 HEADER FROM DATE OF SERVICE (FROM DOS)

For EDS claims, the From Date of Service is the first claim line's date. The To Date of Service is the last claim line's date. All the dates in between can be the same or different.

The FROM and TO Dates of Service can cover more than 2 calendar months.

If a claim is an adjustment or Date of Service is old, two separate claims will probably be created.

On Medi-Cal/Physician (Claim type 4) claims if a beneficiary goes to a physician two or more times in a particular month it is possible to have different FROM Date of Service and TO Date of Service dates. Some doctor offices bill monthly and therefore a claim will list all services rendered and there will be a range in FROM and TO Dates of Service. If the doctor office bills for each service date, the FROM and TO Date of Services will be identical.

36.0 AID CATEGORY

The same aid code that is in the Bene ID. This field is populated from C54-AID-CAT-109. EDS began to always put the DE109 AID CAT aid code into the Bene ID Aid Code. We will have a duplicate of the of the Bene ID Aid Code reported in the new Aid Category field.

**Kim's comments- "The Sonoma & Placer county folks wanted aid category a few years ago. I didn't understand how the aid code was misnamed and used until now. Kill this code unless the new RFF034 now carries the aid category + aid code."

37.0 FFP INDICATOR

Space = non-8H aid code (non-FPACT) default

38.0 CROSSOVER STATUS CODE

The above values are derived from the Medicare Status we receive on the FAME eligibility data. The Medicare Status on the FAME file is currently a two-byte field and it is translated to a 1 byte in CA-MMIS.

39.0 OTHER COVERAGE INDICATOR

EDS sets the Other Coverage Indicator to '1', when the claim is not a Medicare crossover and the C54-CLM-3RD-PTY-AMT is not = zero.

40.0 SOCIAL SECURITY NUMBER

This field may contain an EDS pseudo number. If EDS cannot find a match, they invent a number, just as DHS does. Unfortunately we don't have a cross-reference or access to this file. This number will always end in a "Q". You will see this number almost all of the time on Presumptive Eligibility (PE) claims (Aid code 7F and 7G) as SSN is not a requirement for this benefit. The qualified provider of PE must order residency forms and PE benefits cards from DHS. The reason for this is the two forms have pre-printed 14-character beneficiary IDs on them for filling purposes. There is no place to enter a SSN on either form.(The 14 character beneficiary ID is also not kept on MEDS so there is no real way to capture who received PE benefits and then became Medi-Cal eligible for pregnancy related services. The only other identifying information on the PE claims is 12 characters of the last name and 3 characters of the first name and the date of birth. Also many PE claims don't even have anything in the name field at all, so the only personal information on the nameless claims is the date of birth. June 2000 using March 2000 claims for research.)

This field may contain the HAP (Health Access Program) ID. This number will always start with a "9" and end with a "Y".

Right now this ID is used for Family P.A.C.T. claims, which have an aid code of 8H. It is possible it will be used for other programs in the future. Also, since the client having the service doesn't have to give their SSN, the name field is usually filled with spaces, zeros, or the words "NO NAME". This was discovered by using the March 2000 EDS file while looking for CINs in this SSN field during January 2001.

The Children's Treatment Program (CTP) moves a 9 character ID with the 9th position of the ID of "J" or a "K" to the SSN field. This ID is also used to build a 14 character Bene ID with the county code, aid code of "94", "M", followed by the CTP claim form ID. The claims are for non-Medi-Cal children. When a CTP claim is submitted they must attach a copy of the CHDP claim noting treatment required. EDS takes the pre-imprinted number from the CHDP claim and uses that as the ID number for the CTP claim. They all have the generic 94 as the aid code. These all show up on the CMSP payment tape.

DHS also run these claims against the Healthy Families eligibility file to see if they were within the

90-day period before enrollment into HF, if so, DHS collects the additional FFP for them. So these claims can also appear on the HF claim tape. Giordano, Eve of DHS Payment Systems Division at EDS on-site gave this explanation on 3/14/01 as to why we see claims that in the SSN field has Js and Ks as the ending character. Not on EPSDT except for Supplemental Security Income claims.

41.0 BIRTH DATE

Plan Code	Source	Format
00	DELTA	CCYYMMDD
01	DDS	' '
01	DSS	CCYYMMDD
02	Encounter	CCYYMMDD
01,02	MIO	CCYY
04	HPSM	CCYYMMDD
04	SBHI	CCYYMMDD
05	EPSDT	CCYYMMDD
06	DDS	CCYYMMDD
08	SD/MC	CCY Y
09	EDS	CCYYMMDD

43.0 PROVIDER NAME

This field is a space on EPSDT. Starting with the July 1999 file, SD/MC claims now have the provider name, but before that the field was a space.

DDS starts with last name and then first name starts in column 196.

Encounter data's starts with last name and then first name for individuals. Facilities/clinic names use their normal business name.

Monterey claims for physicians names list "LASTNAME, MD FIRSTNAME". Many outpatient clinics have OP in their name. Many hospitals have IP in their name. Many Long Term Care facilities have LTC in their name.

44.0 MINOR CONSENT SERVICE CODE

This is required on EDS claims and comes from MEDS/FAME.

The minor consent code is the last byte of the 3-digit restricted services code on the FAME file. A leading zero is dropped on the RFF035-file because it used to be a two-byte field in the old days.

When a record is identified as a minor consent, MEDS inquiry access by CRT operators is limited based on password authorization to access minor consent records. If an unauthorized person attempts to view a minor consent case on MEDS, the message will say that no record has been found. It happens that many times the child will have a record under their own SSN based on a family's eligibility and a minor consent record. This insures that the adult/guardian/family member involved in the case doesn't have access to this information. The recipient ID used is a pseudo MEDS ID. No address is stored with this record as the Medi-Cal card is issued at the Medi-Cal office for the child.

46.0 FI CLAIM TYPE

01 = Pharmacy (Form 30-1)
02 = Long Term Care (Form 25-1)
03 = Hospital Inpatient (Form 16-1 or UB-92)
04 = Outpatient (Form 15-1 or UB-92)
05 = Medical/Allied (Form 40-1 or HCFA-1500)
06 = code not used at DHS

07 = Vision (Form 45-1)
09 = code not used at DHS

Encounter has data in this field.

DDS and DSS have spaces in this field.

47.0 RECIPEINT PREPAID HEALTH PLANS(PHP) CODE

DDS and DSS have spaces in this field.

Monterey claims always have their code of 508 in this field.

48.0 FI PROVIDER TYPE CODE

This field is not required from Delta Dental, CHDP, SD/MC or state hospitals. Additions to the list are transmitted via an Operating Instruction Letter (OIL) from DHS' Payment System Division (PSD) to EDS. The codes are on the provider's record on EDS' Provider Master File and on CAMMIS table 0205.

Not on DDS or DSS files.

Monterey does uses this field, but they don't use 3 character one as of their May 2000 file.

49.0 CATEGORY OF SERVICE

Each category of service has multiple service codes. These are obtainable on EDS CA-MMIS table 4201. Updates to this data element are transmitted via an Operating Instruction Letter (OIL) from DHS' Payment System Division (PSD) to EDS.

This field is not required from Delta Dental, CHDP, SD/MC or state hospitals.

Not on DDS, DSS, Monterey or Encounter files.

51.0 SECONDARY DIAGNOSIS CODE(ICD)

Encounter sometimes has data in this field. DDS and DSS have spaces in this field.

53.0 INPATIENT ADMISSION NECESSITY/TYPE CODE

* Note: There is no delivery admit code for UB-92 claim forms but deliveries can be determined by the existence of procedure codes 59400-59410 or 59510-59525 in either the Primary or Secondary Surgical Code fields.
NOTE: For encounter claims where the newborn remains an in-patient when the mother is discharged "3" is used to identify the newborn's inpatient stay.

54.0 FI DISCHARGE/PATIENT STATUS CODE

Encounter claims also use this field for outpatient claims if applicable to the claim. If none of the medical outpatient codes are applicable to the claim, the field is space filled.

65.0 CCN LINE NUMBER

EDS makes an RFF035 using the same 11 character ICN key, so that we usually have one claim with a detail segment for each claim line EDS has processed under that ICN key. This is how the Segment Count field on the file is determined.

On EDS claims the claim line # is always 00. That is why we are moving the real claim line number to the segment, so we have all 13 characters. 00 is moved into the last 2 characters of ICN. Now 14.0 will have the 2 characters to make a whole 13 characters ICN.

67.0 DETAIL MEDI-CAL PAID AMOUNT

ON MIO PROCESSED INPATIENT CLAIMS, THESE DETAILS WERE ADJUSTED TO ACCOUNT FOR AUDIT OFFSETS. CSC AND EDS DO NOT MAKE THIS ADJUSTMENT.

This amount is usually zero on Medicare/Medi-Cal crossover claims. Most claims from contract hospitals have zeros in this field.

73.0 OTHER HEALTH CARE COVERAGE

There are three kinds of OHC codes, (1) Cost Avoidance, (2) Prepaid Health Plans/Health Maintenance Organizations (PHP/HMO), and (3) Pay-and-Chase. When claims come in and the beneficiary's OHC code is a cost avoidance code, the claim is rejected. The provider must bill the insurance carrier first, before Medi-Cal is billed. If the insurance carrier does not pay for that service, the claims is reprocessed with the insurance carrier's rejection, so Medi-Cal will pay. If a pay-and-chase OHC claim comes in, the claim will be paid and the State of California, through EDS starting in April 1991 will bill the insurance carriers directly. Each service rendered is coded with an OHC code to say whether that service is covered by the health insurance policy the Medi-Cal beneficiary is carrying. The first detail OHC code is moved to the header OHC code field for easier computer processing. Therefore, it is possible that different OHC codes can be each detail depending if the service rendered was payable under that insurance company's policy.

When a provider is checking for eligibility either using a MOPI (MEDS ONLINE POS INQUIRY) or CATs(common Application Transaction System) or the internet MEDI-CAL site if they have a provider number, etc., this is the kind of message they will get back for the beneficiary on the date of service in question:

LAST NAME : LASTNAME EVC #: 614JG1NF8D.
CNTY CODE: 04. PRMY AID CODE: 39
MEDI-CAL ELIGIBLE W/ NO SOC. OTHER HEA
HEALTH INSURANCE COVERAGE UNDER CODE A
CARRIER NAME: BLUE SHIELD OF CALIFORNIA
HMO. COV:OIM P V.

Other Coverage is any private health insurance plan or policy under which a recipient is entitled to receive health care services. Other Coverage includes benefits available through commercial insurance companies, prepaid health plans(PHPs), Health Maintenance Organizations (HMOs), as well as any organization that administers a health plan for professional associations, unions, fraternal groups, employer-employee benefit plans, including self-insured and self-funded plans.

Eligibility under Medicare is not considered Other Coverage; however, Medicare supplement policies are considered Other Coverage. The provider of medical services should refer recipients with PHP/HMO coverage to their plans for covered treatment, except in emergencies. Medi-Cal will not reimburse providers for plan covered services, including emergency services, if the recipient chooses to go elsewhere for treatment.

If the beneficiary does have eligibility for that date of service a EVC (Eligibility Verification Confirmation) number is assigned and it is used to confirm the beneficiary was eligible in case the claim is denied.

Many providers will have print copies of this information just in case.

74.0 EPSDT SERVICE INDICATOR

The EPSDT Service Indicator will only be available on EDS claims.

76.0 TAR CONTROL NUMBER

The first two bytes provide information on the type of TAR that was submitted. The next eight bytes are a serial number that is printed uniquely on each paper TAR form. The final byte (at least for pharmacy TARs) has the following meanings:

0 – Regular TAR
1 – Price Override TAR
3 – Negotiated price TAR

Within this number are various parts that identify claims where the authorization originated. The TAR Control Number will allow a user to track back to the original TAR that was used to approve payment of a claim. In addition, useful information on the type of TAR can be derived from portions of the TAR Control Number.

For all claim types except LTC (Long Term Care), the first two-bytes of the 11-digit TAR Control Number designates the Field Office Unit Code and the 11th digit is the Pricing Indicator.

LTC TAR Control Numbers are only nine bytes long (first two-byte is the Field Office Unit Code followed by a 7-byte sequential number.) The 10th and 11th bytes are zero filled.

79.0 PROCEDURE CODE OR DRUG TYPE

Delta Dental codes are published in Title 22, California Code of Regulations, section 51506 as 4-digit codes all beginning with a '9'; however, the code appeared as a 3-digit code without the leading '9' on the paid claims. See "Appendix P. DELTA DENTAL CODES" for Delta Dental procedure codes before the change to HCPCS Levels II and III effective with July 1993 month of payment.

81.0 ACCOMMODATION CODE

The accommodation code is used by EDS, State Hospitals, Developmental Centers, and county organized health systems to denote long term care facility accommodations. The Long-Term Care (Vendor Codes 47 & 80) claims use 2-digit accommodation codes as prescribed in the Provider Manual and do not use procedure codes. The third byte of this field is always a space

82.0 TOOTH OR MODIFIER

EPSDT, DDS, and SD/MC claims contain spaces in this field.

83.0 UNITS

Generally, this field contains days for inpatient claims but for other claims the interpretation is more difficult. For example, physicians may bill visits, surgeries, anesthesia units, injections, lab procedures, x-rays, etc., and this field describes the quantity of such services. On Pharmacy claims (Claim Type 3 in Data Element 04), the Segment Count (Data Element 02) indicates the number of prescriptions billed on this claim unless the Segment Count equal zero. The units field on Pharmacy claims indicates number of tablets/capsules or medical supply volume.

Vendor Code 83 (Pediatric Subacute Rehab/Weaning) is found on Claim Type 2, but in this unique case, the reported Days Stay and Units are not inpatient days. These services are billed by long term care facilities on the EDS long term care form (converted to Claim Type 2 for paid claims) for the facilities' convenience and would more

appropriately be billed on the outpatient claim form. When counting inpatient days for long term care, the days reported for Vendor Code 83 should not be included.

Per Michael K. Fitzwater, Medical Care Statistics Section, April of 2001:
"Claim lines for ancillary services, at least for some hospitals, have numbers other than zero in Units of Service field for hospital inpatient claims. In counting days it will be necessary to check the Procedure Code field to select for inpatient days. This would apply to vendor codes 50 (hospital inpatient), 60 (hospital inpatient) and 63 (mental health inpatient)."
Here is a list of the procedure codes indicating paid days:

For Procedure Indicator = 1
0075 - 0081
0083 - 0092
0094 - 0219
1075 - 1081
1083 - 1092
1094 - 1219
For Procedure Indicator = 7 (L.A. County hospital waiver codes)
0001 – 0099

Nursing facilities (vendor code 80) and Intermediate Care Facilities (vendor code 47) have a blank Procedure Code field, but only have one detail line. A brief scan of these records indicates that only paid days are present in the single detail.

Bonnie Williams suggested that the Days of Stay field would be sufficient for these latter two vendor codes. The sample I am working with indicates that the Days of Stay do equal the Units of Service field for these vendor codes."

84.0 PRESCRIPTION NUMBER

San Mateo (HPSM), Santa Barbara (SBHI), and Encounter and do not list prescription numbers.

87.0 PRESCRIBING/REFERRING PROVIDER NUMBER

For EDS, these are the referring/prescribing by claim type:

Pharmacy	Prescribing provider
Hospital inpatient	Admitting provider
Outpatient	Rendering Provider
Physician/Medical	Rendering Provider
Vision Rendering Provider	
Long Term Care	Referring Provider

It is on EDS, SBHI, Encounter and HPSM.

Not on SD/MC, EPSDT, DELTA, PCSP and DDS.

Provider types to be checked are:

02 Durable Medical Equipment (DME)
21 Orthotist
24 Pharmacy (HCFA 1500 claim form only)
28 Portable X-Ray
29 Prosthetist

Claims will suspend for this audit if the field on the form is filled in with a space or zeroes, or that the referring provider number is the same as the billing provider number (this indicates self-referring and is in violation of Business and Professions Code, Section 650.01), provider prefixes that start with G*, HS*, LT*, YYY, ZZR, ZZT, and ZZW because these provider prefixes do not designate individual providers.

For encounter files this field will never have a group provider or facility license number. The data dictionary says that if the referring physician is a "Primary Care Physician (PCP), then the PCP's provider or license number is used. If no referral is given, the filed is left blank. Prescribing Physician: All pharmacy records enter the provider number, license number or Drug Enforcement Authority number of the physician who prescribed the medication or authorized the medical supply. Admitting Physician: For all hospital and long-term care records, enter either the Medi-Cal provider number or the State license number of the physician who admitted the patient into the hospital. Left justify this field with trailing spaces."

For EDS claims, Karen Royal has given us this information as of December 2001. For Pharmacy and LTC claims, C54-A-REFER-PRESC-PROV-No is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For inpatient, C54-IN-ADMIT-PROV-NO is mapped to the current 35-file to the current 35-file field WS-SEG-PRESC-REFERR- PROV-NO. For outpatient, C54-OUT-RENDER-PROV-NO is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For xover(old), C54-IN-ADMIT-PROV-NO (MEDICARE-CLM-TYPE =03 ONLY) is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. For xover(new), C54-XO-RENDER-PROV-NO is mapped to the current 35-file field WS-SEG-PRESC-REFERR-PROV-NO. The current field on the 35-file, WS-SEG-PRESC-REFERR-PROV-NO, will become F35B-PRESC-REF-REND-PROV-NUM on the new 35-file layout.

90.0 DRUG MANUFACTURER

On a Claim Type 3-Pharmacy claim (Vendor Code 26) this is a two position alpha code to identify the drug manufacturer. See "DATA ELEMENT:VENDOR CODE".

91.0 FI TYPE OF SERVICE

For EDS, this value is from their procedure master . The EDS type of service is also referred to as the EDS procedure type.

EDS' drug claims do not have type of service code since they come from the Formulary file, not the Procedure code file, which is where EDS keeps their Type of Service code. Starting in March 1994, they will move a 'X' into this field for drug claims.

See "APPENDIX X. COMPARISON OF EDS' TYPE OF SERVICE CODES TO DHS's FIELDS" for a comparison of EDS' vs. DHS's type of services and other codes.

92.0 MEDI-CAL REIMBURSED AMOUNT

EDS' Inpatient, Inpatient Crossover and New Part B Crossovers claims do not have claim line reimbursement amounts. Inpatient claims will use the detail Medi-Cal Paid/Allowed Amount reflect the allowed amount for each line from the claim form. The Crossovers will use the total Reimbursement amount for the total/last detail line, while all the other detail lines will contain zeroes.

94.0 ORIGINAL PLACE OF SERVICE

See "DATA ELEMENT:DHS PLACE OF SERVICE (POS)"for a comparison of the respective data elements' place of service codes.

EDS' Long Term Care and Inpatient claims have spaces in this field.

97.0 DRUG REFILL NUMBER
Populated from C54-DRUG-REFILL-NUM. This is not collected on the paper pharmacy claim form, nor is it requested in the Medi-Cal POS Specifications. However, the information is available on many of the NCPDP(National Council of Prescription Drug Programs) transactions received by Medi-Cal.

APPENDIX AB 35-FILE EDITS

LVL	S35-FILE-ELEMENT	EDITS	PIC
01	F35B-PAID-CLAIM-RECORD	No Edit	
05	F35B-HEADER	No Edit	
10	F35B-SEGMENT-CNT	MUST BE >= 0 AND <= 99 … For compound drug claim it must be > 0 (always one 'MAIN' segment with compound drug claims)	PIC S9(04) BINARY
10	F35B-PLAN-CODE	MUST BE VALID FOR THE SUBMITTER. 00 = DELTA DENTAL 01= DSS PCSP; DDS WAIVER; DDS TCM; MEDI-CAL TCM 02 = ENCOUNTER DATA FROM MANAGED CARE PLANS 04 = COHS 05 = CHDP 06 = STATE HOSPITALS / STATE DEVELOPMENTAL CTRS 08 = SHORT-DOYLE/MEDI-CAL 09 = EDS	PIC X(02)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-CLAIM-TYPE	MUST BE VALID FOR PLAN CODE. PC DHS CT 00 5 (DENTAL) 01 1 (OUTPATIENT) 02 1-5 (VARIOUS) 04,09 1-4 (VARIOUS) 05 6 (CHDP) 06 2 (INPATIENT) 08 1-2 (OUTPAT, INPAT) IF PLAN CODE = 02, 04 or 09, MUST BE VALID FOR FI CT. FI CT DHS CT 01 3 (DRUG) 02,03 2 (INPATIENT) 04 1 (OUTPATIENT) 05,07 4 (MEDICAL)	PIC X(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-CCN	MUST BE NUMERIC. MUST BE VALID FORMAT BREAK OUT THE JULIAN DATES AND COUNTY CODE PORTIONS TO EDIT THE FORMAT. Plan Code ICN FORMAT 00 0000YJJJ99999 01, 05,08 YYJJJ99999999 02,09 YJJJ999999999 04 AND HCP 506 AND CLAIM TYPE NE ‘3’ YJJJ999999999 04 AND HCP 506 AND CLAIM TYPE EQ ‘3’ 30YYJJJ999999 04 AND HCP 505 (Santa Cruz) YYJJJ99999999 04 AND HCP 508 (Monterey) YYJJJ99999999 04 CCYYJJJ999999 HCP TO CC 502 42 503 41 504 48 507 28 509 57 06 999999999YYMM	PIC S9(13) COMP-3
10	F35B-BENE-ID	see below	
15	F35B-BID-COUNTY	see below	

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	F35B-BID-CNTY	MUST BE IN VALID RANGE 01-58. MUST BE VALID FOR COHS HCP CODE. COHS VALID BID PHP COUNTY 502 42 503 41 504 48 505 44 506 30 507 28 508 27 509 57	PIC 9(02)
15	F35B-BID-AID-CODE	MUST BE IN VALID RANGE PER LOOKUP TABLE in he.copylibm.cobol(aidcodpc), 88 level valid-aid	

20	F35B-BID-CASE-NUMBER	IF DIGIT 1 = '9' AND AID CODE IS 10, 20, OR 60, THEN
		DIGITS 2-10 SHOULD BE NUMERIC (SSN).
		IF DIGIT 1 = 'M' AND DIGIT 10 = 'P', THEN
		DIGITS 2-9 SHOULD BE NUMERIC
		AND DIGIT 2 SHOULD = '8' OR '9' (PSEUDO SSN).
		IF DIGIT 1 = 'M' AND DIGIT 10 NOT = 'P', THEN
		DIGITS 2-10 SHOULD BE NUMERIC (SSN).
		IF DIGIT 1 = 'C', THEN
		DIGIT 2 SHOULD = '9'
		AND DIGIT 10 SHOULD BE ALPHABETIC
		AND NOT = 'P' OR SPACE (CIN).
		IF DIGIT 1 NOT = '9', 'M', OR 'C', THEN
		DIGITS 2-7 SHOULD NOT
		CONTAIN SPACES (CASE NUMBER).
		ALSO CHECK FBU AND PERSON NUMBER
		FOR THIS PATH.
			PIC X(07)

20	F35B-BID-FBU	MUST NOT CONTAIN ANY SPACES.	PIC X(01)
20	F35B-BID-PERSON-NUMBER	MUST NOT CONTAIN ANY SPACES.	PIC X(02)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-BENE-NAME	MUST NOT CONTAIN ALL SPACES	PIC X(15)
10	F35B-BENE-SEX	MUST CONTAIN VALUES 1, 2, F, OR M.	PIC X(01)
10	F35B-BENE-RACE	IF PLAN CODE = 09, IF AID CODE IS 10, 20, OR 60, MAY CONTAIN SPACES. ELSE MUST CONTAIN VALUES 1-9, A, C, H, J, K, M, N, P, R, T, V, Z END-IF END-IF FROM MTR110 IF PLAN-CODE = '6' INSPECT HDR-RACE-CODE CONVERTING '23456E089A' TO '325CJN8888' IF NOT VALID-RACE-CODE MOVE '8' TO HDR-RACE-CODE END-IF END-IF	PIC X(01)
10	F35B-BENE-HIC	No Edit	PIC X(12)
10	F35B-PROVIDER-ZIP-CODE	MUST BE > 00100.	
10	F35B-PROVIDER-NUMBER	MUST NOT CONTAIN ALL SPACES	
10	F35B-REIMBURSEMENT-RATE	No Edit	PIC 9(03)
10	F35B-PATIENT-LIABILITY	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35B-PROVIDER-CNTY	MUST BE IN VALID RANGE 01-58 ... Provider County could be a 99 for out-of -state providers.	PIC 9(02)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-PROVIDER-SPECIALTY	IF VENDOR CODE = 20 OR 22, THEN MUST NOT CONTAIN all SPACES OR all ZEROES. from MTR110 IF TRANS-MANDIBULAR-JAW, OR HEALTH-MANPOWER-PILOT, OR IMMIG-REFORM-CONTROL, OR ROOT-CANAL-THERAPY MOVE '99' TO HDR-PROVIDER-SPECIALTY END-IF	PIC X(02)
10	F35B-VENDOR-CODE	IF PLAN CODE NOT = 05 (CHDP), THEN MUST BE VALID PER VALUES IN MTR100, working storage 88 level w-vendor-valid. MUST BE VALID FOR CERTAIN CLAIM TYPES. DHS CT VALID VENDOR 2 (INPAT) 47,50,56,57,60,63,64,80,95. 3 (DRUG) 26 5 (DENT) 27 IF PLAN CODE = 02, 04, OR 09, THEN must be valid for provider type per correlation lookup table in working storage	PIC X(02)
10	F35B-DISCHARGE-CODE	IF PLAN CODE = 02, 04, OR 09 AND DHS CLAIM TYPE = 2 (INPAT) AND MEDICARE INDICATOR = SPACE, THEN MUST BE IN RANGE 1-9. IF PLAN CODE = 06, THEN MUST BE IN RANGE 0-9	PIC X(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-SURGERY-CODE	IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT) AND PRIMARY SURGERY CODE NOT = SPACES OR ZEROES, THEN MUST CONTAIN SPACE OR 'S'	PIC X(01)

10	F35B-MEDICARE-INDICATOR	LTC claims sometimes contain the
		patient liability amount in the Medicare
		deductible amount field, so
		if vendor code = 47 or 80, then skip;
		else
		if coinsurance not = 0 or
		Medicare deductible not = 0,
		then must = 1.
		if Medicare indicator = 1, then
		header OHC indicator should = space.
			PIC X(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-ADMISSION-DATE	MUST BE NUMERIC. LTC CLAIMS DO NOT REQUIRE THE ADMISSION DATE BUT IF IT IS THERE, THE FORMAT SHOULD BE EDITED. IF MEDICARE INDICATOR = SPACE AND PLAN CODE = 02, 04, 06, OR 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN IF VENDOR CODE = 47 OR 80 AND ADMISSION DATE > 0, THEN MUST CONTAIN VALID CC, YY, MM, DD; ELSE IF VENDOR CODE NOT = 47 OR 80, THEN ADMISSION DATE MUST BE > 0 AND MUST CONTAIN VALID CC, YY,MM,DD. Additional instructions: If > end of month of process month/year THEN move zeroes to field and create special error report	PIC X(08)

LVL	S35-FILE-ELEMENT	EDITS	PIC

10	F35B-DISCHARGE-DATE	IF NOT NUMERIC, MOVE ZEROES TO FIELD.
		
		IF MEDICARE INDICATOR = SPACE, THEN
		IF (PLAN CODE = 06 AND DHS DISCHARGE CODE > 6) OR
		(PLAN CODE = 02, 04 or 09
		AND DHS CLAIM TYPE = 2
		AND DHS DISCHARGE CODE NOT = 6 or 8), THEN
		MUST BE > 0 AND
		MUST BE > ADMISSION DATE AND
		MUST CONTAIN VALID CC, YY,MM,DD AND
		MUST BE < CHECK DATE.
		
		Additional instructions: If > end of month of process month/year
		THEN move zeroes to field and create special error report
			PIC X(08)

10	F35B-CHECK-DATE	MUST BE NUMERIC. MUST BE > 0. must contain valid date. AND must be less than or equal to the last day of the processing month	PIC X(08)
10	F35B-ADJUDICATION-DATE	MUST BE NUMERIC. IF PLAN CODE = 02, 04 or 09, THEN MUST BE > 0 AND MUST CONTAIN VALID CC, YY,MM,DD. MUST BE <= CHECK DATE	PIC X(08)
10	F35B-CO-INSURANCE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0 Report the number of records with an apparently invalid sign (COHS have unique adjustment methods) 5% error on other edits	PIC S9(7)V9(2) COMP-3

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-HDR-MEDI-CAL-AMT-BILLED	IF F35-HDR-MEDI-CAL-AMOUNT-BILLED NOT NUMERIC MOVE 019 TO W-I-ERROR PERFORM ERROR END-IF IF F35-NEGATIVE-ADJUSTMENT AND F35-HDR-MEDI-CAL-AMOUNT-BILLED > ZERO) OR (NOT F35-NEGATIVE-ADJUSTMENT AND F35-HDR-MEDI-CAL-AMOUNT-BILLED < ZERO) MOVE 020 TO W-I-ERROR PERFORM ERROR end-if IF NOT F35-MEDICARE-IND-1 AND F35-ADJUSTMENT-INDICATOR = SPACES AND F35-OTHER-COVERAGE-INDICATOR NOT = '1' AND F35-PATIENT-LIABILITY = ZERO Total the values of all the detail billed fields IF THE TOTAL OF THE DETAIL BILLED VALUES ARE NOT EQUAL TO THE HDR VALUE MOVE 021 TO W-I-ERROR PERFORM ERROR end-if	PIC S9(7)V9(2) COMP-3

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-HDR-MEDI-CAL-AMOUNT-PAID	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0. AND must = sum of the detail billed amounts when checking if the sum of the detail billed amounts total to the header billed amount, skip the following claims: - crossovers (medicare indicator = 1) - adjustments (adjustment indicator not equal space) - claims with other health coverage (ohc indicator = 1) - claims with patient liab (patient liability not equal zero)	PIC S9(7)V9(2) COMP-3
10	F35B-MEDICARE-DEDUCTION-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
10	F35B-MEDICARE-DEDUCTION-CODE	MUST CONTAIN SPACE, A, B, OR C	PIC X(01)
10	F35B-FAMILY-PLANNING-CLAIM	No Edit	PIC X(01)
10	F35B-ADJUSTMENT-INDICATOR	MUST CONTAIN SPACE OR BE IN RANGE 1-6. For some COHS data, the Adjustment Indicator may not agree with the positive/negative sign of the counter fields in the detail segments. It should, however, agree with the sign in the header counter fields.	PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-DAYS-STAY	IF not numeric -- error IF negative adjustment and > 0 -- error IF not negative adjustment and < 0 -- error IF not F35-MEDICARE-IND-1 and inpatient-claim LOOP FOR EACH SEGMENT IF numeric IF vendor code = '50' OR '60' OR '63' IF procedure code BED-CODES ADD F35-UNITS (SEG) TO A-UNITS IF vendor = '47' OR '80' ADD F35-UNITS (SEG) TO A-UNITS End loop IF F35-DAYS-STAY NOT = A-UNITS -- error IF DRUG CLAIM THEN A-UNITS CANNOT BE = ZERO IF DRUG CLAIM COUNT NUMBER > 0 BUT LESS THAN 1 IF THE TOTAL NUMBER OF DRUG CLAIMS >0 BUT < 1 UNIT IS GREATER THAN 5% OF TOTAL DRUG CLAIMS ERROR IF THE TOTAL NUMBER > 0 BUT < 1 UNIT IS GREATER THAN 10% OF TOTAL DRUG CLAIMS SEVERE ERROR	PIC S9(3) COMP-3
10	F35B-OTHER-COVERAGE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-ADJUSTMENT-CCN	MUST BE NUMERIC. IF ADJUSTMENT INDICATOR NOT = SPACE OR 6, THEN MUST BE > 0 AND FORMAT MUST BE THE SAME AS NOTED ABOVE FOR ICN/CCN	PIC S9(13) COMP-3
10	F35B-HDR-FROM-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE. MUST BE <= HEADER TO-DOS	PIC X(08)
10	F35B-HDR-TO-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE.	PIC X(08)
10	F35B-AID-CATEGORY	Aid-Category should have the same edit as the Bene ID Aid Code.	PIC X(02)
10	F35B-FFP-IND	MUST BE SPACE	PIC X(01)
10	F35B-CROSSOVER-STATUS-CODE	Valid is 1, 2, 3, or space	PIC X(01)
10	F35B-OTHER-COVERAGE-INDICATOR	IF HEADER OTHER COVERAGE AMOUNT NOT = 0, THEN MUST = 1; ELSE MUST = SPACE.	PIC X(01)
10	F35B-SSN-OR-MEDS-ID	MUST NOT CONTAIN ANY SPACES	
15	F35B-SSN-OR-MEDS-ID-1	No Edit	PIC X(01)
15	F35B-SSN-OR-MEDS-ID-2-8	No Edit	PIC X(07)
15	F35B-SSN-OR-MEDS-ID-9	No Edit	PIC X(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-BIRTHDATE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE	PIC X(08)
10	F35B-CCS	MUST BE '1' OR SPACE	PIC X(01)
10	F35B-PROVIDER-NAME	MUST NOT CONTAIN ALL SPACES.	PIC X(28)
10	F35B-MINOR-CONSENT-SERVICE	No Edit	PIC X(02)
10	F35B-RESTRICTED-SERVICE	No Edit	PIC X(02)
10	F35B-FI-CLAIM-TYPE	IF PLAN CODE = 02, 04 or 09, THEN MUST BE IN RANGE 01-05 OR 07	PIC X(02)
10	F35B-HEALTH-PLAN-CODE	see below	

15	F35B-PHP-CODE	IF PLAN CODE = 02 OR 04, THEN
		MUST NOT CONTAIN SPACES OR ALL ZEROES.
		IF PLAN CODE = 04 (COHS), THEN
		MUST BE VALID FOR SUBMITTER (VIA PARM?)
		COHS
		HCP CODE SUBMITTER
		502 SANTA BARBARA
		503 SAN MATEO
		504 SOLANO
		505 SANTA CRUZ
		506 ORANGE
		507 NAPA
		508 MONTEREY
		509 YOLO
			PIC X(03)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-FI-PROVIDER-TYPE	IF PLAN CODE = 02 OR 09 OR 04 , THEN MUST be valid per working storage table (values listed below). Valid 3-digit Provider Type codes: 001 thru 058; 060 thru 062, 065 thru 067; 072 thru 075; 080 thru 082, 084; 090, 098	PIC X(03)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-CATEGORY-OF-SERVICE-2	IF PLAN CODE = 09, THEN MUST NOT CONTAIN ALL SPACES OR ZEROES Data Element 4200 - Category of Service to Provider Type Format 01: Lists provider types and the applicable categories of service for which the provider types are eligible. Format 01 01- 04 Table ID (4200) 05 - 06 Provider Type 07- 10 Blank 11 - 12 Format = Always 01 13 - 80 Categories of Service (2 positions separated by a comma) Format 02: Lists the categories of service and the vendor code used for reporting purposes. Format 02 01 - 04 Table ID (4200) 05 - 06 Provider Type 07- 10 Blank 11 - 12 Format = Always 02 13 - 14 Categories of Service (definition is as follows)* 15 - 16 Vendor Code (definition is as follows)* 17 Blank *Columns 13 -17 repeat as necessary up 13 entries not to exceed column 80. The first two positions are the category of service (for the defined provider type) which will report to the appropriate vendor code (column 15 -16). If all categories are to report to only one vendor code, the first two positions should be 00.	PIC X(03)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-PRIMARY-DIAGNOSIS	IF DHS CLAIM TYPE = 2 (INPAT) AND MEDICARE INDICATOR = SPACE, THEN MUST NOT CONTAIN ALL SPACES AND MUST NOT CONTAIN ALL ZEROES.	PIC X(06)
15	F35B-PRIM-DIAG-1-5	No Edit	
20	F35B-PRIM-DIAG-1-4	No Edit	
25	F35B-PRIM-DIAG-1-3	No Edit	
30	F35B-PRIM-DIAG-1	No Edit	PIC X(01)
30	F35B-PRIM-DIAG-2	No Edit	PIC X(01)
30	F35B-PRIM-DIAG-3	No Edit	PIC X(01)
25	F35B-PRIM-DIAG-4	No Edit	PIC X(01)
20	F35B-PRIM-DIAG-5	No Edit	PIC X(01)
15	F35B-PRIM-DIAG-6	No Edit	PIC X(01)
10	F35B-SECONDARY-DIAGNOSIS	field may contain spaces or zeroes, but must be > LOW-VALUES	PIC X(06)
15	F35B-SEC-DIAG-1-5	No Edit	
20	F35B-SEC-DIAG-1-4	No Edit	
25	F35B-SEC-DIAG-1-3	No Edit	
30	F35B-SEC-DIAG-1	No Edit	PIC X(01)
30	F35B-SEC-DIAG-2	No Edit	PIC X(01)
30	F35B-SEC-DIAG-3	No Edit	PIC X(01)
25	F35B-SEC-DIAG-4	No Edit	PIC X(01)
20	F35B-SEC-DIAG-5	No Edit	PIC X(01)
15	F35B-SEC-DIAG-6	No Edit	PIC X(01)
10	F35B-EMERGENCY-IND	No Edit	PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-ADMIT-TYPE	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04 or 09 AND CLAIM FORM INDICATOR = 'U', THEN MUST = 1, 2, 3, 4, OR 9. These errors should not be set on any claim type other than '2' inpatient	PIC X(01)
10	F35B-PATIENT-STATUS	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN If the claim-form-indicator is 'U', THEN the code MUST be valid per working storage table values listed below: 01 thru 09; 20; 30 thru 32; 40 thru 42. 50, 51. If the claim-form-indicator is NOT = 'U', THEN the code MUST be valid per working storage table values listed below: 00 thru 13; 32	PIC X(02)
10	F35B-PRIMARY-SURGERY-CODE	IF DHS CLAIM TYPE = 2 (INPAT) THEN MUST CONTAIN SPACES, ZEROES, OR BE IN RANGE 10000-69999.	PIC X(05)
10	F35B-SECONDARY-SURGERY-CODE	IF DHS CLAIM TYPE = 2 (INPAT) THEN MUST CONTAIN SPACES, ZEROES, OR BE IN RANGE 10000-69999.	PIC X(05)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-SURGERY-DATE	IF DHS CLAIM TYPE = 2 (INPAT), THEN MUST BE NUMERIC. IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 2 (INPAT), THEN IF > 0, THEN MUST CONTAIN VALID CC, YY,MM,DD. ALSO MUST BE > 0 IF INPAT PRIMARY SURG CODE NOT = SPACES OR ZEROES OR IF INPAT SECONDARY SURG CODE NOT = SPACES OR ZEROES.	PIC X(08)
10	F35B-CLAIM-FORM-INDICATOR	MUST CONTAIN SPACE, 'U', 'H', OR 'N'.	PIC X(01)
10	F35B-ADMIT-SOURCE	IF MEDICARE INDICATOR = SPACE AND CLAIM FORM INDICATOR = 'U', THEN MUST BE IN RANGE 1-9, OR 'A' or space. Space = Newborn or Not a transfer or not a UB-92 Claim form. These errors should not be set on any claim type other than '2' inpatient	PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-BENE-CIN	MAY BE BLANK, BUT IF IT IS NOT BLANK, THEN MUST BEGIN WITH '9' AND END WITH AN ALPHA OTHER THAN 'P'. Report the number of claims with a blank Bene-CIN Call the CIN validation module Report the number of claims with a non-blank but invalid CIN. For each field, report number of times claim values or RACE, GENDER and DATE-OF-BIRTH do not match those on MEDS Count the number of times the CIN number on the claim is changed	PIC X(09)
15	F35B-RELATED-CAUSE-CODE	New Field, Recommended edit: Validate per table of allowed values AA Auto Accident AB Abuse AP Another Party Responsible EM Employment OA Other Accident (occurs three times)	PIC X(02)
10	F35B-BILLING-PROVIDER-TAXONOMY	New Field, Recommended edit: Validate per table of allowed values HIPAA-related edits. Standards to be established when HIPAA is implemented.	PIC X(10)
10	F35B-RECORD-IDENT-NUMBER	New Field -- added during ITSD processing, no edit necessary	PIC S9(15) COMP-3
05	F35B-CLAIM-DETAILS	No Edit	PICS9(7)V99 COMP-3

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
10	F35B-DETAIL-SEGMENT OCCURS 0 TO 99 TIMES DEPENDING ON F35B-SEGMENT-CNT INDEXED BY F35B-I1 F35B-I2	No Edit	
12	F35B-MAIN-SEGMENT		
15	F35B-SEGMENT-TYPE	Must be 'M' or 'C'	PIC X(01)
15	F35B-CCN-LINE-NUMBER	Must Be Numeric	PIC 9(02)
15	F35B-DET-MEDI-CAL-AMT-BILLED	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35B-DET-MEDI-CAL-AMOUNT-PAID	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35B-MEDICARE-AMOUNT-BILLED	MUST BE NUMERIC	PIC S9(7)V9(2) COMP-3
15	F35B-MEDICARE-AMOUNT-PAID	MUST BE NUMERIC	PIC S9(7)V9(2) COMP-3
15	F35B-DET-FROM-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE. MUST BE <= DETAIL TO-DOS	PIC X(08)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-DET-TO-DATE-OF-SERVICE	MUST BE NUMERIC. MUST BE > 0. MUST CONTAIN VALID CC, YY,MM,DD AND MUST BE < CHECK DATE	PIC X(08)
15	F35B-PCCM-IND	No Edit	PIC X(01)
15	F35B-OHC-CODE	No Edit	PIC X(01)
15	F35B-EPSDT-SERVICE-IND	No Edit	PIC X(01)

15	F35B-MIO-POS	IF MEDICARE INDICATOR = SPACE, THEN
		MUST be in range 0-8.
		If Plan Code = 02, 04 , or 09, THEN
		MUST be valid for FI place of service (POS)
		per correlation lookup tables in MTR100,
		working storage 88 levels
		W-MIO-POS-MATCH
		and W-MIO-POS-MATCH-2.
		Blank DHS POS is okay for pharmacy Claim Type 3
			PIC X(01)

15	F35B-TAR-CONTROL-NUMBER	Must contain only values A-Z or 1-0 other characters are set to 0	PIC X(11)
15	F35B-DRUG-PRODUCT-ID-QUALIFIER	No Edit	PIC X(02)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-PROCEDURE-INDICATOR	IF MEDICARE INDICATOR = SPACE, AND IF PLAN CODE NOT = 05 OR 06, THEN MUST BE APPROPRIATE FOR PROCEDURE CODE FORMAT. IF PROC IND = '3' (STATE DRUG CODE/NDC), THEN PROC CODE BYTES 1-4 MUST = LOW-VALUES OR NOT = SPACES; ELSE IF PROC IND = '9' (HCPCS), THEN PROC CODE BYTES 7-11 MUST = A0001-Z9999; ELSE IF PROC IND = '4' (CPT-4), THEN PROC CODE BYTES 7-11 MUST = 00100-99999; ELSE IF PROC IND = '2' (SMA), THEN PROC CODE BYTES 7-11 MUST = 00001-00099 AND VENDOR CODE MUST = 77; ELSE IF PROC IND = '7' (L.A. Waiv), THEN PROC CODE BYTES 7-11 MUST = 00001-00099; ELSE IF PROC IND = '1' (UB-92) and VENDOR CODE = 50 OR 60 OR 63 (HIP), THEN PROC CODE BYTES 8-10 MUST = 075-999.	PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-PROCEDURE-AREA	IF MEDICARE INDICATOR = SPACES AND PLAN CODE NOT = 05 (CHDP) OR 06 (STATE HOSPITALS) IF PROC INDICATOR = 3 PROC CODE BYTES 1-11 MUST NOT = ALL SPACES OR ZEROES; END-IF IF PROC INDICATOR = 1, PROC CODE BYTES 7-10 MUST NOT = ALL SPACES OR ZEROES AND BYTE 11 MUST = SPACE AND DHS CLAIM TYPE MUST = 2 (INPAT); END-IF IF PROCEDURE INDICATOR = 2, 4, 7, 8, OR 9 PROC CODE BYTES 7-11 MUST NOT = ALL SPACES OR ZEROES AND DHS CLAIM TYPE MUST NOT = 2 (INPAT) END-IF END-IF IF PROC INDICATOR = 3 AND PROC CODE BYTES 5-9 ARE STATE DRUG CODES 9900A-9999Z, and first four bytes are not low-values Error 073 move low-values to first four bytes end-if If first four bytes are low-values Move in-drug-manufacturer to out-drug-manufacturer if bytes 5-9 = '9900A' THRU '9999Z' move 'Y' to Medical-Supply-Ind else move 'N' to Medical-Supply-Ind	

LVL	S35-FILE-ELEMENT	EDITS	PIC
		end-if Search for state drug code on Formulary file If not found error 073 end-if end-if If first four bytes are not = low-values Move spaces to out-drug-manufacturer Search for Procedure-area value on Formulary file If found If formulary pricing indicatory = 'M' or 'I' (incontinence medical supply) Move 'Y' to Medical-Supply-Ind else Move 'N' to Medical-Supply-Ind end-if end-if If not-found move in-medical-supply-ind to out-medical-supply-ind error 078 end-if end-if	

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	F35B-PROC-CODE-PREFIX	IF F35B-PROCEDURE-INDICATOR NOT = '3' AND F35B-PROC-CODE-PREFIX NOT = SPACES MOVE F35B-PROC-CODE-PREFIX TO P-DET-VALUE-CHAR MOVE 100 TO W-I-ERROR PERFORM 6000-COUNT-ERROR PERFORM 7200-WRITE-ERROR-REPORT END-IF	PIC X(06)
20	F35B-PROCEDURE-CODE	No Edit	
25	F35B-PROC-CODE-FIRST-4		PIC X(04)
25	F35B-PROC-CODE-LAST-1		PIC X(01)
15	F35B-PRODUCT-ID-AREA REDEFINES F35B-PROCEDURE-AREA		
20	F35B-PRODUCT-ID	May contain values such a 'Karo syrup or 'egg whites'	PIC X(20).
20	F35B-NDC-UPC-HRI-CODE	No Edit	
25	F35B-NDC-UPC-HRI-LABELER	No Edit	PIC X(05)
25	F35B-NDC-UPC-HRI-PRODUCT	No Edit	PIC X(04)
25	F35B-NDC-UPC-HRI-PACKAGE	No Edit	PIC X(02)
20	F35B-MEDI-CAL-CODE-PREFIX	No Edit	PIC X(04)
20	F35B-MEDI-CAL-DRUG-AREA	RAIS Question For pharmacy claims must be numeric - should we require a minimum length? Actually, Pharmacy claims should be alpha/numeric as medical supply claims comes in on Pharmacy claims and there are a few NDCs which have alpha characters. I would suggest then that the edits be that the field is either 7 or 11 in length.	
25	F35B-MEDI-CAL-DRUG-CODE	No Edit	
30	F35B-MEDI-CAL-DRUG-CD	No Edit	PIC X(04)
30	F35B-MEDI-CAL-DRUG-STR	No Edit	PIC X(01)
25	F35B-MEDI-CAL-DRUG-MFG	No Edit	PIC X(02)

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-DET-DIAGNOSIS	New Field, Recommended edit: Validate per table of allowed values	
20	F35B-DET-DIAGNOSIS-1-5	No Edit	
25	F35B-DET-DIAGNOSIS-1-4	No Edit	
30	F35B-DET-DIAGNOSIS-1-3	No Edit	
35	F35B-DET-DIAG-1	No Edit	PIC X(01)
35	F35B-DET-DIAG-2	No Edit	PIC X(01)
35	F35B-DET-DIAG-3	No Edit	PIC X(01)
30	F35B-DET-DIAG-4	No Edit	PIC X(01)
25	F35B-DET-DIAG-5	No Edit	PIC X(01)
20	F35B-DET-DIAG-6	No Edit	PIC X(01)
15	F35B-ACCOMMODATION-CODE	IF MEDICARE INDICATOR = SPACE, THEN IF PLAN CODE = 02, 04, 06, OR 09 AND DHS CLAIM TYPE = 2 (INPAT) AND VENDOR CODE = 47, 56, 57, OR 80 (LTC), THEN MUST NOT CONTAIN SPACES OR ALL ZEROES.	
20	F35B-ACCOM-CODE	No Edit	
25	F35B-ACCOM-1	No Edit	PIC X(01)
25	F35B-ACCOM-2	No Edit	PIC X(01)
20	F35B-ACCOM-H	No Edit	PIC X(01)
15	F35B-TOOTH-OR-MODIFIER	No Edit	PIC X(02)
15	F35B-UNITS	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0. IF DHS CLAIM TYPE = 2 (INPAT), THEN IF UB-92 CODE (LAST 3 BYTES) = ANCILLARY CODES 082, 093, OR 250-999, THEN UNITS MUST = 0 Cannot be zero on drug claims.	PIC S9(8)V999 COMP-3

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-PRESCRIPTION-NUMBER	IF PLAN CODE = 02, 04 or 09 AND DHS CLAIM TYPE = 3 (DRUG), THEN MUST NOT CONTAIN ALL SPACES OR ZEROES	
15	F35B-COPAY-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V99 COMP-3
15	F35B-PRICE-RESTRICTION	No Edit	PIC X(01)
15	F35B-EPSDT-REFERR-CDS	No Edit	PIC X(02)
15	F35B-COPAY-IND	Must contain one of the following valid values: 'N' or blank or low-values - No Copay Deduction 'A' - Adjusted Copay (not currently used) 'F' - FPACT 'H' - Copay taken on another detail 'L' - Limited Copay (allowable less than Copay) 'S' - Standard Copay applied 'Z' - Copay applicable but allowable was zero 10 C54-COPAY-INDICATOR PIC X(01). ADJ-DEDUCTION VALUE 'A'. HIST-NOT-APPLIED VALUE 'H' LMT-DEDUCTION VALUE 'L'. NO-DEDUCTION VALUE 'N' SPACE. STD-DEDUCTION VALUE 'S'. ZERO-DEDUCTION VALUE 'Z'. APPLIED VALUE 'A' 'S' 'L'. NOT-APPLIED VALUE 'N' 'H' 'Z' SPACE.	PIC X(01)
15	F35B-DRUG-MANUFACTURER	No Edit	PIC X(02)
15	F35B-FI-TOS	No Edit	PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-MEDI-CAL-REIMBURSE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35B-DET-OTHER-COVERAGE-AMOUNT	MUST BE NUMERIC. IF THERE IS A NEGATIVE ADJUSTMENT INDICATOR (2,3,5), THEN MUST BE <= 0	PIC S9(7)V9(2) COMP-3
15	F35B-MEDICARE-PAID-AMT-CALC REDEFINES F35B-DET-OTHER-COVERAGE-AMOUNT	No Edit	PIC S9(7)V9(2) COMP-3
15	F35B-ORIG-POS-2	IF MEDICARE INDICATOR = SPACE IF PLAN CODE = 02, 04 , or 09, THEN MUST BE VALID PER MTR100 working storage 88 level w-fi-pos-valid. For a pharmacy claim, blank is okay	PIC X(02)
20	F35B-ORIG-POS-1	No Edit	PIC X(01)
15	F35B-SMART-KEY	No Edit	
20	F35B-SMART-KEY-GTC	No Edit	PIC X(02)
20	F35B-SMART-KEY-STC	No Edit	PIC X(04)
20	F35B-SMART-KEY-HICL	No Edit	PIC X(05)
20	F35B-SMART-KEY-STR	No Edit	PIC X(04)
20	F35B-SMART-KEY-DOSE	No Edit	PIC X(03)
20	F35B-SMART-KEY-RT	No Edit	PIC X(02)
20	F35B-SMART-KEY-PS	No Edit	PIC X(03)
20	F35B-SMART-KEY-UDUU	No Edit	PIC X(01)
15	F35B-DRUG-BASIS-OF-COST-DETERM	No Edit	PIC X(02)
15	F35B-DRUG-REFILL-NUMBER	New Field, Recommended edit: Must be numeric	PIC 9(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-DAYS-SUPPLY	MUST BE NUMERIC. IF PLAN CODE = 02, 04 , OR 09 AND DHS CLAIM TYPE = 3 (DRUG), THEN MUST NOT = 0	PIC S9(3) COMP-3
15	F35B-MEDICAL-SUPPLY-IND	For claim type "3" - Drug Valid values are Y and N (yes and no) for other claim types Y, N, and space The value of this field may be reset based on the edit for the PROCEDURE-AREA	PIC X(01)
15	F35B-TOOTH-SURFACES	No Edit	
20	F35B-TOOTH-SURFACE-1	No Edit	PIC X(01)
20	F35B-TOOTH-SURFACE-2	No Edit	PIC X(01)
20	F35B-TOOTH-SURFACE-3	No Edit	PIC X(01)
20	F35B-TOOTH-SURFACE-4	No Edit	PIC X(01)
20	F35B-TOOTH-SURFACE-5	No Edit	PIC X(01)
15	F35B-BILLED-CODE-IND	Billed-Code-Ind is created by ITSD during paid claims processing.	PIC X(01)
15	F35B-DET-FFP-IND	IF PLAN CODE = 09, THEN MUST CONTAIN SPACE, 1, 2, OR 3	PIC X(01)
15	F35B-DUR-ALERT-DATA		

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	F35B-DUR-CONFLICT-ALERT	New Field, Recommended edit: Validate per table of allowed values DUR-CONFLICT CODE Additive-Toxicity AT Drug Allergy - conflict DA Drug-Disease-Contraindicated DC Drug-Interactions DD Early-Refill ER Adult-High-Dose HD Geriatric-High-Dose HD Pediatric-High-Dose HD Iatrogenic-Side-Effect-(Inferred) IC Ingredient duplication ID Adult-Low-Dose LD Geriatric-Low-Dose LD Pediatric-Low-Dose LD Underutilization - late refill LR Medical-Disease-Diagnosed Contraindicated MC Incorrect Duration MX Drug Age Conflict PA Drug Pregnancy conflict PG Drug Gender - conflict SX Therapeutic duplication TD NO CODE SPACES	PIC X(02)

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	F35B-DUR-INTERVENTION-ALERT	New Field, Recommended edit: Validate per table of allowed values Intervention pharmacist consulted with: consulted with code prescriber M0 patient P0 another source R0 NO CODE SPACES	PIC X(02)
20	F35B-DUR-OUTCOME-ALERT	New Field, Recommended edit: Validate per table of allowed values Outcome code Filled, false positive 1A Filled presecription as is 1B Filled with different dose 1C Filled with different directions 1D Filled with different drug 1E Filled with different quantity 1F Filled with prescriber approveal 1G Prescription not filled 2A Prescription not filled -- Directions clarified 2B NO CODE SPACES	PIC X(02)
15	F35B-COMPOUND-CODE	New Field, Recommended edit: Validate per table of allowed values CMPD-DRUG-NO-ATTACH 0 CMPD-DRUG-ATTACH-PRESENT 1	PIC X(01)
15	F35B-COMPOUND-DRUG-ATTACHMENT	New Field, Recommended edit: Validate per table of allowed values WILL NOT BE FILLED UNTIL SDN202 IS COMPLETED	PIC 9(01)

PAID CLAIMS/ENCOUNTERS DATA STREAM STANDARD 35-FILE DATA ELEMENT DICTIONARY

LVL	S35-FILE-ELEMENT	EDITS	PIC
15	F35B-COMPOUND-DRUG-NBR-INGRED	New Field, Recommended edit: Must be numeric If a compound drug is reported using the 'most expensive ingredient' method, there will be one (1) compound drug segment.	PIC 9(02)
15	F35B-PRESC-REF-REND-PROV-NUM	IF MEDICARE INDICATOR = SPACE If PLAN CODE = 02, 04 or 09 and CLAIM TYPE = 2(INPAT) or 3 (DRUG) and VENDOR CODE = 26, 50, 60 or 63, THEN field must not contain all spaces or zeros.	PIC X(09)
15	F35B-PRESC-REF-REND-PROV-TAXON	New Field, Recommended edit: Validate per table of allowed values HIPAA-related edits. Standards to be established when HIPAA is implemented.	PIC X(10)
12	F35B-COMPOUND-DRUG-SEGMENT		REDEFINES F35B-MAIN- SEGMENT
15	F35B-SEGMENT-TYPE-C	New Field : value must be 'C'	PIC X(01)
15	F35B-CMPND-GENERAL-INFO	No Edit	

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	F35B-CMPND-DOSAGE-FORM	New Field, Recommended edit: Validate per table of allowed values 1 = Capsule 2 = Ointment 3 = Cream 4 = Suppository 5 = Powder 6 = Emulsion 7 = Liquid 10 = Tablet 11 = Solution 12 = Suspension 13 = Lotion 14 = Shampoo 15 = Elixir 16 = Syrup 17 = Lozenge 18 = Enema	PIC X(02)
20	F35B-CMPND-INCENTIVE-AMOUNT	New Field, Recommended edit: Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-FEE	New Field, Recommended edit: Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-INCENTIVE-AMOUNT-PD		PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-ACTUAL-NBR-INGR		PIC 9(02)
20	F35B-CMPND-ROUTE-OF-ADMIN	No Edit	PIC 9(02)
20	F35B-CMPND-UNIT-FORM-IND		PIC 9(01)
20	F35B-CMPND-CONTAINER-COUNT	New Field, Recommended edit: Must be numeric	PIC S9(03) COMP-3
20	F35B-CMPND-PROCESS-APPRVD-INGR		PIC X(01)

LVL	S35-FILE-ELEMENT	EDITS	PIC
20	FILLER		PIC X(40)
15	F35B-CMPND-INGREDIENT-INFO	No Edit	
20	F35B-CMPND-INGREDIENT-AREA	No Edit	
25	F35B-CMPND-INGR-NDC	New Field, Recommended edit: Valid NDC code	PIC X(11)
25	FILLER		PIC X(29)
20	FILLER		REDEFINES F35B-CMPND-INGREDIENT-AREA
25	F35B-CMPND-INGR-PRODUCT-ID	New Field, Recommended edit: ?	PIC X(20)
25	FILLER		PIC X(20)
20	FILLER		PIC X(10)
20	F35B-CMPND-INGR-PROD-ID-QUAL	New Field, Recommended edit: Validate per table of allowed values	PIC X(02)
20	F35B-CMPND-INGR-BASIS-OF-COST	New Field, Recommended edit: Validate per table of allowed values	PIC X(02)
20	F35B-CMPND-INGR-DISP-FEE-CODE	New Field, Recommended edit: Validate per table of allowed values A THRU I, M	PIC X(01)
20	F35B-CMPND-INGR-METRIC-QTY	New Field, Recommended edit: Must be numeric	PIC S9(8)V9(3) COMP-3
20	F35B-CMPND-INGR-BILLED-AMOUNT	New Field, Recommended edit: Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-INGR-ALLOWED-AMOUNT	New Field, Recommended edit: Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-INGR-REIMBURSE-AMT	New Field, Recommended edit: Must be numeric	PIC S9(7)V9(2) COMP-3
20	F35B-CMPND-INGR-SMART-KEY	See Below	
25	F35B-CMPND-INGR-SMART-KEY-GTC	New Field, Recommended edit: Validate per table of allowed values	PIC X(02)

LVL	S35-FILE-ELEMENT	EDITS	PIC
25	F35B-CMPND-INGR-SMART-KEY-STC	New Field, Recommended edit: Validate per table of allowed values	PIC X(04)
25	F35B-CMPND-INGR-SMART-KEY-HICL	New Field, Recommended edit: Validate per table of allowed values	PIC X(05)
25	F35B-CMPND-INGR-SMART-KEY-STR	New Field, Recommended edit: Validate per table of allowed values	PIC X(04)
25	F35B-CMPND-INGR-SMART-KEY-DOSE	New Field, Recommended edit: Validate per table of allowed values	PIC X(03)
25	F35B-CMPND-INGR-SMART-KEY-RT	New Field, Recommended edit: Validate per table of allowed values	PIC X(02)
25	F35B-CMPND-INGR-SMART-KEY-PS	New Field, Recommended edit: Validate per table of allowed values	PIC X(03)
25	F35B-CMPND-INGR-SMART-KEY-UDUU	New Field, Recommended edit: Validate per table of allowed values	PIC X(01)
20	F35B-CMPND-INGR-CUTBACK-REASON		PIC X(03)
20	FILLER		PIC X(40)
15	FILLER		PIC X(39)
15	F35B-CMPND-SEGMENT-ID-NBR-X		
20	F35B-CMPND-SEGMENT-ID-NBR		PIC 9(02)

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