Disproportionate Share Hospitals

Eligibility Re-Verification Process User Manual

Updated with new Information

Information Technology Services Division/
Medi-Cal Application Section
&
Medi-Cal Eligibility Branch

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Purpose of Document

The purpose of this User Manual is to provide a collection of information regarding the Disproportionate Share Hospital (DSH) eligibility re-verification process to all parties participating in the process. This manual includes an overview of the process, detailed instructions for each step of the process and several appendices to provide additional insight. The main focus of this manual is on the submitter/auditor portion of the process.

Updates:

- Updated to include the 14-character BIC ID number.
- Updated sections referring to DSH Database to clarify time period on file.

Overview

Background

DHS initiated a project to improve the DSH eligibility re-verification process. The two-phased project enhanced the matching process as well as supporting administrative processes.

The Disproportionate Share project was initiated to provide better support to the disproportionate share hospitals and their vendors. This project was split into two phases to allow for quicker implementation of the matching process enhancements. The objective for Phase 1 was to improve the current eligibility re-verification process used by hospitals, their vendors/agents and DHS. Specifically, Phase 1 implemented:

- Expanded the search criteria to include name and date of birth
- Automated the matching process to include a DSH database

Phase 2 of the project enhanced the matching process as well as improved various administrative aspects of the process. The DSH process includes:

- Automated file transfer of request files between submitters and DHS via the Medi-Cal web site rather than diskettes
- Simplified request file preparation with a single file layout (with new fields) for all requests
- Synchronized old and new matching processes, to the extent possible
- A process to provide CMS auditors and submitters with an automated, electronic attestation letter that will be delivered via the Medi-Cal web site
- A process to ensure the definitions for Title XIX and restricted Title XIX aid codes stay accurate and current via enhancements to DHS aid code addition processing
- Enhanced the submitter agreement form to ensure data security and proper usage of data released to submitters
- Established a method for tracking DSH processing usage (by submitter) for possible recovery of costs associated with DSH processing

This manual provides an overview of the DSH process to reflect recent improvements.

DSH Re-Verification Processing

Re-verification of disproportionate share patient's eligibility status is needed by hospitals to address CMS audits and lawsuits. In some cases, the re-verification requires access to eligibility data no longer available on the Automated Eligibility Verification System (AEVS), Medi-Cal Internet eligibility verification (real-time or batch processing) applications, or Point of Service (POS) network. As a result, hospitals need the Department's assistance to re-verify patient eligibility against historical data.

As of April 2004, the Department has agreed to allow Managed Care Plans/Health Maintenance Organizations (with prior approval) to use the DSH system to obtain verification of eligibility in order to obtain higher Medicare + Choice capitation payments available for Medi-Cal eligible beneficiaries.

Process Overview

Introduction

The DSH eligibility re-verification process relies on a coordinated effort of several parties to ensure timely completion of all steps in the process.

Parties Involved

Processing eligibility re-verification requests from hospitals relies on a coordinated process involving various parties.

The re-verification process involves the following parties:

- Submitters are responsible for formatting and creating the inquiry portion of the request record. Submitters include:
  - Disproportionate Share Hospitals (also known as DSH or hospitals)
  - 3rd party vendors (also known as vendors or agents)
- DHS is responsible for processing all inquiry requests from valid submitters. Within DHS, the following organizational units participate in the process:
  - Medi-Cal Eligibility Branch (MEB) is responsible for ensuring the submitter is valid, coordinating the set up of the submitter ID/passwords, and setting the overall policies regarding eligibility
  - Information Technology Services Division/Medi-Cal Applications Section (ITSD/MAS) is responsible for processing all requests
- EDS is responsible for supporting the Medi-Cal web site that is used for automated file transfer of request/response files
- CMS/Medicare Intermediaries (also known as auditors) provide advice to MEB on interpretation of disproportionate share rulings and receive response related information from the re-verification processing

High-Level Overview of Eligibility Re-Verification Process

At the highest level, the eligibility re-verification process includes the following steps:

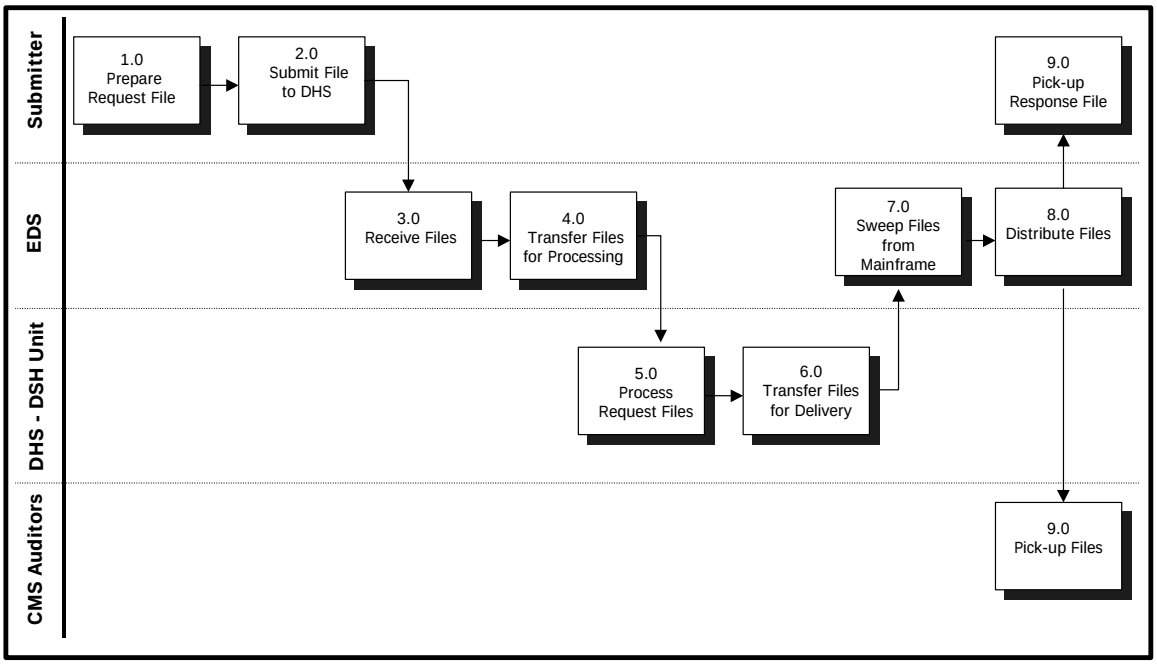
- The submitter prepares a file of all requests for eligibility re-verification
- The submitter uploads their file to the Medi-Cal web site
- EDS receives the file from the Medi-Cal web site
- EDS transfers the file to the DHS mainframe for processing
- DHS (ITSD/MAS) processes the request file
- DHS (ITSD/MAS) transfers all files associated with the DSH processing (such as the response and attestation files) to EDS
- EDS receives the files from DHS
- EDS distributes the files to the appropriate locations on the Medi-Cal web site

- Submitters and auditors download their files from the Medi-Cal web site

The new file transfer process is analogous to the postal service. Submitters 'deliver' their request files into their individual locations on the Medi-Cal web site (similar to a 'mailbox'). Each 'mailbox' is secured and can only be accessed by the submitter using a unique ID/password. EDS 'picks' up all files from all 'mailboxes' at the end of the day. EDS 'delivers' the files to DHS for processing. Once DHS has processed the files, they are 'delivered' back to EDS for distribution. EDS 'posts' the files back into the submitters' and auditors' mailboxes for 'pick up.'

The Internet site is available to users 24x7. However, file processing by EDS and DHS occurs during normal business hours Monday through Friday (excluding State holidays).

A pictorial view representing the process and the parties involved is shown in the following process flow diagram. The next section provides a detailed description of each step of the process.



Process – Detailed Description

1.0 Prepare Request File

The hospital or their vendor is responsible for preparing the request file that triggers the eligibility re-verification process.

For hospitals using vendors to create their request files, a letter must be submitted by the hospital to MEB authorizing the vendor to request eligibility information on behalf of the hospital. The letter outlines the specific period of the eligibility request and is only valid for that specific period. A template of the letter is provided in ***Appendix A.***

Step	Action	Tips/Tools
1.1	Submitter determines whether the DSH processing is appropriate based on the date of service (DOS) that eligibility re-verification is being requested	If the DOS is within the last 13 months (known as current) **STOP**, you must use the AEVS/Internet/POS process For all DSH re-verification requests (except current) - use the file format found in ***Appendix C***
1.2	Submitter prepares the request file	Make sure you have a valid submitter ID. To request a submitter ID, refer to ***Appendix B*** The file size must be appropriate for the time of day the upload will occur (up to 2 Mb for regular business hours from 8 am to 6 pm and up to 6 Mb for off-hours from 6 pm to 8 am). Request files can be zipped to allow more records per file (see Step 1.3) Prepare the file using the appropriate valid values, refer to the data dictionary in ***Appendix C*** The process allows multiple years to be submitted on one file. **NOTE:** Before submitting multiple years on one file, check with your Medicare Intermediary (auditor) to determine

Step	Action	Tips/Tools
		if this is appropriate for your situation Remember, send only one provider per file All data must be submitted in upper case **ALL** request files **MUST** have a header record (refer to ***Appendix C*** for more information)
1.3	Submitter prepares the file for sending	The Medi-Cal web site is a secured, HIPAA compliant site**. Do not password protect or encrypt files** Each request file can be individually compressed using PKZIP or WINZIP Do not bundle several files with compression software

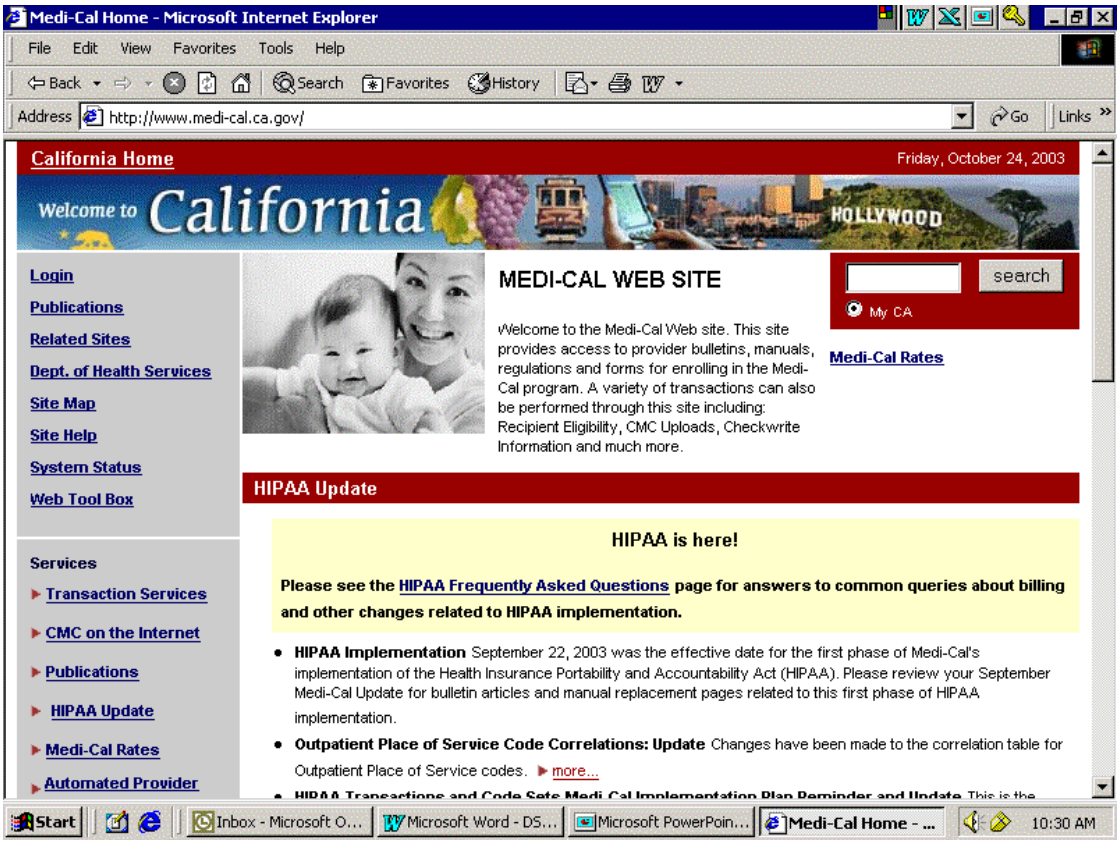
2.0 Submit Request File to DHS

The Medi-Cal web site provides submitters with an automated file transfer method – expediting the processing time.

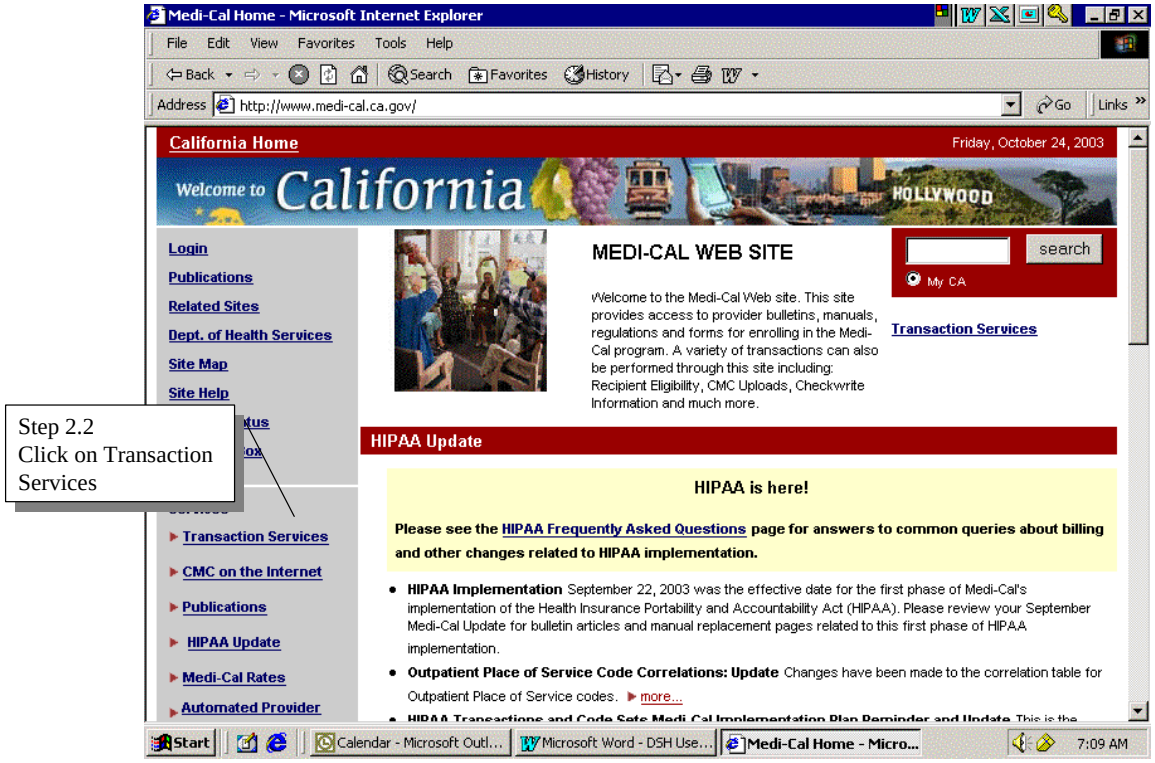
The submitter is responsible for submitting the file(s) to DHS for processing. All files must be submitted using the Medi-Cal web site. The submitter must have all appropriate agreements approved by MEB before submitting files for processing. The submitter must have a valid submitter ID and an electronic mailbox (on the Medi-Cal web site) set up. To request a submitter ID and electronic mailbox, refer to the forms found in ***Appendix B***.

Step	Action	Tips/Tools
2.1	Submitter accesses the Medi-Cal web site via the Internet	The Medi-Cal web site address http://www.medi-cal.ca.gov

The following "Welcome" screen will appear upon entry into the Medi-Cal web site.



Step	Action	Tips/Tools
2.2	Submitter clicks on “Transaction Services” option	

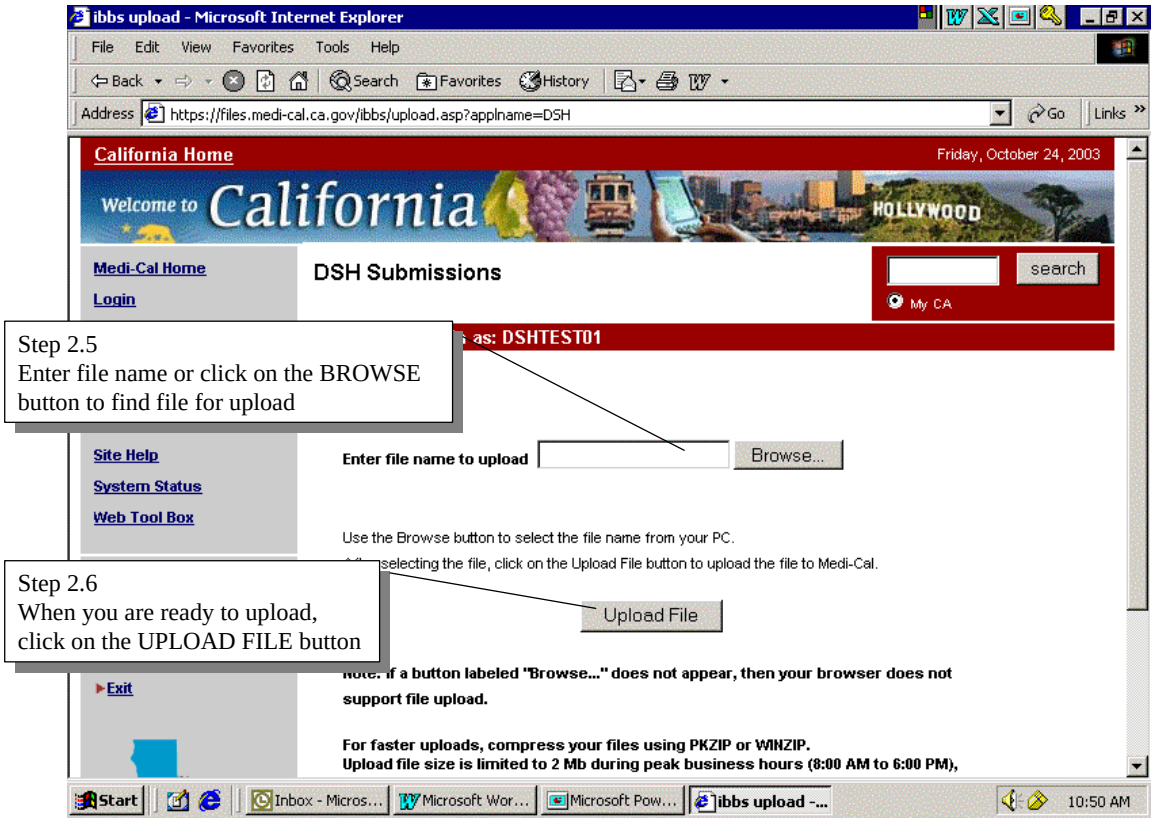


Step 2.2
Click on Transaction Services

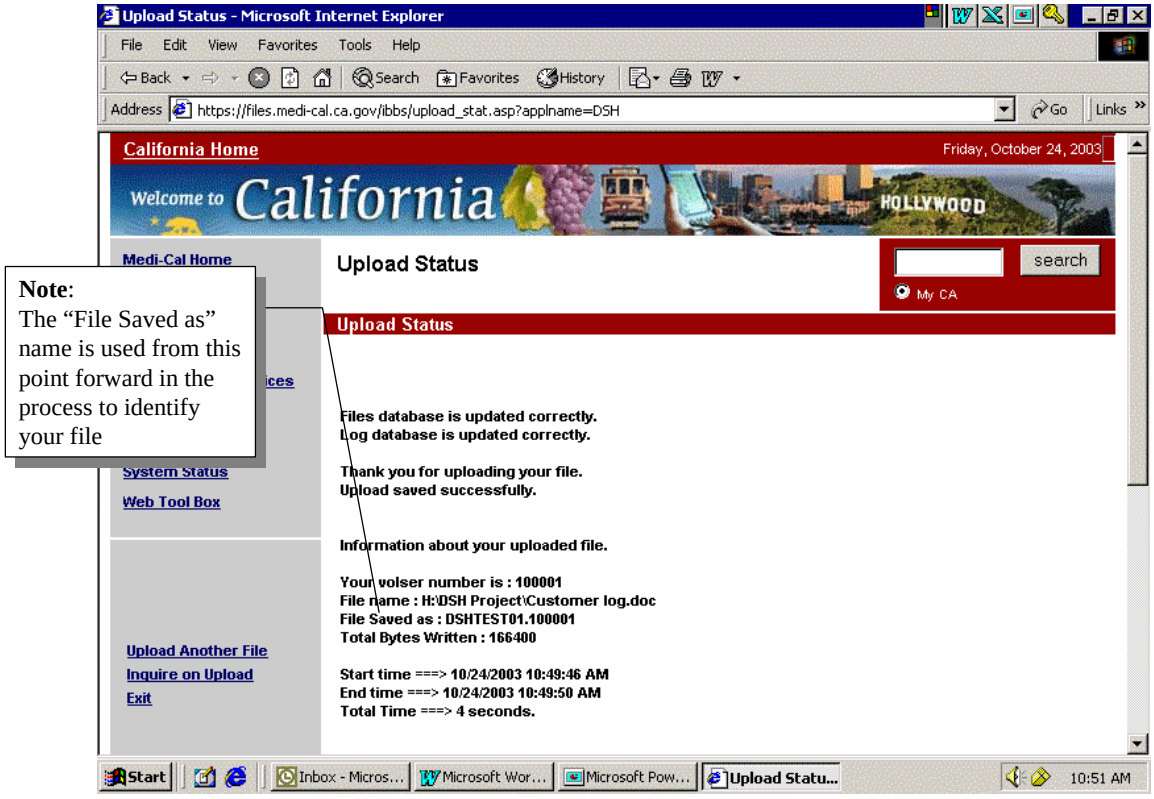
Step	Action	Tips/Tools
2.3	Submitter enters their user ID/ password and clicks the SUBMIT button	The user ID and password are assigned by MEB after the submitter's Internet Agreement (refer to **Appendix B**) has been approved

Step	Action	Tips/Tools
2.4	Submitter clicks either "DSH Uploads" or "Disproportionate Share Hospital (DSH) Submission Files" option to begin the submission process	The side menu item "DSH Uploads" and the center menu item "Disproportionate Share Hospital (DSH) Submission Files" are the same function

Step	Action	Tips/Tools
2.5	Submitter types in the location and name of the file to be uploaded or clicks the BROWSE button	
2.6	Once the file name is provided, the submitter clicks the UPLOAD FILE button	For faster uploads, compress your files using PKZIP or WINZIP (see Step 1) The file size must be appropriate for the time of day the upload will occur (see Step 1)



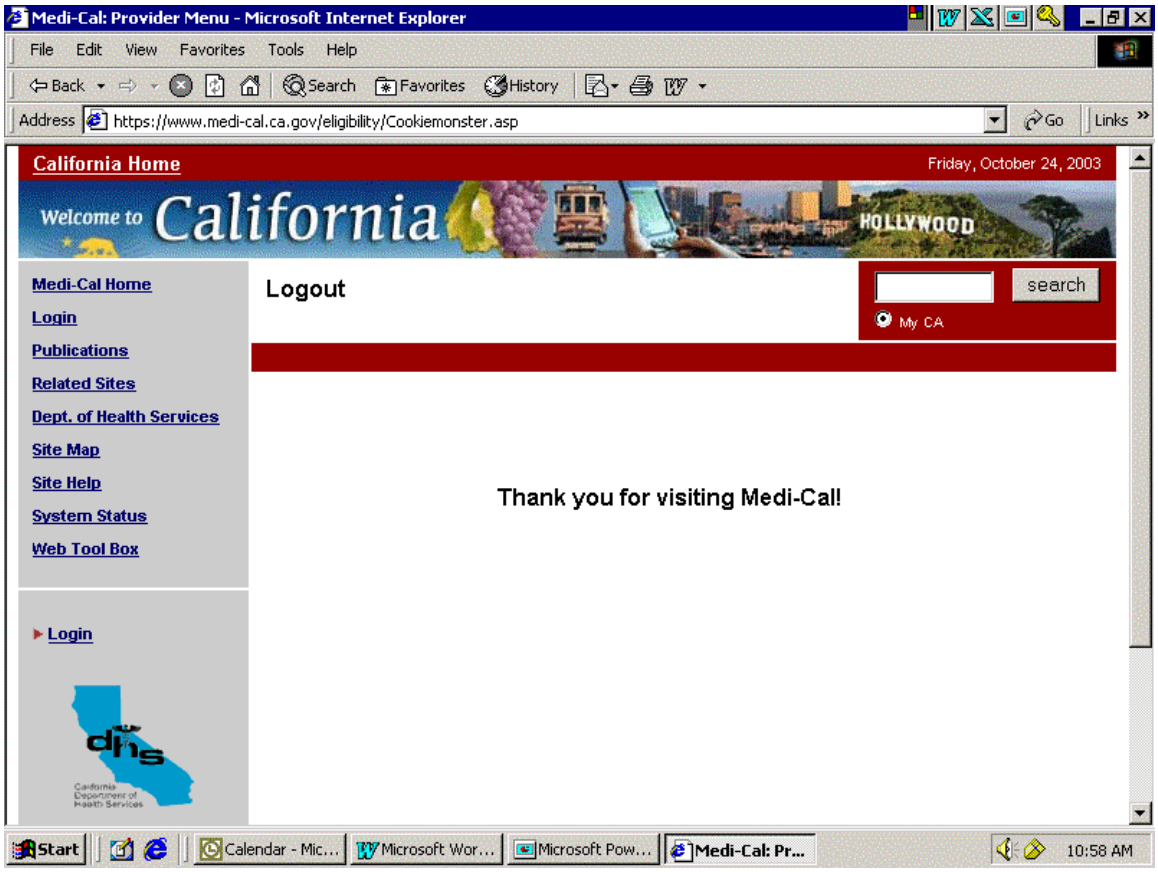
Step	Action	Tips/Tools
2.7	Upon completion of the upload, an Upload Status screen will appear	Note the "File Saved as:" name. This is the file name assigned by the upload process and will be used from this point forward on the web site to identify your file



Note:
The "File Saved as" name is used from this point forward in the process to identify your file

Now that the upload process is completed, the submitter may:

- Upload additional files – click on "Upload Another File" option and follow the steps outlined in this section
- Inquire on all files that have been uploaded and not processed by EDS – refer to ***Appendix E*** for more details
- Exit – click on the "Exit" option to log out of the session, when you have successfully logged off, the following screen will appear



3.0 Receive Request Files

Files are retrieved from the Internet mailboxes nightly.

At 9 pm on a nightly basis, EDS retrieves all files from the individual locations on the Internet (the submitter 'mailboxes').

4.0 Transfer Files for Processing

Files are transferred to DHS for eligibility re-verification processing.

After EDS retrieves the files, EDS transfers the request files from the Internet site to the EDS mainframe for transfer (via FTP) to the DHS mainframe.

5.0 Process Request Files

Files within the current eligibility window WILL NOT be processed by DHS.

The DSH Unit within ITSD/MAS processes the request files using the DSH matching process and supporting programs. This process creates response files as well as attestation letter files for both the submitter and auditor. For more information on the matching process, refer to the *Re-verification and Matching Program* section in this manual.

6.0 Transfer Files for Delivery

Files are transferred back to EDS for distribution.

The DSH Unit within MAS transfers (via FTP) all files created (such as the response and attestation files) during the matching process to the EDS mainframe.

7.0 Sweep Files from Mainframe

EDS receives the files from DHS for 'posting' into the applicable 'mailboxes.'

EDS takes all files transferred by the DSH Unit to the EDS mainframe and prepares them for 'delivery' to the submitter and auditor 'mailboxes.'

8.0 Distribute Response Files

Files are 'delivered' to the submitter and auditor 'mailboxes.'

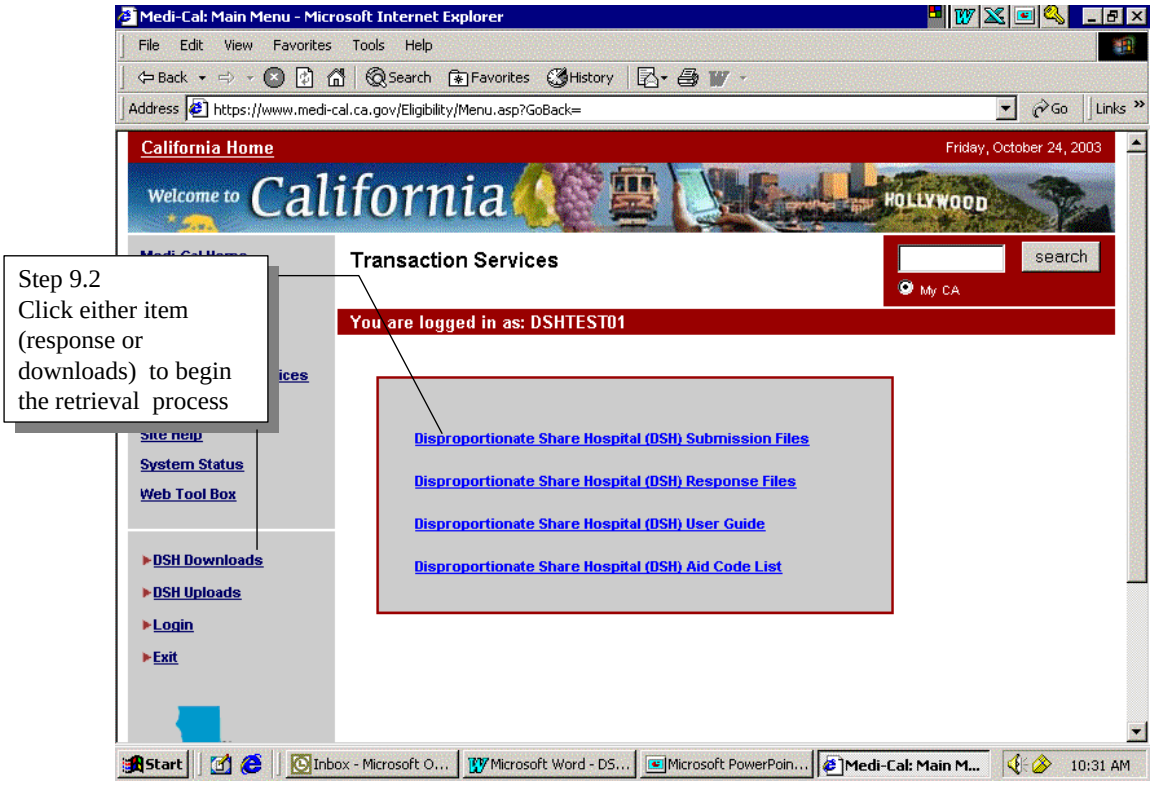
EDS 'delivers' all files created from the matching process to the submitter and/or auditor 'mailboxes.' EDS will deliver files on a daily basis at 5 pm. Files are posted to the Disproportionate Share Hospital (DSH) Response Files (also known as DSH Downloads) portion of the Transaction Services screen.

9.0 Pick-up Files

Submitters and auditors should check their 'mailboxes' frequently for response files.

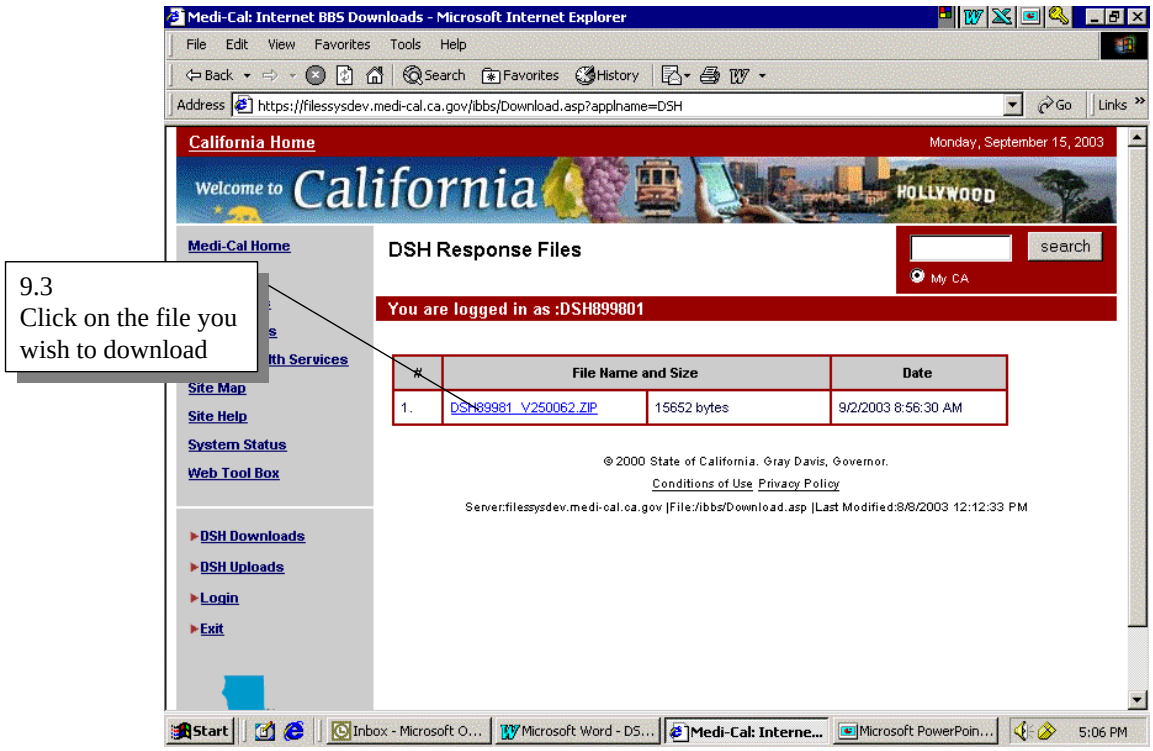
The submitter or auditor is responsible for logging into their mailbox to check for and download response files. An important note - all processed files will remain in the submitter 'mailboxes' for 14 days. After 14 days, files will be purged from the 'mailboxes.' This rule does not apply to Medicare auditors who are allowed 6 weeks.

Step	Action	Tips/Tools
9.1	Submitter/Auditor accesses the Medi-Cal web site and logs into their 'mailbox'	Refer to Step 1 for details on accessing and logging into your 'mailbox' Submitters and auditors have 14 days from 'delivery' date to pick up files – **all files over 14 days old are purged**
9.2	Submitter/Auditor clicks either "DSH Downloads" or "Disproportionate Share Hospital (DSH) Response Files" option to pick-up files	The side menu item "DSH Downloads" and the center menu item "Disproportionate Share Hospital (DSH) Response Files" are the same function

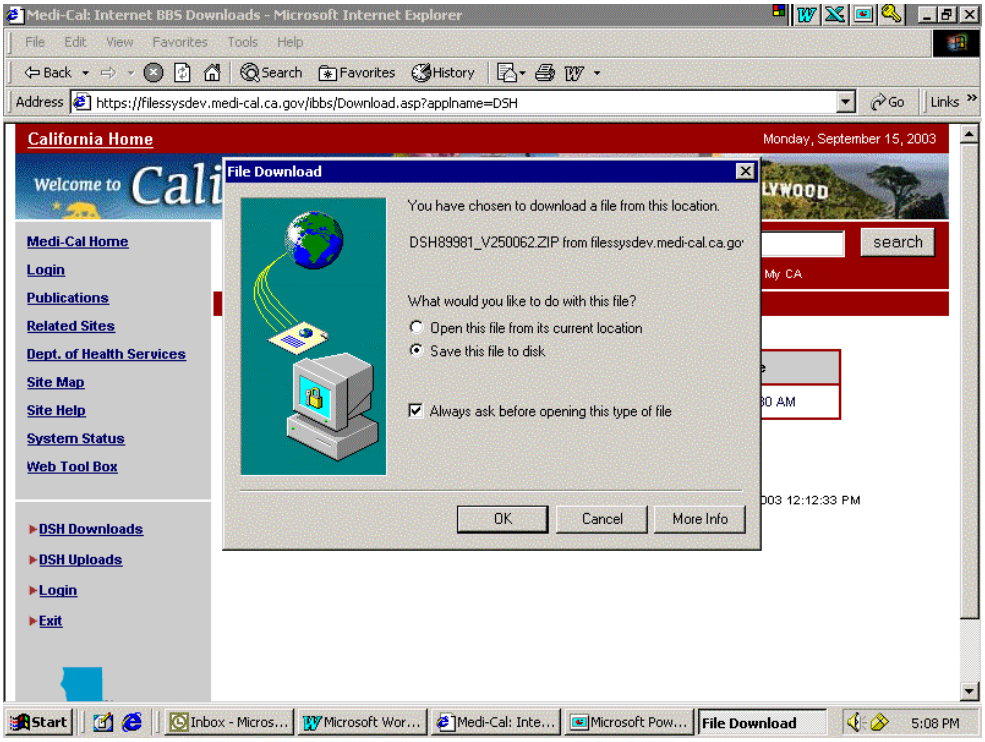


If no files are available, the following screen will appear.

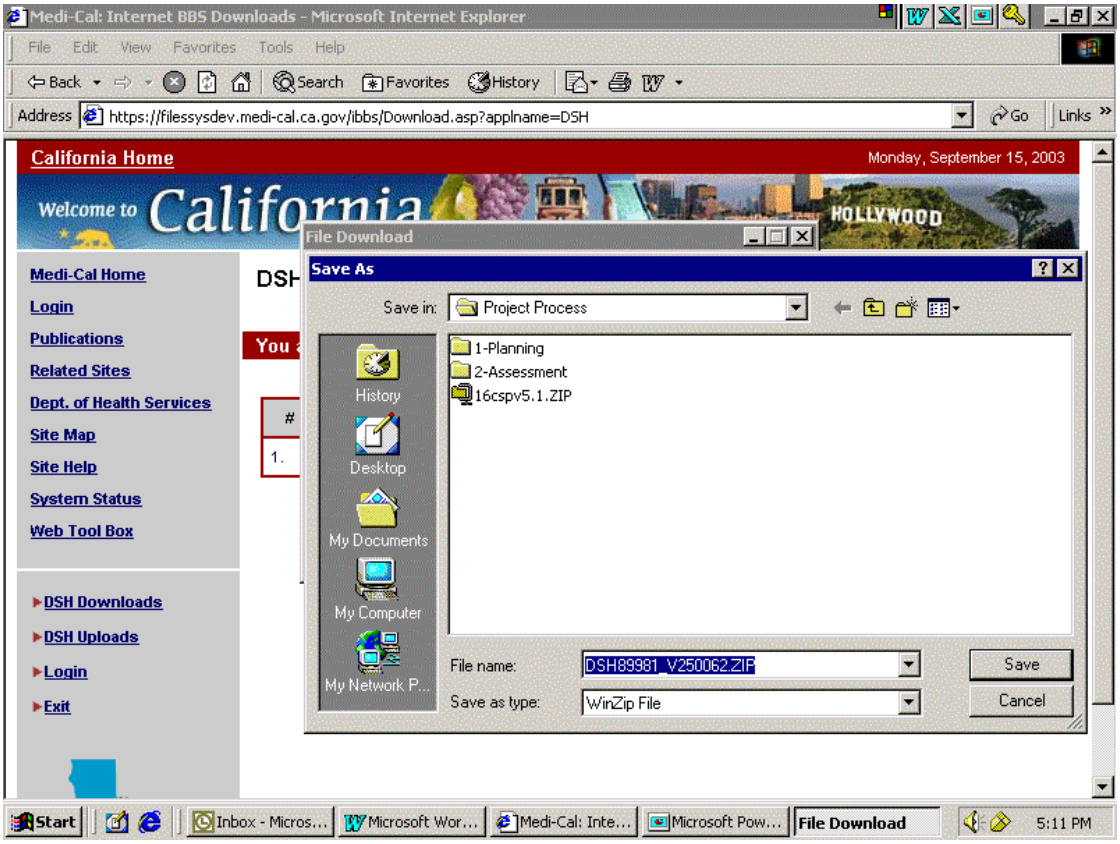
Step	Action	Tips/Tools
9.3	When files are available for download, the submitter/auditor clicks on the file for download	The file name on this screen is the same as the "File Save As" name from Step 2.7



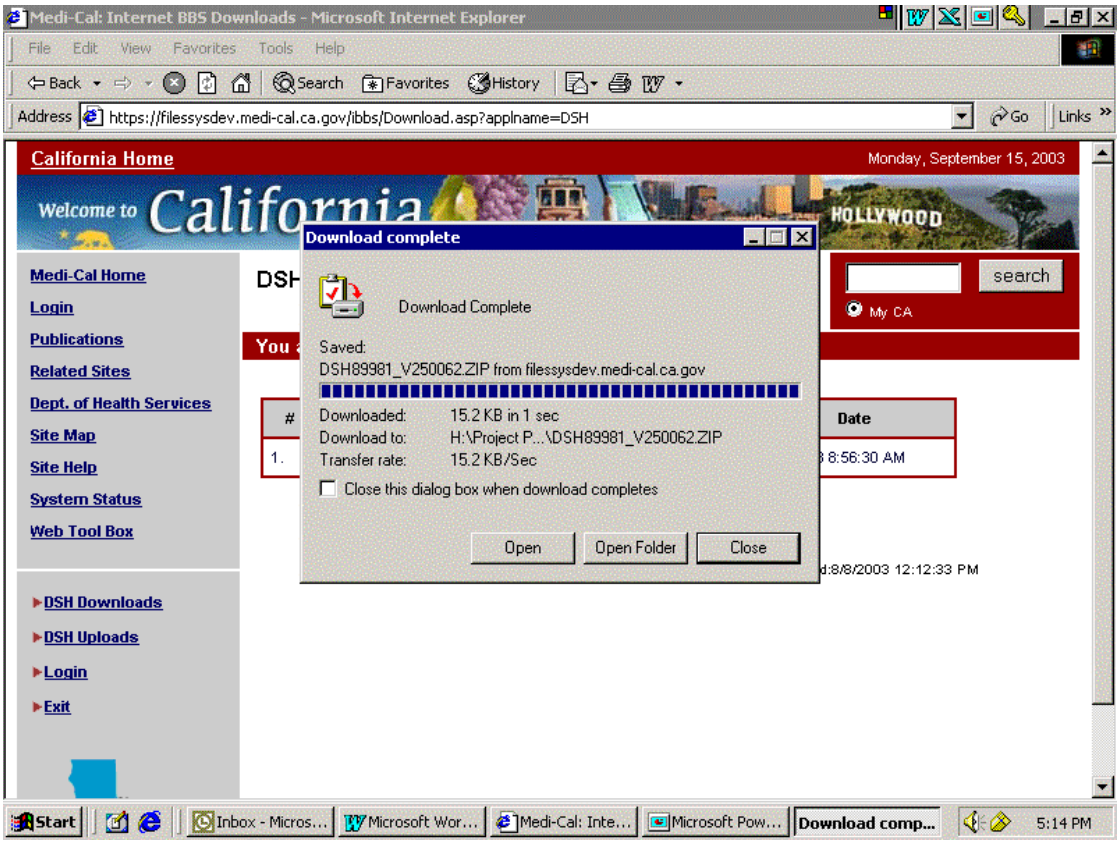
Step	Action	Tips/Tools
9.4	When the File Download dialog box appears, the submitter/auditor clicks the OK button to begin the download process	



Step	Action	Tips/Tools
9.5	When the Save As dialog box appears, the submitter/auditor enters the file name and location on their PC they wish to save the file and clicks the SAVE button	



Step	Action	Tips/Tools
9.6	Once the download process is completed, a Download Complete dialog box will appear. The submitter/auditor clicks the CLOSE button to complete the process	
9.7	When all processing is completed, the submitter/auditor clicks the Exit option to log off the system	



Re-verification and Matching Program

This section provides an overview of the logic performed by the matching program.

*The matching process uses the Disproportionate Share Hospital Database (DSHDB) to determine eligibility. The DSHDB is an extract of the Monthly Medi-Cal Eligibility File (MMEF). For more information on the DSHDB, refer to **Appendix F.***

Overview of Program Logic

#1 Validate Submitter ID

The input submitter code (Submitter ID field) is examined to determine if it's valid. Invalid entries result in a response code of "9" in the Medi-Cal Eligibility Indicator field. However, since the input submitter ID is used to route the response record to the appropriate submitting entity, the submitter may not receive a response record in these cases.

#2 Validate Auditor ID

The input auditor code (Auditor ID field – refer to ***Appendix C*** for more details) is examined to determine if it's valid. Invalid entries result in a message appearing in the filler field of the header record.

#3 Edit Date of Service

Next, the match process will edit the inquiry Date of Service (DOS) field for both valid format and inquiry window.

- **Valid Format** – The valid format for the DOS is a numeric year and the month between 01 – 12. If the DOS is not in a valid format, a response code of "6" will be returned in the Medi-Cal Eligibility Indicator field.
- **Valid Inquiry Window** - The valid inquiry window precedes the standard 13-month claims adjudication time period (current and prior 12 months). For example, if the current month of Medi-Cal eligibility is 12/2002, then the inquiry window starts at 11/2001 (2002/12 – 13 months = 2001/11). Eligibility inquiries for dates of service within the last 13 months should be processed via the AEVS, Internet, or POS network and will not be processed by this program. Inquiries with a DOS that is too recent will result in a response code of "7" in the Medi-Cal Eligibility Indicator field.

Remember, at least one (1) of three (4) search criteria must be on the request records:
1. *SSN; or*
2. *Medi-Cal ID;*
3. *BIC ID number; or*
4. *First name, last name AND date of birth*

*Refer to **Appendix H** for more tips on the matching process.*

#4 Examine Recipient ID

After verifying the DOS, the appropriate database search key will be identified. The following edits attempt to identify the recipient's MEDS ID, which is then combined with the year of service (within the DOS field) and used to read the DSHDB.

- If the Social Security Number (SSN) is present on the inquiry record, then it will be used to read the DSHDB.
- If there's no input SSN, or the input SSN was not found on the DSHDB, then the Medi-Cal ID or BIC ID number is examined. If the Medi-Cal ID or BIC ID number contains less than 14 characters, then the first nine (9) characters are examined. If the first character is an "8" or "9" and the last character is a "P", then the Medi-Cal ID

is a pseudo MEDS ID and can be used to read the DSHDB.

- If the Medi-Cal ID contains less than 14 characters, then the first nine (9) characters are examined. If the first character is a "9" and the last character is an alpha (letter) other than "P", then the Medi-Cal ID is assumed to be a Client Index Number (CIN). The CIN is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.
- If the Medi-Cal ID contains 14 characters, then the Medi-Cal ID is assumed to be a county ID or the BIC ID number. The county ID is cross-referenced to its associated MEDS ID and that MEDS ID is used to read the DSHDB.
- If no DSHDB record has been found after examining the SSN, Medi-Cal ID or BIC ID number, then the name and birth date are cross-referenced to a MEDS ID. The cross-referencing must result in a unique, exact match. If more than one match is found having the exact same name and birth date, but having different MEDS IDs, then a response code of "5" is returned. If a unique exact match is found, then that MEDS ID number is used to read the DSHDB.

If none of the recipient identifiers resulted in a record being found on the DSHDB, then a response code of "4" is returned on the response record.

#5 Determine Eligibility

The month of service (within the DOS field) is used to identify the corresponding month of eligibility on the DSHDB record. The eligible aid codes for that month will be examined to determine if a valid Title XIX aid code exists on the record (the aid codes considered Title XIX are listed in ***Appendix G***). The aid codes on the DSHDB will be examined in the following order:

The match process examines four sets of aid codes to determine eligibility.

- Primary Medi-Cal
- Special Program 1
- Special Program 2
- Special Program 3

If an eligible Title XIX aid code is identified, then the share of cost (SOC) indicator is examined. If the SOC indicator indicates an unmet share of cost, then a response code of "2" is returned. If a restricted Title XIX aid code is found during process, it will be returned on the response record for response code "2". If no unmet SOC is indicated, then a response code of "1" is returned.

If there is no aid code found (indicating no eligibility) or, if an aid code is

found but it's not within the defined Title XIX aid code list, then a response code of "3" is returned on the response record. In addition, if the aid code is defined as restricted (see ***Appendix G*** for restricted aid codes) it will be returned.

The recipient's Medicare status code for the month of service is examined. If the Medicare status indicates Medicare Part A eligibility, then the response Medicare Part A indicator is set to "Y" and the Medicare Health Insurance Claim (HIC) number, if present, is moved to the response record.

#6 Create Response Record

Lastly, the response record is written and returned to the submitter with the eligibility response information appended to the original inquiry record. Additionally, once all processing is completed for the submitted file a trailer record (refer to ***Appendix C*** for record format) is produced containing control totals by response code. The auditor's cleansed response file and attestation letter files are also created.

Appendices

Appendix A – Hospital Authorization Letter template

<<Submit on Hospital Letterhead>>

<Date>

Mr. Armando Martinez
Department of Health Services (DHS)
1501 Capitol Avenue, Suite 71.4063
P.O. Box 997417
Sacramento, CA 95899-7417

Re: Medi-Cal Eligibility Re-Verification for Disproportionate Share (DSH) Determination

Dear Mr. Martinez:

By this letter, <***Full Hospital Legal Name***> (Hospital) has designated <***3rd Party Company Name***> (Agent) as its agent to assist in identifying Medi-Cal eligible patients for purposes of determining our Hospital's disproportionate share for the period of <***Beginning Date***> through <***End Date***>. In exchange for the DHS permitting the Hospital and its Agent to re-verify Medi-Cal eligibility of the hospital's inpatients, the Hospital agrees to do so pursuant to the following terms:

1. Hospital and its Agent shall access Medi-Cal eligibility information on the Hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between Agent and Hospital, the Agent will provide data to the DHS to re-verify the eligibility of those patients who we believe were eligible for Medi-Cal coverage for medical care and services that the Hospital provided.
2. Hospital and its Agent shall use recipient Medi-Cal eligibility information the Hospital obtains for the purpose of the Hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHS.
3. The Hospital or its Agent shall not bring any legal action against DHS that is in any way related to the re-verification of Medi-Cal eligibility.
4. The Agent designated by the Hospital to access Medi-Cal eligibility has a signed agreement with the Hospital agreeing to, among other things, the following terms:

- Be bound by paragraphs 1-3 of this request
- Re-verify eligibility only as a direct result of the Hospital's inquiry on a specific individual
- Adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records
- Not alter any of the recipient information
- Not retain any of the recipient information for anything other than Medicare Disproportionate Share payment determination purposes

Please contact us if you have any questions regarding this matter.

Sincerely,

<***Signature***>

<***Hospital Officer Name***>
<***Hospital Officer Title***>

Appendix B – Web Site Agreement Form

Medi-Cal Web Site Agreement Form for Disproportionate Share Hospital Eligibility Re-verification

This agreement is required for all Medi-Cal Disproportionate Share Hospitals (DSH) or vendors intending to utilize the Medi-Cal Web Site applications at: www.medi-cal.ca.gov

1) The California Department of Health Services (DHS) will permit use of the Disproportionate Share Hospital (DSH) eligibility re-verification process for the following organization (Submitter):

   Full Hospital Legal Name/Company Name: _____

   The Submitter requests a Submitter ID to allow access to Medi-Cal eligibility information to assist in the re-verification of eligible patients for purposes of determining hospital disproportionate share. In exchange for the DHS permitting the Submitter to re-verify Medi-Cal eligibility of their hospital's (or their vendor's) inpatients, the Submitter agrees to do so pursuant to the following terms:
   a) The Submitter (a hospital or its designated vendor) shall access Medi-Cal eligibility information for the hospital's inpatients that may be entitled to Medicare Part A benefits. Pursuant to agreements between the vendor and hospital, the vendor will provide data to the DHS to re-verify the eligibility of those patients who may have been eligible for Medi-Cal coverage for medical care and services that the hospital provided.
   b) The Submitter (a hospital or its designated vendor) shall use recipient Medi-Cal eligibility information the hospital obtains for the purpose of the hospital's claiming the Medicare DSH payment and this information shall not in itself give rise to a payment obligation for DHS.
   c) The Submitter (the hospital or its designated vendor) shall not bring any legal action against DHS that is in any way related to the re-verification of Medi-Cal eligibility.
   d) The Submitter agrees to pay for re-verification services once an agreed upon fee schedule is developed by DHS.
   e) When the Submitter is a vendor designated by the hospital to access Medi-Cal eligibility on their behalf, the Submitter has a signed agreement with the hospital agreeing to, among other things, the following terms:
      i) Be bound by paragraphs a-c of this request
      ii) Re-verify eligibility only as a direct result of the hospital's inquiry on a specific individual
      iii) Adhere to relevant confidentiality and privacy laws, regulations, and contractual provisions and established appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of records
      iv) Not alter any of the recipient information
      v) Not retain any of the recipient information for anything other than Medicare Disproportionate Share payment determination

2) DHS will permit use of the California Medi-Cal Web Site by the Submitter subject to the terms and conditions of this agreement. The submitter agrees to limit the usage of the Medi-Cal Web Site to the following Medi-Cal eligibility-related transactions:
   a) Submission and retrieval of DSH inquiry transactions as permitted by DHS and as documented in the *DSH Eligibility Re-Verification Process User Manual* (published by MEB)
   b) Browsing of the Medi-Cal Web Site

   Submitter acknowledges that failure to limit usage of the Medi-Cal Web Site to the above transactions may, at a minimum, result in DHS revoking the privilege to use the Medi-Cal Web Site. Abuse or fraudulent use of transactions available on the Medi-Cal Web Site may result in DHS revoking Submitter access to the Medi-Cal Internet Transaction Services and possible legal ramifications.

3) Submitter agrees to report all malfunctions of the Medi-Cal Web Site to MEB or EDS' POS/Internet Help Desk at the phone number and/or address documented in the *DSH Eligibility Re-Verification Process User Manual.*

4) Submitter acknowledges that neither DHS nor its vendor is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHS.

5) For POS/Internet Help Desk validation, provide the following Submitter contact validation information:

	Primary Contact	**Backup Contact**
Name:		
Telephone Number:		
Email Address:		

   Submitter's Authentication Word: _____

6) Submitter Signature
   I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement. I am providing contact information in the event that both the primary and backup are not the caller requesting help from the POS/Internet Help Desk. The authorized signatory will be contacted to confirm the caller's identification.

   Authorized Signature: _____

   Printed Name of Signatory: _____

   Title: _____

Telephone Number: _____

Date: _____

Return the completed and signed agreement to:
Ana Fellines
Department of Health Services
Medi-Cal Policy Branch
1501 Capitol Avenue, Suite 71.4431
P.O. Box 997417
Sacramento, CA 95899-7417

Appendix C – DSH Request/Response File

The request file contains fixed length records of 120-bytes each formatted and filled by the submitter. Each file will contain one header record and one-to-many request records when sent to the mailbox by the submitter. During processing, DHS updates the header record and request records. Once processing is completed, DHS will create a trailer record containing file counts. The submitter will receive a response file containing one header, one-to-many response records and one trailer record.

Note: All data must be submitted in UPPER CASE.

Header Record Format and Data Dictionary

Note: All file submitted must have a header record.

Field Name	Length
Record Type (new)	1
File Creation/Processed Date	8
Submitter ID	4
Batch Number (new)	3
Federal Provider ID (updated)	6
Auditor Submitter ID (new)	4
Inquiry Range – Beginning Date (new)	8
Inquiry Range – Ending Date (new)	8
Hospital Use Only (new)	15
Filler (or messages)	63
Total Record Length	*120*

Field Name: Record Type (new)

Description:	An indicator regarding the type of record (such as header, request/response, trailer)
Required/Optional:	Required - filled in by submitter
Type:	1 digit
Valid Values/ Format:	1 = header
Tips:	

Field Name: File Creation/Processed Date

Description:	During initial file creation by the submitter, this date indicates the date the request file was created. After DHS processes the file, this date indicates the date the file was processed at DHS.
Required/Optional:	Required - filled in by submitter
Type:	8 digit date
Valid Values/ Format:	YYYYMMDD
Tips:	

Field Name: Submitter ID

Description:	The submitter ID associated with your organization, as assigned by MEB
Required/Optional:	Required – filled in by submitter
Type:	4 digit
Valid Values/ Format:	
Tips:	Put leading zeros in the field, for example – if your submitter ID is 1 then the field must appear as “0001”

Field Name: Batch Number (new)

Description:	A sequential number populated by the submitter to uniquely identify the file
Required/Optional:	Required – filled in by submitter
Type:	3 digit
Valid Values/ Format:	
Tips:	The submitters should begin the batch number at 001 and increment by +1 for each file submitted to DHS. Once the submitter reaches 999, begin back at 001. Put leading zeros in the field.

Field Name: Federal Provider ID (updated)

Description:	The Federal provider ID associated with the hospital or clinic providing the service and inquiring about the eligibility of the recipient
Required/Optional:	Required – filled in by submitter
Type:	6 characters, alphanumeric
Valid Values/ Format:	050###
Tips:	This field MUST be the Federal provider ID and will be used by the CMS auditors to validate the file against the attestation report generated by the DSH process. Incorrect reporting of the Federal provider ID may

	cause the CMS auditors to reject the file.

Field Name: Auditor Submitter ID (new)

Description:	The submitter ID associated with your CMS auditor (contact your auditor for this number)
Required/Optional:	Required – filled in by submitter
Type:	4 digit
Valid Values/ Format:	0000 = no auditor copy needed 9001 = United Government Services 9002 = Mutual of Omaha
Tips:	The auditor submitter ID is used to ensure the attestation report file and auditor copy of the response file are routed to the proper mailbox. Incorrect auditor submitter numbers will cause misrouting of information and may result in the submitter having to reprocess files. If you do not need to have a copy created for your CMS auditor, fill with zeroes.

Field Name: Inquiry Range – Beginning Date (new)

Description:	The date associated with the earliest date of service being requested in the full request file
Required/Optional:	Required - filled in by submitter
Type:	8 digit date
Valid Values/ Format:	YYYYMMDD
Tips:	

Field Name: Inquiry Range – Ending Date (new)

Description:	The date associated with the latest date of service being requested in the full request file
Required/Optional:	Required – filled in by submitter
Type:	8 digit date
Valid Values/ Format:	YYYYMMDD
Tips:	

Field Name: Hospital Use Only (new)

Description:	A free form field for submitter use. DHS will not edit or use this field during processing.
Required/Optional:	Optional – filled in by submitter
Type:	15 alphanumeric
Valid Values/ Format:	

Tips:	Free form – this field is not edited during processing. Your auditor may specify additional information to be placed in this field.

Field Name: Filler (or messages)

Description:	If an error is found with one or more of the ID fields, the filler is used to communication error messages to the submitter
Type:	63 alphanumeric
Valid Values/ Format:	Do not fill this field, this field is populated by DHS during DSH processing If the auditor ID is invalid – an error message “Invalid Federal Auditor ID” will be issued If the submitter ID is invalid – an error message “Invalid Submitter” will be issued
Tips:	

Request/Response Record Format and Data Dictionary

Field Name	Length
Request Portion (filled in by submitter)	
Record Type (new)	1
Record Creation Date	8
Request Record Number (new)	7
SSN	9
Medi-Cal ID or BIC ID number	14
Last Name	20
First Name	15
Birth Date	8
Gender	1
Date of Service	6
Hospital Use Only (new)	15
Response Portion (filled in by DHS/ITSD)	
Medi-Cal Eligibility Indicator	1
Medicare Part A Eligibility Indicator	1
HIC Number	12
Title XIX Restricted Aid Code	2
Total Record Length	*120*

Field Name: Record Type (new)

Description:	An indicator regarding the type of record (such as header, request/response, trailer)
Required/Optional:	Required – filled in by submitter
Type:	1 digit
Valid Values/ Format:	5 = request/response
Tips:	

Field Name: Record Creation Date

Description:	The creation date of the request record
Required/Optional:	Required – filled in by submitter
Type:	8 digit date
Valid Values/ Format:	YYYYMMDD
Tips:	

Field Name: Request Record Number (new)

Description:	A sequential number to uniquely identify the record. The auditor will use this field during their review of the response file
Required/Optional:	Filled in by DHS
Type:	7 digit
Valid Values/ Format:	Zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: SSN

Description:	The nine-digit social security number assigned to the recipient by the Social Security Administration
Required/Optional:	At least 1 search criteria is required (SSN or Medi-Cal ID or BIC ID number or the combination of Last Name, First Name and Date of Birth) – filled in by submitter
Type:	9 digit
Valid Values/ Format:	
Tips:	If field is not used, leave blank – do not zero fill If there are leading zeros in the SSN, make sure they are included **For pre-1993 inquiries – this field is required**. These older inquiries match against an eligibility file that only contains SSN.

Field Name: Medi-Cal ID

Description:	The ID associated with the recipient. The ID can be one of the following: Client Index Number (CIN) assigned by DHS; OR Pseudo MEDS ID assigned by DHS processing; OR County ID assigned by the county: OR the BIC ID number
Required/Optional:	At least 1 search criteria is required (SSN or Medi-Cal ID or BIC ID number or the combination of Last Name, First Name and Date of Birth) – filled in by submitter
Type:	9 - 14 character, alphanumeric
Valid Values/ Format:	Left justify the number with trailing spaces For Pseudo MEDS ID: Nine (9) characters where the first character is an “8” or “9” and the last character is a “P”

	For CIN: Nine (9) characters where the first character is a “9” and the last character is an alpha (letter) other than “P” For County ID or BIC ID number: Fourteen (14) characters
Tips:	If field is not used, leave blank – do not zero fill If there are leading zeros in the ID, make sure they are included Do not use SSN in this field

Field Name: Last Name

Description:	The last name of the recipient
Required/Optional:	At least 1 search criteria is required (SSN or Medi-Cal ID or BIC ID number or the combination of Last Name, First Name and Date of Birth) – filled in by submitter
Type:	20 character, alpha
Valid Values/ Format:	Left justify the last name with trailing spaces
Tips:	For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) If field is not used, leave blank

Field Name: First Name

Description:	The first name of the recipient
Required/Optional:	At least 1 search criteria is required (SSN or Medi-Cal ID or BIC ID number or the combination of Last Name, First Name and Date of Birth) – filled in by submitter
Type:	15 character, alpha
Valid Values/ Format:	Left justify the first name with trailing spaces
Tips:	For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) If field is not used, leave blank

Field Name: Birth Date

Description:	The date of birth associated with the recipient
Required/Optional:	At least 1 search criteria is required (SSN or Medi-Cal ID or BIC ID number or the combination of Last Name, First Name and Date of Birth) – filled in by submitter
Type:	8 digit date

Valid Values/ Format:	YYYYMMDD
Tips:	For the name/date of birth search – all three (3) fields must be present (last name, first name AND date of birth) If field is not used, leave blank

Field Name: Gender

Description:	The gender associated with the recipient
Required/Optional:	Optional
Type:	1 character, alpha – filled in by submitter
Valid Values/ Format:	M = male F = female U = unborn Blank = unknown
Tips:	If the gender is unknown, leave blank

Field Name: Date of Service (DOS)

Description:	The month and year the services were provided, this will be used for determining if the recipient was eligible
Required/Optional:	Required – filled in by submitter
Type:	6 digit date
Valid Values/ Format:	YYYYMM
Tips:	If the date of service spans multiple months, an inquiry record for each month must be created. If the date of service is within the current 13 months, use the AEVS/Internet/POS system for determining eligibility

Field Name: Hospital Use Only (new)

Description:	A free form field for submitter use. DHS will not edit or use this field during processing.
Required/Optional:	Optional – filled in by submitter
Type:	15 alphanumeric
Valid Values/ Format:	
Tips:	Free form – edits are not performed on this field during processing. Your auditor may specify additional data to be placed in this field.

Field Name: Medi-Cal Eligibility Indicator

Description:	The response code generated during the processing of the matching program
Type:	1 character – filled in by DHS
Valid Values/	Blank = unprocessed

Format:	1 = eligible 2 = potentially eligible with unmet share of cost 3 = matched and potentially eligible 4 = unmatched 5 = multiple name match 6 = invalid date of service format 7 = invalid date of service, within 13 month billing window 8 = not being used at this time 9 = invalid submitter ID
Tips:	Refer to the ***Re-verification and Matching Program*** section of the manual for more information on how the response codes are set by the matching program Do not fill this field – This field is populated by DHS during the DSH matching process

Field Name: Medicare Part A Eligibility Indicator

Description:	Indicates whether the recipient is Medicare Part A eligible
Type:	1 character
Valid Values/Format:	Y = eligible for Medicare Part A Blank = not eligible for Medicare Part A
Tips:	Do not fill this field - This field is populated by DHS during the DSH matching process

Field Name: HIC Number

Description:	Medicare Health Insurance Claim (HIC) number
Type:	12 characters
Valid Values/Format:	
Tips:	Do not fill this field - This field is populated by DHS during the DSH matching process

Field Name: Title XIX Restricted Aid Code

Description:	The Title XIX eligible restricted aid code found for the recipient during the matching process – the restricted aid code is only returned for response codes 2 and 3
Type:	2 character
Valid Values/Format:	Refer to ***Appendix G***
Tips:	Do not fill this field - This field is populated by DHS during the DSH matching process

Trailer Record Format and Data Dictionary

Note: Do not create the trailer record – this record is created by DHS during DSH processing.

Field Name	Length
Record Type (new)	1
Response File Creation Date	8
Submitter ID	4
Batch Number (new)	3
File Record Count (updated)	7
Response Code 1 Count (updated)	7
Response Code 2 Count (updated)	7
Response Code 3 Count (updated)	7
Response Code 4 Count (updated)	7
Response Code 5 Count (updated)	7
Response Code 6 Count (updated)	7
Response Code 7 Count (updated)	7
Response Code 8 Count (updated)	7
Response Code 9 Count (updated)	7
Part A Count (new)	7
Filler	27
Total Record Length	*120*

Field Name: Record Type (new)

Description:	An indicator regarding the type of record (such as header, request/response, trailer)
Type:	1 digit
Valid Values/ Format:	9 = trailer
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response File Creation Date

Description:	The date the match process was run and the response file was created
Type:	8 digit date
Valid Values/ Format:	YYYYMMDD
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Submitter ID

Description:	The submitter ID of the organization submitting the request (taken from the header record)
Type:	4 digit
Valid Values/ Format:	
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Batch Number (new)

Description:	A sequential number populated by the submitter to uniquely identify the file (taken from the header record)
Type:	3 digit
Valid Values/ Format:	
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: File Record Count (updated)

Description:	Total number of records contained on the response file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 1 Count (updated)

Description:	Total number of records found to be eligible during processing (response code 1) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 2 Count (updated)

Description:	Total number of records with unmet share of cost (response code 2) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 3 Count (updated)

Description:	Total number of records found but not eligible (response code 3) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 4 Count (updated)

Description:	Total number of records not found during processing (response code 4)
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 5 Count (updated)

Description:	Total number of records with multiple names found during the name/date of birth search (response code 5) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 6 Count (updated)

Description:	Total number of records with invalid format for date of service (response code 6) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 7 Count (updated)

Description:	Total number of records within the current 13 month window (response code 7) on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 8 Count (updated)

Description:	Not used at this time
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Response Code 9 Count (updated)

Description:	Not used at this time
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Field Name: Part A Count (new)

Description:	Total number of records indicating Part A eligibility on the file
Type:	7 digit
Valid Values/ Format:	Numeric, right justified, zero filled
Tips:	Do not fill this field - This field is populated during the DSH matching process

Appendix D – Attestation Letter Report

State of California
Department of Health Services
Disproportionate Share Processing Control Totals

Report #: RS-DSH100-R002 **Process Date: mm/dd/ccyy**

The California Department of Health Services is providing the following Medi-Cal Eligibility control totals report for the attestation of the disproportionate share eligibility re-verification process.

Submitted by: ***<Submitter Name>***

Eligibility data provided for
Federal Provider Number <***Provider Number***>
Dates of Inquiry ***<Inquiry Date Range>***

File processed on ***<Response File Creation Date>***

Processing Control Totals

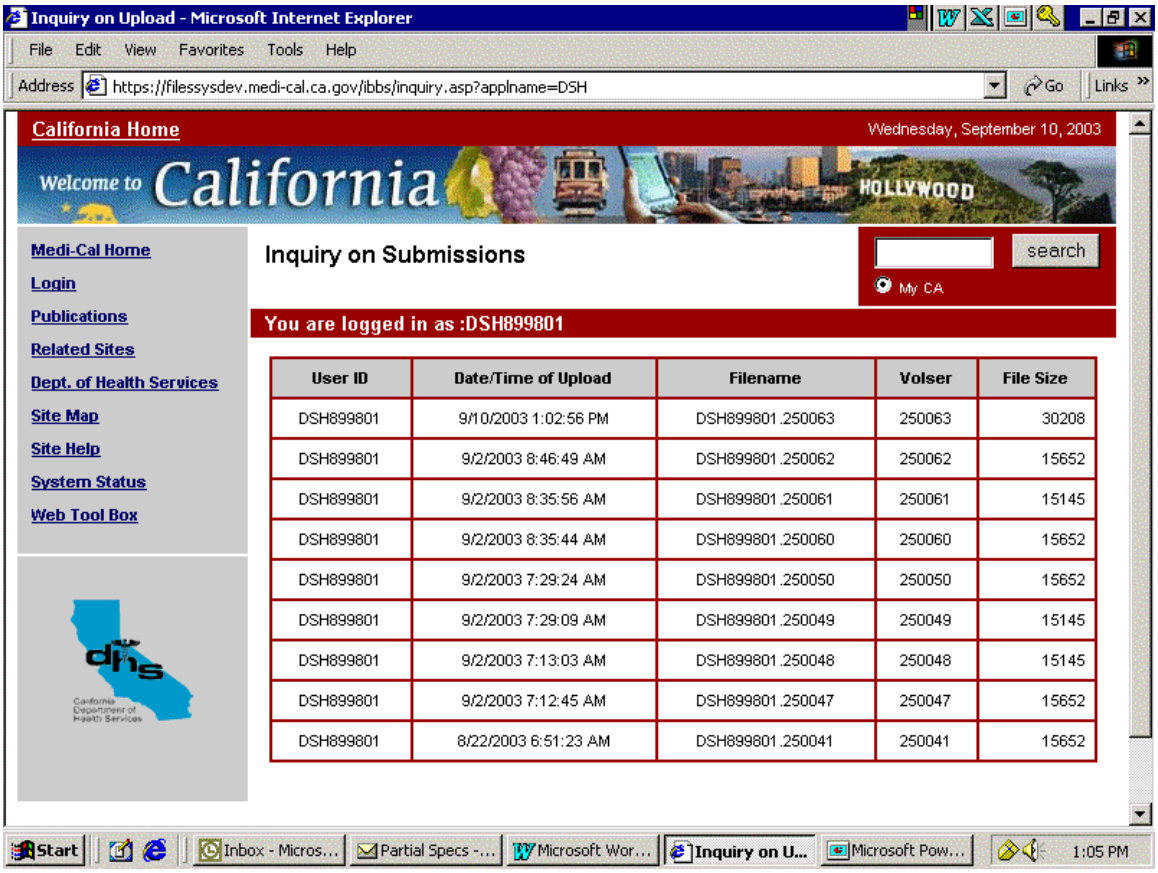
Total number of records processed:	***<File Record Count>***
Total number of records with response code:	
1 (eligible)	***<Response Code 1 Count>***
2 (unmet share of cost)	***<Response Code 2 Count>***
3 (matched and potentially eligible)	***<Response Code 3 Count>***
4 (unmatched)	***<Response Code 4 Count>***
5 (multiple name match)	***<Response Code 5 Count>***
6 (invalid date of service format)	***<Response Code 6 Count>***
7 (date of service too recent)	***<Response Code 7 Count>***
9 (invalid submitter ID)	***<Response Code 9 Count>***
Total number of records with Medicare Part A:	***<Part A Count>***

Sources of Data for the Attestation Report:

1. Submitter Name – the Submitter Name is derived from the Submitter ID on the header record from the submitter. The Submitter ID will be cross-referenced to the Submitter Name using a new file/table maintained by MEB.
2. Provider Number – using the first record from the inquiry/response file, the provider number will be moved to the report as provided by the submitter.
3. Inquiry Date Range – using the first record from the inquiry/response file, the date range will be moved to the report as provided by the submitter.
4. Response File Creation Date – the date from the trailer record will be moved to the report.
5. File Record Count - the count from the trailer record will be moved to the report.
6. Response Code 1 Count (through 9) - the count from the trailer record will be moved to the report.
7. Part A Count - the count from the trailer record will be moved to the report.

Appendix E – Inquire on File Status

Once files have been uploaded for DSH processing, the submitter can confirm the submission by using the "Inquiry on Submissions" option. All files listed on the resulting screen (shown below) are ready for processing and waiting for EDS to 'pick up' for transfer to DHS.



User ID	Date/Time of Upload	Filename	Volser	File Size
DSH899801	9/10/2003 1:02:56 PM	DSH899801.250063	250063	30208
DSH899801	9/2/2003 8:46:49 AM	DSH899801.250062	250062	15652
DSH899801	9/2/2003 8:35:56 AM	DSH899801.250061	250061	15145
DSH899801	9/2/2003 8:35:44 AM	DSH899801.250060	250060	15652
DSH899801	9/2/2003 7:29:24 AM	DSH899801.250050	250050	15652
DSH899801	9/2/2003 7:29:09 AM	DSH899801.250049	250049	15145
DSH899801	9/2/2003 7:13:03 AM	DSH899801.250048	250048	15145
DSH899801	9/2/2003 7:12:45 AM	DSH899801.250047	250047	15652
DSH899801	8/22/2003 6:51:23 AM	DSH899801.250041	250041	15652

It is recommended that submitters upload all files for that day (or session) display the list and save a copy via "Save As" or print this screen for future reference.

Appendix F – DSH Database

The matching program uses the Disproportionate Share Database (DSHDB) to locate the eligibility information for the requested recipient.

Initial Creation and Load

The DSHDB will initially be created from the Monthly Medi-Cal Eligibility File (MMEF) research tapes. The MMEF is the file used for eligibility verification in the existing DSH eligibility verification process. The DSHDB load data will be extracted in six-month intervals, allowing a minimum of six (6) months to a maximum of 12 months of retroactive eligibility reporting to occur. For example, the DSHDB records for the time period 01/1999 through 06/1999 will be created from the January 2000 MMEF file.

The DSHDB will contain client demographic data (such as name and birth date) and a table containing monthly eligibility data (such as eligible aid codes, Medicare statuses and unmet share of cost indicators) for each month in the eligibility year. The DSHDB file contains the following fields:

- MEDS ID
- Year of Eligibility
- Starting Month of Eligibility
- Last Name
- First Name
- Middle Initial
- Birth Date
- Gender
- Client Index Number (CIN)
- HIC Number
- Eligibility History Table, containing:
    - Eligibility Aid Code - Primary
    - Eligibility Aid Code – 1st Special
    - Eligibility Aid Code – 2nd Special
    - Eligibility Aid Code – 3rd Special
    - Medicare Status Code
    - Medical Health Care Plan Indicator
    - Unmet Share of Cost Indicator

The DSHDB data is frozen in time and subsequent client demographic updates will not be applied. For example, if recipient Jimmy Smith was known by SSN 111-22-3333 in 1999 and subsequently changed his name and SSN to James Smith, 123-45-6789, in 2001, the DSHDB for 1999 will have Jimmy Smith using SSN 123-45-6789. When the 2001 DSHDB records are created, James Smith, 123-45-6789 will be loaded as a new record. This is being done under the assumption that providers of service will submit their eligibility inquiries based upon patient information as it was on the date of service.

Database Update Process

After the initial load process is completed, the DSHDB will be updated monthly after the MEDS Renewal process has completed, rolling the MEDS system into the new month of eligibility (this happens around the 25th of each month). Using the pre-renewal MEDS database backups as input, a DSHDB record will be created containing the 12th prior month of eligibility. These monthly DSHDB updates will be applied to the DSHDB, either adding a new record for the eligibility year or adding a new month of data to an existing DSHDB record.

Appendix G – Aid Code Information

MEB maintains the most current definition of Title XIX and Restricted Title XIX aid codes used by the DSH matching process. For the most current version of these definitions, refer to the main DSH screen.

For a description of the restricted aid code and their narrative descriptions, refer to the information contained at:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/obra_z01.doc

For a full list of all aid codes used by DHS and their narrative descriptions, refer to the information contained at:
http://www.dhs.ca.gov/mcss/GeneralInfo/Aid_Codes_Documentation.pdf

Appendix H – Frequently Asked Questions

Q1: What are the most common errors found during file processing?

A:
During testing of Phase 2, the most common errors were regarding the file formatting. Many submitters did not follow the file layout (found in ***Appendix C***) causing their files to be returned unprocessed. Another common error was the file did not have a header record. With Phase 2, all request files must contain one (1) header record along with the one to many request records. Without the header record DHS cannot process the file. NOTE: It is very IMPORTANT to follow the file format in ***Appendix C***…this will ensure proper processing of your files.

Q2: Who gets the attestation letter?

A:
The intent of the attestation letter is to provide file counts to the auditors to allow them to verify the right files were used during their audits. Beginning with Phase 2, the attestation letter is now automatically created during the file processing. A 'readable' print file is created and sent to both the auditor and submitter.

Q3: Why do I need a submitter ID?

A:
The submitter ID is used to verify the submitter is valid and has an Internet Agreement on file with DHS. For Phase 2, the submitter ID is also used to route the processed files to the proper box on the web site.

Q4: Can I use the old format for years prior to 1993? If not, why?

A:
A feature of Phase 2 is the consolidation of all file formats into one. The only acceptable file format allowed for processing is shown in ***Appendix C***. Keep in mind, pre-1993 request must have the SSN field supplied – this is the only field available for matching on older eligibility files used during DSH processing. When processing they need to be in calendar year per file.

Q5: Can you send a disk to the auditor for a file already processed and sent to us?

A:
To ensure a copy of the response file created by DHS is sent to your auditor, make sure you provide the Auditor ID in the appropriate field on the header record. This ID will trigger the process to create a copy of the response file and send it to the auditor's box.

Q6: Can I get current eligibility information? If not, where do I get current eligibility information?

A:
Current eligibility information is NOT available from the DSH re-verification process. If the date of service you are using for verification is within the last 13 months, you must use the POS, AEVS or Internet eligibility methods.

Q7: How far back does the re-verification process allow requests?

A:
DHS has eligibility information back to 1987. All requests for re-verification must be submitted using the file formats shown in ***Appendix C*** and submitted via the Medi-Cal web site.
Remember all files submitted pre-1994 need to be submitted by calendar year.

Q8: Do we have to include the Auditor ID on the header record?

A:
No, the Auditor ID field is used during the matching process to create a copy of the response file for the auditor. If you do NOT need a copy of the file to be automatically sent to your auditor, please type zeros in the Auditor ID field. Refer to Appendix C for more details on the Auditor ID field and valid values.

Q9: In the past I have received response code 1 and now I get a response code 3 on the same record, why?

A:
During Phase 1 the matching process was enhanced to use a defined list of aid codes to determine eligibility. This list of aid codes has been modified since Phase 1 (and will continue to be modified) – the result of these modifications is that previous inquiries results may change. For the most current version of the aid code definition, refer to ***Appendix G*** for more information.

Q10: Can I get a control total report?

A:
The control total report was available prior to Phase 1. Beginning with Phase 1 (and continuing with this Phase), the control total counts are available on the trailer record. During the DHS processing, the final step of the matching program is to tabulate various counts and create a trailer record to be sent back on the response file. For more information on the trailer record, refer to ***Appendix C.***

Q11: What format should data be submitted?

A:
All requests for eligibility re-verification must be sent in the format shown in ***Appendix C.*** Any deviations from this format will cause errors in the processing (either the file is not processed or the results are not correct).

Q12: Can data be entered into a spreadsheet and sent to DHS for processing?

A:
All requests for eligibility re-verification must be sent in the format shown in ***Appendix C.***

Q13: How can I find out the status of my files?

A:
The Medi-Cal web site provides an inquiry function to allow the submitter to check on file uploads.

Q14: Who do I call about problems?

A:
If you are having problems accessing the Internet web site – call the POS Help Desk at 1-800-541-5555**.**

If you have questions or problems regarding your responses – call MEB at the number listed in ***Appendix I***.

Q15: Can you shed some insight on the various types of identifiers used to match the recipient for eligibility processing?

A:
Here is a brief history on the Medi-Cal identifiers.

The plastic Beneficiary Identification Card (BIC) debuted in 1994. Before that, DHS mailed paper ID cards to the recipients every month. The primary identifier on the paper cards was the county-ID - a 14-character identifier with the format cc-aa-sssssss-f-pp, where:

cc = county code. A numeric value from 01-58. Counties are numbered in alphabetic order starting with Alameda (01) and ending with Yuba (58).

aa = aid code. An alphanumeric code used to describe scope of coverage and funding sources.

sssssss = serial number. An alphanumeric identifier assigned by the counties to group members of the same welfare case.

f = family budget unit (FBU). An alphanumeric value used by the counties to group members of the same case into sub-units based on eligibility, residence, etc.

pp = person number. A numeric value that identifies the individual members of a case.

For non-county managed recipients (such as SSI/SSP - aged, blind, disabled, healthy families, etc.) MEDS assigns a pseudo (or fake) county-ID consisting of cc-aa-SSN or cc-aa-CIN.

Pre-1994, most claims were billed using the county-id. Starting in 1994, BIC cards were issued with either the SSN or CIN as the primary identifier on the face of the card. At that point, providers starting putting the BIC ID number (SSN or CIN) on the claims. The Fiscal Intermediaries (FI) have access to all of the eligibility data via their connection to DHS. When the FI get a claim billed with an SSN or CIN, they access our data to retrieve the county code, aid code, etc. to determine how to adjudicate the claim. During processing, the FI puts a "fake" county-ID on the claim using the county code and aid code used for adjudication and the provider-submitted identifier.

To determine which ID you have, use the same logic used by DHS during the matching process:

1. If you have a 14-byte identifier, then it's probably a county-ID or a BIC ID number. Remove the dashes and put it in the Medi-Cal ID field.
2. If you have a 9-byte identifier, then it can be an SSN, pseudo-ID or CIN. If all 9 bytes are numeric, then put it in the SSN field and leave the Medi-Cal-ID blank. If it's not numeric, then put it in the Medi-Cal ID field and DHS figure it out during the match process.
3. If you have a 10-byte identifier, then it's probably an SSN or CIN with the check digit attached. Put it in the Medi-Cal ID field and DHS will figure it out during the match process.
4. If you have a 13-byte identifier, then it's probably an FI "fake" county-id. Assume the last 9-bytes are an SSN, CIN or pseudo-ID and put those last 9 bytes in the Medi-Cal-ID field.
5. If you have an 11-12 byte identifier then you'll have to look at your data to see if there are any patterns. A simple edit to identify a pseudo-ID is that the first byte is 8 or 9 and last byte is P. A simple edit to identify a CIN is that the first byte is 9 and last byte is alphabetic other than P.
6. The only identifier other than those discussed above is the Medicare Health Insurance Claim (HIC) number. The HIC number is usually an SSN followed by a 1 to 3-byte alphabetic suffix.

Remember, if the SSN and Medi-Cal ID fields don't result in a match, the DSH matching logic will attempt to do a name/birth date match. So, you always have one last chance for a match to be found.

Q16: How can I get better name matches?

A:

Many times the name match fails because submitters include the middle initial in the first name field. The first name should ONLY include the first name of the recipient. Keep in mind some first names are more than one name (such as Mary Ann) – in these cases the first name field should contain the full (multiple) first name.

Q17: Where can I get the most current version of the User Manual?

A:
The User Manual is available on the Medi-Cal web site. The main DSH screen provides an option to view and print the latest version of the User Manual.

Q18: Where can I get the most current version of the aid codes used for DSH processing?

A:
The main DSH screen on the Medi-Cal web site provides an option to view and print the latest version of the aid codes used for DSH processing.

Appendix I – Contact Information

For more information regarding the DSH process or problems, contact:

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