STATE OF CALIFORNIA

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL MANAGEMENT INFORMATION SYSTEM

Procedure File
Procedures Manual

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Section 1 - Introduction

This document is a desktop reference manual for Change Support data file analysts responsible for the Procedure Code Master File (RF-F-070). This manual contains procedures and standards used to maintain and update File RF-F-070, and contains the information necessary to train new analysts.

1.1 Change Support (CS) Unit

The Change Support unit is responsible for updating File RF-F-070. Refer to Figure 1.1, which illustrates the Change Support organization.

1.2 File RF-F-070 Overview

The Procedure Code Master File (RF-F-070) is stored on a Virtual Storage Access Method (VSAM) file for online inquiry and updating, and a sequential tape file, which is used by the claims processing subsystem for adjudication.

The File RF-F-070 contains all valid procedure codes allowed by the Medi-Cal program. It also contains criteria necessary for the proper adjudication of claim lines. The data includes, but is not limited to the following:

- Procedure Type
- Procedure Code
- Treatment Authorization Request (TAR)
- Family Planning
- Unit Values
- Professional Component
- Service Limitation Indicators
- Action (Pend/Deny) Indicators
- Early Periodical Screening, Diagnosis, and Treatment (EPSDT)

The Procedure Code Master File (RF-F-070) is maintained on the Contractor's automated systems equipment for ease of data accessibility and accurate monitoring of updates. File RF-F-070 maintenance involves both automated and manual interaction.

The Procedure Code Master File (RF-F-070) receives updates through online data entry. Computer programs designed to maintain File RF-F-070 perform the actual updating. Computer programs also produce output from the File RF-F-070 in the form of reports. These reports provide audit trails and system checks on file activity.

After the Contractor reviews the reports, they are forwarded to the Department of Health Services (DHS) personnel for review and approval in accordance with the Request for Proposal (RFP) requirements.

The CS data file analyst performs the manual activities related to Procedure Code Master File (RF-F-070) maintenance. These activities include updating the file and reviewing output (reports) for accuracy.

1.3 Manual Environment

Procedure Code Master File (RF-F-070) manual activities are tightly controlled and performed by trained Contractor personnel.

The Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS), including the Current Procedural Terminology (CPT-4), is the primary reference for the Procedure Code Master File (RF-F-070) activity. Other references are the California Standard Nomenclature (CSN), 1969 California Relative Value Study (CRVS), 1974 CRVS Pathology Section, Title 22, and DHS policy statements. DHS uses these references to develop Operating Instruction Letters (OILs) to direct the Contractor in the maintenance and update of the Procedure Code Master File (RF-F-070).

Updates are entered through online data entry. Online updates can be run against the Procedure Code Master File (RF-F-070) on a daily basis.

Contractor personnel receive and review automated reports after the online inputs have been run through the batch update process. These reports include audit trails and file listings. Proofed listings are then delivered to DHS for review.

Data file analysts correct any errors found and apply them to the file. CS staff promptly investigate ad resolve any irregularities.

1.4 Automated System Environment

The automated system environment consists of computer programs that update the Procedure Code Master File (RF-F-070) and produce audit trail reports and file listings. These reports are generated as the update process occurs. Upon completion, they are manually reviewed.

Procedure Code Master File (RF-F-070) reports are available in printed copies and on microfiche. The reports are as follows:

- Procedure Master File Listing
- Procedure Audit Trail and Control

1.5 Automated System Interface

Coordination between the manual and automated system environments involve strict, controlled procedures. This ensures efficient data communication between the systems and guarantee that all data collected is applied against the file. The Contractor uses the following procedures to interface the manual and automated systems:

- CS obtains changes and updates through DHS initiated OILs, System Development Notices (SDNs), and Change Orders.
- CS enters Procedure Code Master File (RF-F-070) updates online.
- Data analysts carefully analyze audit trails or listings resulting from the update run.
- Data analysts forward the reports to DHS for review.

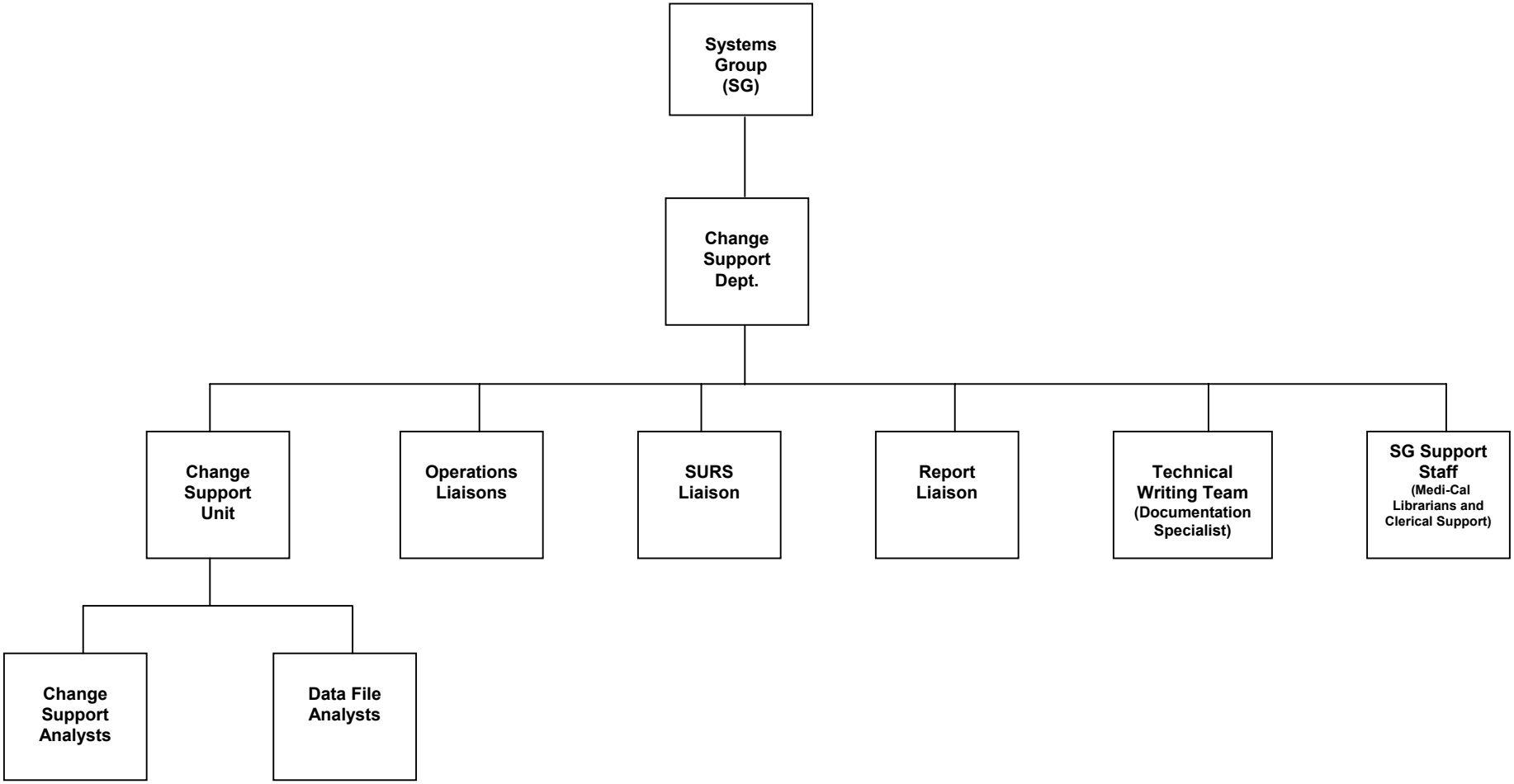

Figure 1.1 - Change Support Organization

Section 2 - Policies and Standards

Section 2 contains a description of the policies and standards used to maintain the Procedure Code Master File (RF-F-070).

2.1 RFP Requirements

RFP requirements related to File RF-F-070 are discussed in this section.

CS maintains accurate and up-to-date reference files for proper claims adjudication. The Procedure Code Master File (RF-F-070) is updated in an accurate, efficient, and timely manner.

DHS notifies the Contractor of any additions, deletions, or changes to the Procedure Code Master File (RF-F-070), and provides the Contractor with the procedure codes that are acceptable or unacceptable under the Medi-Cal program. Change Support updates the Procedure Code Master File (RF-F-070) within five days of receipt of DHS-approved updates. All transactions to the Procedure Code Master File (RF-F-070) are edited, and only valid transactions are used to modify the file.

Drug prices on the Procedure Code Master File (RF-F-070) are updated at least monthly.

The Contractor produces and delivers all audit trails to DHS within five days of applying updates to the Procedure Code Master File (RF-F-070). All identified errors are corrected and re-applied to the file.

The Procedure Code Master File (RF-F-070) listing is produced on DHS requested media, and delivered quarterly on the fifth state work day following the end of the quarter. DHS may request additional copies, which the Contractor will deliver within seven days of the request.

2.2 Reference Material

The CS data file analyst uses this manual, Title 22, HCFA Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT-4), and DHS Operating Instruction Letters (OILs) publications as reference materials. Although the analyst must be aware of the pricing procedures and rate structures in these publications, no action is taken against the Procedure Code Master File (RF-F-070) without DHS direction, such as an OIL.

2.2.1 Title 22, California Code OF Regulations (CCR)

Title 22 establishes current rates and guidelines effective within the Medi-Cal program. Those pertaining to the Procedure Code Master File (RF-F-070) are detailed below.

<u>SECTION 51503 – PHYSICIAN SERVICES</u>

Section 51503 contains current conversion factors. These factors are used as multipliers against the 1969 unit values except for pathology, which uses the 1974 CRVS unit values. The resulting converted price is stored on each procedure record.

SECTIONS 51505.3/51533 - SMA SERVICES

These Title 22 sections define SMA (Schedule of Maximum Allowances) codes, their HCPCS equivalents, and rates that are covered benefits of the Medi-Cal program. SMA and HCPCS codes exist on the Procedure Code Master File (RF-F-070) as fixed price maximums. The relevant CCR sections are as follows:

- 51505.3 Psychology Services
- 51506 Dental Service
- 51507 Physical Therapy
- 51507.1 Occupational Therapy
- 51507.2 Speech Therapy and Audiology
- 51509 Hospital Outpatient Clinics
- 51509.1 Organized Outpatient Clinics
- 51514 Chiropractic Services
- 51514.5 Acupuncture Services
- 51515 Prosthetic and Orthotic Appliances
- 51517 Hearing Aids
- 51518 Optometry Services
- 51519 Eye Appliances
- 51521 Durable Medical Equipment
- 51523 Home Health Agency Services
- 51527 Medical Transportation Services
- 51528 Paramedic Ambulance Services
- 51529 Pathology Services
- 51531 X-Ray
- 51532 EPSDT
- 51533 Heroin Outpatient Services Detoxification
- 51534 Home and Community Based Services

SECTION 51509-ORGANIZED OUTPATIENT CLINICS

Section 51509 contains regulations dictating methods for calculating the reimbursement for these providers. The methodology uses 1969 CRVS units, except for pathology, which uses the 1974 CRVS unit values, multiplied by specific conversation factors. The conversion factors are stored on the Multiplier Table 2. This table is used in conjunction with the California Medicaid Management Information System (CA-MMIS) Table 0215 to determine prices according to provider type as defined in Section 51509 of Title 22.

2.2.2 California Standard Nomenclature (CSN)

The pricing data on the Procedure Code Master File (RF-F-070) combines unit value information extracted from the 1969 and 1974 California Relative Value Studies (CRVS), the California Standard Nomenclature (CSN), Title 22 and the Current Procedural Terminology (CPT-4). Acceptable procedure codes are extracted from the CPT-4 and the HCFA Common Procedure Coding System (HCPCS) publications, and Title 22.

The CRVS is a comprehensive, categorized listing of major and minor procedures of Medicine (medical care and associated services), Anesthesia, Surgery, Radiology/Nuclear Medicine and Pathology. The CRVS contains unit values for each procedure within each category rated from minor to the most complex. The values reflect the median charges made by physicians in California. The 1969 and 1974 (pathology) CRVS unit value system is mandated by DHS for Medi-Cal claims adjudication.

DHS establishes all rate calculations, except those for injection codes, and transmits this information to the Contractor through an OIL. Procedure unit values are obtained from the 1969 and 1974 (pathology) CRVS according to Medi-Cal pricing policies. For those procedure numbers not having a fixed unit value (by report, service only, and relativity not established), some pseudo values have been approved by DHS for automated processing, and some values are reviewed manually.

Procedure rates are either calculated as a fixed priced rate (most often used for HCPCS Level III codes) or by multiplying the applicable unit value by the conversion factors established in Sections 51503 and 51509 of Title 22.

CRVS/CSN unit values continue to be used even though the CPT-4 procedure-coding scheme has been adopted by DHS for Medi-Cal claims.

2.3 Background and Historical Information

It is important to understand the background and history of the Procedure Code Master File (RF-F-070) in order to be able to properly interpret the information it contains.

2.3.1 Procedure Coding Schemes

The Medi-Cal program uses a combination of professionally accepted standard procedure codes, such as the CPT-4, and DHS-defined Medi-Cal specific procedure codes, such as the Level III HCPCS codes. Over time, however, the standards and coding schemes used have changed. Originally, Medi-Cal used a combination of California Relative Value Studies (CRVS) and Schedule of Maximum Allowance (SMA) codes. CRVS codes were developed and maintained by the California Medical Association (CMA), and SMA codes were developed and maintained by DHS, published in Title 22. The CRVS eventually gave way to the California Standard Nomenclature (CSN), but this did not alter the definition or unit values of the procedure codes.

Concurrently, the American Medical Association (AMA) published the Current Procedural Terminology (CPT-4) in an attempt to standardize the coding scheme used throughout the country. The Federal Health Care Finance Administration (HCFA) also began to require State Medicaid reporting to be uniform, so that data could be compared effectively. To comply with HCFA's reporting requirements, DHS decided to adopt the CPT-4 in-lieu-of the CSN.

In November 1987, DHS implemented a conversion to the CPT-4 coding scheme. Because both the CRVS/CSN and the CPT-4 use a structure of 5-digit numeric codes categorized the same way, it was not possible to allow the CRVS/CSN coding scheme and the CPT-4 coding scheme to co-exist in the CA-MMIS. To be able to distinguish

between a CRVS/CSN code and a CPT-4 code, significant changes were made to the CA-MMIS. The Procedure Code Master File (RF-F-070) was modified to include distinct procedure type codes indicating CRVS/CSN or CPT-4. All CRVS/CSN codes were given distinct procedure type codes and end-dated effective October 31, 1987. All CPT-4 codes valid at that time were assigned different, but also distinct, procedure type codes and contain a begin date of November 1, 1987. The November 1987 CPT-4 conversion did not alter the SMA coding scheme.

HCFA continued to pursue standardization of reporting and claims for Medicaid and Medicare. As a result the HCPCS coding scheme was developed. HCPCS consists of three levels – Level I, which is the CPT-4; Level II, which are HCFA developed and maintained codes for items and services not defined in the CPT-4; and Level III, which is a block of codes set aside for individual states and carriers to define items and services unique to their program(s). In 1989, DHS decided to adopt the remaining levels of the HCPCS coding scheme and initiated SDN 9020 - HCPCS Level II and III Conversion.

The conversion to HCPCS Level II and III required extensive changes to CA-MMIS. In October of 1992, the conversion was implemented. The structure of Level II and III codes is visibly different than that of SMA codes. Level II and III codes are most easily distinguished by a structure of 5-digit alphanumeric codes beginning with an alpha character and followed by four numerals. Level II or III can further be identified by the value of the beginning alpha character. Level III codes begin with a W through Z. All other alpha values denote Level II codes. SMA codes are 5-digit numeric codes consisting of a 4-digit numeric code defined by Title 22, and preceded by a zero to fit into the computer systems five-byte procedure code field. There was no need to establish separate procedure type codes. The conversion was handled on the Procedure Code Master File (RF-F-070) by end-dating the SMA codes, effective November 28, 1992 (allowing a 60-day grace period for billing), and begin-dating the Level II and III codes valid at that time effective October 1, 1992.

HCPCS codes (Levels I, II and III) are deleted, revised, or added annually by the American Medical Association (AMA) and HCFA. Each annual update requires an SDN to identify and change affected programs and reports in CA-MMIS. To assist in completing the SDN, the Contractor and DHS cooperatively developed a process manual specifically for the annual HCPCS update. The annual update affects the Procedure Code Master File (RF-F-070) due to the number of new codes being added, definitions being changed, and old codes that require a change to an obsolete or non-benefit status.

2.3.2 Anesthesia Codes

In May 1998, Medi-Cal adopted the CPT-4 method of billing anesthesia. Prior to that time, Medi-Cal required using a combination of the procedure code for the service rendered and a procedure modifier indicating anesthesia. OIL #355-97 contained the directive to adopt the CPT-4 anesthesia billing codes and to discontinue using the procedure code and modifier method. Although the CPT-4 anesthesia codes had previously existed on the Procedure Code Master File (RF-F-070), they had been in a non-benefit status.

The Procedure Code Master File (RF-F-070) was updated to convert the anesthesia records for the CPT-4 anesthesia codes to a benefit status and to convert the anesthesia records for surgery, radiology, pathology, and medicine services to a non-benefit status, effective May 1, 1998.

2.3.3 Vaccines for Children

Effective for dates of service on or after June 15, 1995, OIL #133-95 - VFC Program, dated April 27, 1995, established a program within CA-MMIS under which federally-purchased vaccine is supplied to physicians free of charge to administer to eligible children under the age of 19. The VFC codes reimburse providers for the administration of the vaccine only, since the vaccine is provided free from the Federal government. The Medi-Cal billing codes for injections (non-VFC, for vaccine plus administration costs) require justification of medical necessity if the recipient is 18 years of age or younger. Justification is limited to vaccine shortage, disease epidemic, vaccine delivery problems, or circumstances where the beneficiary does not meet the special conditions of the VFC special order vaccines. Providers who wish to receive free vaccine must enroll in the VFC program, even if they are already enrolled as Medi-Cal or Child Health and Disability Prevention (CHDP) providers. The fact that a provider is not enrolled in the VFC program is not acceptable justification. Medi-Cal reimburses providers for the cost of medically necessary vaccines, not covered by VFC, that are administered to Medi-Cal eligible children.

VFC procedure codes fall into the Injection code series (X) of Level III HCPCS codes used by Medi-Cal. OIL #277-95 was written in response to the Budget Act of 1995, Assembly Bill 903, which mandated an increase in the Medi-Cal reimbursement rates for the administration of vaccines. There are many other injection codes, which are not vaccines, that will continue to be unchanged at the administration fee rate of $4.46. This creates a system problem, because most of the injections (vaccines and non-vaccines) have a conversion indicator (data element 1552) of 30. Conversion factor 30 allows one administration fee reimbursement and automatically subtracts the fees out on multi-units of service. Currently, all injections that are hard coded in the logic under conversion factor 30 have the same reimbursement for the administration fee. SDN 6005 - Medi-Cal Rate Increase For Administration of Vaccines, dated March 26, 1996, was submitted to the Contractor to authorize system changes.

Due to a delay in implementation of SDN 6005, OIL #215-96 was issued to make immediate, but temporary, system changes to allow implementation of the intent of OIL #277-95. VFC codes with a Pend/Deny Indicator (Data Element 1508) of U, P, or O, were reassigned to a conversion indicator of 9 (fixed rate) instead of 30. The increased administration fee for vaccines was added to the price (data element 1505) for the procedure code, however, with conversion indicator 9, the system would not automatically subtract the administration fee out on multi-units of service. VFC codes being billed with multi-units of service will either suspend with the error code appropriate for the Pend/Deny indicator, or be automatically cutback to the Max UVS quantity on file.

The various age and policy limitations for VFC codes are controlled through the Minimum and Maximum Age indicators, and/or the Pend/Deny indicators as instructed in the OIL(s).

Effective for dates of service on or after September 22, 2003, VFC procedure codes are billed with the following CPT procedure codes:

90632	**90646**	**90659**	**90703**	**90713**	**90723**
90633	**90647**	**90669**	**90705**	**90716**	**90743**
90634	**90648**	**90700**	**90706**	**90718**	**90744**
90636	**90657**	**90701**	**90707**	**90720**	**90746**
90645	**90658**	**90702**	**90712**	**90721**	**90748**

Some procedure codes can be billed by Non-VFC providers for recipients who are 19 years of age or older. Tthe VFC provider indicates that they are billing for VFC-supplied vaccines by submitting the procedure code with Modifier SL (State Supplied). Claims submitted without the SL modifier, for recipients 19 years of age or older, will be paid using the price on file. Claims submitted without the SL modifier for recipients under the age of 19 will require medical necessity justification. Justification is limited to vaccine shortage, disease epidemic, vaccine delivery problems, or circumstances where the beneficiary does not meet the special conditions of the VFC special order vaccines. Claims submitted with the SL modifier for recipients under the age of 19 will be paid using the administration fee for VFC.

2.4 Drug Codes (Injections) on File RF-F-070

RFP Section 3.5.2.3 (37) requires the Contractor to update prices for injection codes based on wholesale price changes. The Contractor is to notify DHS of any changes.

2.4.1 Drug Price Change Process

Injection codes are identified by procedure type I, and begin with an X. Prices for injection codes are based on the Average Wholesale Price, less 5 percent (AWP5%), for a National Drug Code (NDC) representative of the injection drug. The Change Support data file analyst works with the Contractor's pharmacist consultant to determine if any price changes have occurred. The pharmacist consultant determines the representative NDC appropriate for the injection code. The Pharmacist bases the representative NDC on cost, availability, pharmacological properties, and other factors deemed important.

The CS data file analyst contacts the pharmacist consultant to request updates to drug prices on the Procedure Code Master File (RF-F-070). The pharmacist consultant responds with a list of the X codes and their corresponding representative NDCs. The CS analyst obtains the current AWP-5% cost from the Medi-Cal Formulary File, and calculates the Procedure Code Master File (RF-F-070) price at the NDC AWP-5% plus a $4.46 administration fee. If any of the NDCs have had a change in the AWP-5% price, the CS analyst updates the affected X codes on the Procedure Code Master File (RF-F-070) with the new calculated amount. The pharmacist consultant approves the injection code price changes prior to updating.

Following update of the Procedure Code Master File (RF-F-070), the CS analyst submits a letter to DHS documenting the updates applied.

To facilitate the process, a matrix of the NDC code to X code is maintained. The matrix contains at a minimum: the NDC, the drug name, the X injection code, the current Procedure Code Master File (RF-F-070) price, the AWP, the AWP-5% + $4.46, and a notation as to whether the price changed. This matrix, although not required, is useful in establishing an audit trail for prices that have changed and to set a starting point for the next month's drug price update process.

2.4.2 Obsolete Injection Codes

An obsolete injection code is defined as a product that has not been sold by any manufacturer in the form identified by the descriptor for two years or more. In order to maintain a current listing of HCPCS Level III (California only) injection codes, the Contractor adheres to the following procedures when an obsolete injection code is identified.

When the Contractor's pharmacist, physician, or other staff identifies an obsolete code, it is forwarded to the Contractor's pharmacist consultant for review. The Contractor's pharmacist consultant researches the code, and if it is appropriate to delete it, the pharmacist submits the information to the Change Support data file analyst. The CS analyst formally transmits the recommendation to DHS that the obsolete code be placed in a non-pay status. If DHS concurs, they transmit an OIL to make the necessary Procedure Code Master File (RF-F-070) changes.

Section 3 - Procedure Code Master File (RF-F-070) Update Procedures

The CA-MMIS Procedure Code Master File (RF-F-070) contains procedure billing codes for provider's to use when submitting claims for reimbursement of services rendered. On October 1, 1992, Medi-Cal converted to using Health Care Financing Administration's Common Procedure Coding System (HCPCS) codes to comply with federal requirements.

The HCPCS coding system consists of three levels:

- Level I-Current Procedural Terminology, 4th Edition (CPT-4) codes for physician Services.
- Level II-National codes for supplies, materials, and non-physician services.
- Level III-Local codes specific to California not covered by Level I or II.

File RF-F-070 can only be updated when an OIL is initiated by DHS, with the exception of drug prices for injection codes. DHS is notified monthly of any drug price updates.

The Procedure Code Master File (RF-F-070) transaction process begins with DHS OILs, or drug price updates, and ends when the appropriate transactions are applied to the file and verified by control reports. Figure 3.1 depicts the Procedure Code Master File (RF-F-070) transaction process.

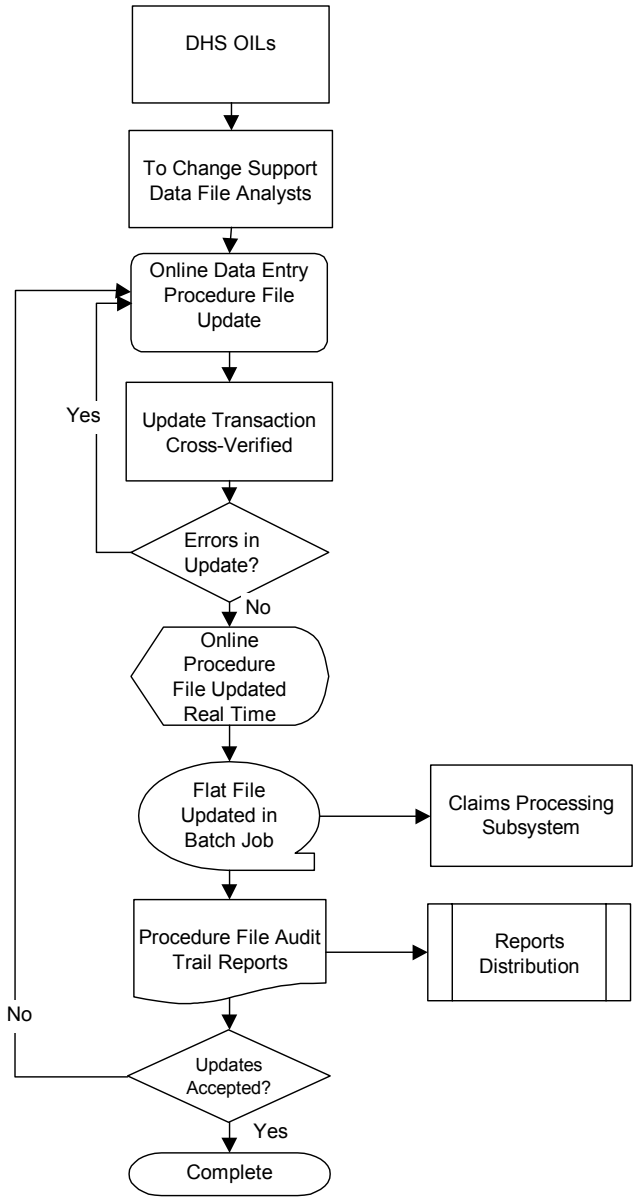

Figure 3.1 - Procedure Code Master File (RF-F-070) Transaction Process

3.1 Input Transactions

Updates to the Procedure Code Master File (RF-F-070) are controlled through three update screens. The Procedure Update Entry Selection Screen (RSF580) allows the user to access the Procedure Update Main Detail Screen (RFS582) and the Procedure Update Occurrences Screen (RSF584). The update screens allow users to add procedure records to File RF-F-070, change records already on the file, or delete records, depending on the selection chosen at the entry selection screen. The Procedure Code Master File (RF-F-070) Multiplier Table is updated through the Procedure Update Multiplier Table Screen (RFS590). Refer to Section 3.3 for information concerning online updates to the multiplier table. These screens are not inquiry options and should not be used for that purpose. Screens that display the same information as the update screens, but which inhibit input, are available for inquiry purposes.

The Procedure Code Master File (RF-F-070) is updated with information received from OILs. In most cases, the OIL transmits the Procedure File Update Form (refer to Figure 3.2), which contains the relevant information currently on the file and the proposed changes and/or additions to the information. In some cases involving a large number of Procedure Code Master File (RF-F-070) changes, the OIL will transmit a list of affected procedure codes and the specific data element changes desired.

Stringent data control procedures are applied to all data input to the update screens. An analyst who did not originally enter the input data cross-verifies the data to ensure accuracy. The system edits all input before updating the Procedure Code Master File (RF-F-070). If any errors are present, they are highlighted and the file is not updated. Change Support (CS) personnel review update audit reports daily to ensure that the correct data was applied to File RF-F-070.

The analyst should update SYSIN MCW309P with any new lab panel codes added to File RF-F-070.

Header Fields

1 PROCEDURE CODE MASTER FILE (RF-F-070) UPDATE

*Change ☐ Add ☐ Delete ☐ *Effective Date: 2 _____ End Date: 3 _____

*Procedure Code: 4 _____ Description: 5 _____

Taxable: ☐ *Update 1560 Table if checked.*

Detail Fields

		Current Information		Proposed Information
1.	Procedure Type(s)		*Required*	
2.	Sex Restriction			
3.	Minimum Age-from-to			
4.	Maximum Age-from-to			
5.	Asterisk (*) Indicator			
6.	Admit Indicator			
7.	Third Party Liability			
8.	EPSDT			
9.	Family Planning			
10.	80% Cutback Indicator			
11.	NMP Indicator			
12.	Maximum Period/UVS		*G, W, M = Block Bill*	
*13.	Conversion Indicator			
*14.	Unit Date From			
15.	Unit Date To			
*16.	Basic Unit Value			
+17.	Price		*Assigned by System*	
18.	Rental From Date			
19.	Rental Thru Date			
20.	Rental P/D Indicator	(not currently in use)		(not currently in use)
21.	Rental Fee			
22.	Service Date	(not currently in use)		(not currently in use)
23.	Service Period		*Use 959 Table*	
24.	Service Frequency		*Use 959 Table*	
25.	Service Limit		*Use 959 Table*	
+26.	Service Error	completed by EDS	*EnterE/C if known*	completed by EDS
27.	Follow-Up Days			
28.	Split Bill	*Update 384 table*	*modifiers 26, TC,ZS*	
+29.	Diagnosis Error	completed by EDS		completed by EDS
30.	Indicator Specific Date			
31.	Pend/Deny Indicator			
32.	ER Indicator			
33.	TAR Indicator		*4 =Update 1355 table*	
34.	I/E Place of Service		*List place of svc codes*	
35.	I/E Range Indicator			
36.	Diagnostic Range From		*Up to ten DX ranges*	
37.	Diagnostic Range To		*are available*	
38.	LAB			
39.	Specialty Ranges	(not currently used)		(not currently used)

*Required for any change.

+Completed / Assigned by Change Support/ System

PDF USE ONLY

REC'D ON:

DATE OF INPUT: OPERATOR ID:

VERIFIED ON: VERIFY OPERATOR ID:

g:\forms\procfile.wpw

Figure 3.2 – Procedure Code Master File (RF-F-070) Update Form

3.1.1 Procedure Update Entry Selection Screen (RFS580)

This subsection describes the fields on the Procedure Update Entry Selection Screen (RFS580). The following Procedure Code Master File (RF-F-070) update selections are available:

1. Add a procedure
2. Change a procedure
3. Delete a procedure

For add and delete selections, all fields on the entry selection screen must be completed before an update screen can be accessed. These fields include the selection type and the procedure key, composed of the procedure type and procedure code. The procedure type entered must be valid: (Refer to section 3.1.2-Procedure Update Main Detail Screen (RFS582) for a list of valid procedure types.)

For an example and a complete description of Screen RFS580, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen RFS580 Field Descriptions:

(1) Selection Code:

Selection Code 1: Enter this selection code to add procedure codes to the Procedure Code Master File (RF-F-070).

Selection Code 2: Enter this selection code to change procedure codes already on the Procedure Code Master File (RF-F-070).

Selection Code 3: Enter this selection code to delete procedure codes already on the Procedure Code Master File (RF-F-070). Enter this selection code to delete procedure records from the master file. If the wrong procedure code is entered accidentally, the entire procedure record is deleted and must be recreated with an add (Selection Code 1) transaction.

Note: Procedure codes should be deleted from the Procedure Code Master File (RF-F-070) only when they were entered erroneously, and then only when no claims have been paid with the erroneous code. If a procedure code is not acceptable for Medi-Cal billing, it should be end-dated with the appropriate Pend/Deny indicator instead of being deleted from the file.

3.1.2 Procedure Update Main Detail Screen (RFS582)

This subsection describes the fields on the Procedure Update Main Detail Screen (RFS582). Where applicable, related error codes are indicated for the field. The word *required* next to any field description means that the information must be entered to complete the field--there is no default value.

For an example and a complete description of Screen RFS582, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen RFS582 Field Descriptions:

1) Procedure Type (1503)--*Required*:

This field classifies procedures into distinct procedure groups. It is carried over from the entry selection screen. Valid procedure types and their descriptions are listed below.

Code	Description	The related error codes are 424 and 415
A	LA County	
B (Not in use; see O)	Assistant Surgeon	
C (Not in use; see P)	Podiatrist	
I	Injections	
J	Anesthesia	
K	Surgery	
L	Radiology	
M	Pathology	
N	Medicine	
O	Assistant Surgeon	
P	Podiatrist	
S	ICD-9 volume 3	
1	HCPCS/SMA	
2 (Not in use; see I)	Injections	
3 (Not in use; see N, K)	Ophthalmology	
4	Cost Centers	
5 (Not in use; see J)	Anesthesia	
6 (Not in use; see K)	Surgery	
7 (Not in use; see L)	Radiology	
8 (Not in use; see M)	Pathology	
9 (Not in use; see N)	Medicine	
0	Other	

2) Procedure Code (0500)--*Required*:

This field is carried over from the entry selection screen. There are five types of procedure codes:

1. The first type on the Procedure Code Master File (RF-F-070) is CPT-defined. CPT procedure ranges are 00100-01999, and 10000-99999. The CPT-4 is equivalent to HCPCS Level I. These codes were effective 11/01/87.

2. The second type of procedure code on the Procedure Code Master File (RF-F-070) is CSN-defined. The CSN procedure code range is 10000-99999. These codes became obsolete 10/31/87.
3. The third type of procedure code resides in Title 22, California Code of Regulations (CCR), and is defined as an SMA. SMAs are four-digit numeric codes. Since the procedure code field is five bytes, the field is right justified with a zero to the left. SMAs that are Medi-Cal benefits are discussed in Section 2 of this manual. These codes became obsolete 10/01/92.
4. The fourth type of procedure code was imposed on State Medicaid Management Information Systems and is defined as HCPCS Level II and III. These codes, which replace SMA and Medi-Cal only codes, are used to bill for dates of service on or after l0/01/92. HCPCS codes are four-digit numeric, prefixed by an alpha character.
   - Level II HCPCS procedure codes are A0001-V9999.
   - Level III HCPCS procedure codes are W0001-Z9999.
   - Medi-Cal allowed codes are X and Z prefixes only.
5. Finally, with DHS approval, the Contractor defines a small number of procedure codes to facilitate manual pricing and automated claims adjudication. These codes consist mainly of injection codes and miscellaneous items.

   The related error codes are 0400, 0403, 0415, and 0424.

3) Medicare Code (0532):

Reflects a preliminary structure of Medicare codes payable by the Medi-Cal program. The field's default value equals the procedure code.

4) Last Activity Date (0552):

A system-generated date indicating when changes were last made to the Procedure Code Master File (RF-F-070) record.

5) Procedure Name (0510):

Procedure name is a free form, forty-byte, alpha field containing a description of the procedure. The procedure name reflects the description in the CPT/HCPCS/Title 22.

Medi-Cal only CPT-4 look-alike five-digit numeric codes were translated into codes within the HCPCS system and the obsolete codes were placed in deny status on the Procedure Code Master File (RF-F-070). However, since the HCPCS conversion in 1992, CPT-4 (Level 1) codes have been activated by HCFA that use a five-digit numeric code that was previously a Medi-Cal only code before the conversion. Although the code number is re-activated, it is not the same service, creating potential for confusion. When the Contractor updates the File RF-F-070 for a description change, an Asterisk/Year descriptor identifier is used before the name to indicate it was previously a Medi-Cal only code.

6) Effective Date (0551)--*Required*:

The effective date is the date on which the procedure becomes an active code of the Medi-Cal program. The date format is YYMMDD.

7) Ending Date (0528):

The ending date is the date on which the procedure ceases to be an active code of the Medi-Cal program. The date format is YYMMDD.

The default is 691231 for all transactions. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

8) Sex Code (0524):

Indicates sex restrictions:

Code	Description
M	Restricted to males
F	Restricted to females
B	No restrictions

The default is B (no restrictions). The related error codes are 0401, 0404, and 0425.

9) Minimum Age (0525):

Establishes the minimum age of a beneficiary upon whom the procedure is performed. Input as a whole figure equivalent within the range of 01 to 98.

The default is 00.

10) Maximum Age (0537):

Specifies the maximum age of a beneficiary upon whom the procedure is performed. Input as a whole figure equivalent within the range of 01 to 99. The maximum-free restrictions may not be less than the minimum age. Codes 00 and 99 for the minimum and maximum ages (respectively) indicate there are no age restrictions. A claim for a recipient who is 100 or more years old will suspend for Error Code 0426, which will be overridden by the examiners.

The default is 99. The related error codes for minimum and maximum age are 0411 and 0426.

11) Asterisk (*) Indicator (1514):

Indicates those procedures defined in the CPT/CSN as star or asterisk procedures which are surgical codes that do not include the associated pre-op and post-op services. An asterisk enables providers to be reimbursed for the pre-op and post-op services.

Code	Description
*	Is an asterisk procedure
‘ ‘ (blank)	Is not an asterisk procedure
The default is blank.	A related error code is 949.

Note: If an asterisk is entered and later needs to be removed, enter a space. The system will store a blank on the file.

12) Admit Type (1519):

Defines a procedure as to the type of admission.

Code	Description
1	Emergency

2	Elective
3	Delivery
4	Newborn

The default is blank. The related error codes are 0402 and 0405.

13) TORT Liability (0585):

Third Party Liability indicator.

Code	Description
Y	Procedure is defined as third party by DHS
N	Not third party

The default is N. When this indicator is set to Y, claims bearing the procedure code will be reported on the Report CP-O-004B.

14) EPSDT (0588):

Indicates which procedures are defined as Early/Periodic, Screening, Diagnosis and Treatment (EPSDT).

Code	Description
Y	Procedure is defined as EPSDT related by DHS
N	Not EPSDT

The default is N. This indicator affects Reports MR-O-160/162, and the CHDP Extract Files (MR-F-589/590). This indicator has no connection to the EPSDT public health program.

15) Family Planning (0589):

DHS defines some procedure codes as family planning related.

Code	Description
Y	Family planning related
N	Not family planning related

The default is N.

16) 80 Percent Cutback Indicator (0580):

This field indicates cutbacks to certain procedures, determined by the place where service was rendered (80% reimbursement for common office procedures).

Code	Description
1	80% cutback if POS is 23 or B (Emergency Room), or 22 or 5 (Outpatient Hospital)
0	100% Reimbursement

The default is 0.

17) NMP Indicator (1524):

Indicates whether a non-medical practitioner may perform the procedures.

Code	Description

Y	May be performed by a non-medical practitioner
N	Not available to a non-medical practitioner

The default is N. The related error code is 0460.

18) MAX Period (0571):

The period of time for maximum units.

Code	Description
D, 0, 9	Daily
W	Weekly (must be block billed)
M	Monthly (must be block billed)
S	Single Service (cannot be block billed) - default
G	Global Services (must be block billed)
	(applies only to procedure types K/6 - SDN 6006)
The default is S.	The related error codes are 0410 and 0470.

19) Maximum Units (0566):

The maximum number of units, visits, or studies per UVS period that may be reimbursed under the particular procedure. Values range from 00 to 99.

The default is 99. If the claim is from/thru (block) billed, the system will allow the maximum value times the number of days billed. For example, if the max value = 2 and the claim bills two days (such as, 8/11/99-8/12/99), the system will allow a quantity of four.

The Max Period and Maximum units are used in conjunction with the Pend/Deny indicator. If the Pend/Deny indicator is zero (0), an original claim will be cutback by the system if billing over the maximum unit amount for the MAX Period. If the Pend/Deny indicator is a U, original claims billing over the maximum amount will suspend for Error Code 0409. All resubmissions and adjustments suspend for Error Code 0409 if billing over the maximum amount.

20) Conversion Indicator (1552)--*Required*:

Directs the system to the proper method for calculating the payable amount for the procedure. Refer to CA-MMIS Table 0215 (Provider Specialty and Type Restrictions) for associated procedure codes. (Request Report RF-O-401 through the online report-request option to obtain a listing of this table.)

Conversion Indicator

Code	Description
* 1	Medicine 1 - Primary Care
2	Anesthesiology
3	Surgery 1 - OB Care
4	Surgery 2 - Other Surgery
5	Radiology
6	Pathology

*7	Other Medicine
8	No Pricing Factor - Review
9	Fixed Price
10	Podiatry Radiology
* 11	Community Clinic 1 - Primary Care
* 12	Community Clinic 2 - Other Medicine
13	Nurse Anesthesia
14	Surgery 3 - Abortion
15	Podiatry Surgery
16	Surgery 4 - Gyn Care
17	Medical Emergency
18	Surgery Emergency
19	Podiatry Medicine
20	Surgery 5 – Abortion
* 21	Clinic Surgery 5
* 22	Clinic Medicine 1 - Primary Care
* 23	Clinic Medicine 2 - Other Medicine
* 24	Clinic Surgery 1 - OB Care
* 25	Clinic Surgery 2 - Other Surgery
* 26	Clinic Surgery 3 - Abortion
* 27	Clinic Surgery 4 - Gyn Care
28	Clinic Anesthesia
* 29	Clinic Radiology
+ 30	Injections (Procedure type I)
* 31	Well Child Exams
* 32	Well Child Exams (Free/Comm)
* 33	Well Child Exams (Other clinic)
* 34	Comprehensive OB
35	Non-Clinic Abortion
* 36	Clinic - Abortion
37	Anesthesiology - OB Physician
38	Anesthesiology - OB Nurse
39	Anesthesiology - OB Clinic
40	Non-Clinic - OB/Gyn Care
* 41	Clinic - OB/Gyn Care

42	Fixed Price
01	Primary Care 1
11	Community Clinic Primary Care 1
22	Community Clinic Primary Care 1
*43	Community Clinic Primary Care 1 (age 0-17)
*44	Community Clinic Primary Care 1 (age 0-17)
*45	Primary Care 1 (age 00-17)
*46	Podiatry Primary Care 1 & 2 (age 00-17)
*47	Community Clinic Primary Care 2 (age 00-17)
*48	Community Clinic Primary Care 2 (age 00-17)
*49	Primary Care 2 (age 00-17)
*50	Community Clinic Primary Care 2
*51	Community Clinic Primary Care 2
52	Podiatry Primary Care 1 & 2
53	Primary Care 2
54	Tubal Sterilization
*55	Clinic Tubal Sterilizations
56	(No description available)
57	(No description available)
58	ICD9 Vol 3 Procedure Code

* These indicators are used in conjunction with CA-MMIS Table 0215 to calculate reimbursement for specific provider types.

+ Conversion Indicator 30 should be entered only on injection records that are eligible for administration fees. The initial administration fee for injections should be added to the Unit Price on file. The system will calculate reimbursement and cut back the administration fees when the quantity exceeds one.

21) Unit Date From (1500):

Date the procedure Unit Value is effective. The system can store up to 7 occurrences for Unit Date From. The date format is YYMMDD.

The default is the effective date.

22) Unit Date To (1501):

Date the procedure Unit Value ends. Up to 7 Unit Date To occurrences are kept on file. The date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

23) Basic Unit Value (1502):

Contains the unit value or fixed-price amount corresponding to the Conversion Indicator. The unit value times the Conversion Indicator determines the Medi-Cal allowable

amount for the procedure in most circumstances. Multipliers defined in the Conversion Indicator determine pricing calculations.

The amount is entered right-justified, zero filled to the left. There is an implied decimal between the second and third bytes, counting from the right.

Example:

Unit value 5.83 would be entered as:

BYTE# 7 6 5 4 3 2 1

0 0 0 0 5 8 3

24) Price (1505):

The price field is system-generated. Input is prohibited. It defines the Medi-Cal allowed amount for the procedure. It is determined by multiplying the dollar conversion stated in Title 22 and defined in Data Element (DE) 1522 (Conversion Indicator - field 20) times the basic Unit Value (DE 1502 - field 23).

The related Error Codes are 0412, 0413, and 0421.

25) Rental Date From (1511):

The beginning effective date of the rental amount. The date format is YYDDMM.

The default is the effective date.

26) Rental Date To (1512):

The ending effective date of the associated rental amount. The date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

27) Rental Pend/Deny Indicator (1551): (Not in use)

Rental Pend/Deny Indicators are associated with Durable Medical Equipment (DME) and Prosthetics and Orthotics (P&O).

Code	Description
S	Suspend if billed amount is over calculated file price
D	Deny claim - not a covered benefit
M	Manual Review (such as, not medical review)
O	Default - no suspension or denial is applicable

28) Rental Fee (1513):

Rental fees reside in Title 22 and are associated with Durable Medical Equipment (DME) and Prosthetics and Orthotics (P&O). Rental rates are fixed-priced and entered right justified, zero filled to the left. An implied decimal resides between the second and third bytes, counting from the right.

Example:

Rental rate $20.21 would be entered as:

BYTE# 7 6 5 4 3 2 1

0 0 0 2 0 2 1

29) Service Date: (Not in use)

This field is currently not used. Input is prohibited.

30) Service Period (0562):

Defines limitations in years and months within which a given number of occurrences of a procedure are allowed. The format is YMM.

Code	Description
Year (Y)	
0	0 Years
1-8	1-8 Years
9	Forever
Month (MM)	
00	0 Months
01-11	1-11 Months
The default is 00.	This field should not be used.

31) Service Frequency (0563):

Indicates the number of times a procedure may be reimbursed within a given period. Code whole figure equivalent between 01 and 99.

The default is 00. This field should not be used.

32) Service Limit (0565):

Used by the system conjunction with service edits.

Code	Description
1	Dental - Bypass site-code check
2	Dental - Do not bypass site-code check
3	Apply service limit edit to different providers
4	Service limit edits only apply to the same provider
The default is 0.	This field should not be used.

33) Service Error Number (1520):

The associated error number applied if the service limitations are violated. Error numbers are defined by the Change Support unit.

The default is 0000. This field should be used for informational purposes only to reference the combination audit number assigned to the procedure code.

The Service Period, Service Frequency, Service Limit, and Service Error Number fields work in conjunction to establish service frequency limitations. When used, this feature carries the Service Error Number on the claim record into the weekly cycle to audit against history claims. This feature is limited in scope, however, as it looks backward only at history claims (such as, it looks for conflicting claims with older dates of service

than the current claim date of service and does not look for newer dates of service.) Service limitations should be applied through the use of the 0959 table only.

34) Follow-Up Days (1515):

The number of days after a surgical procedure that are considered included in the reimbursement for the surgery. Field is right-justified, zero filled to the left.

The default is 000. The related error code is 0949.

35) Split Bill (1507):

The percentage allowable for professional component. The figure must be entered right-justified, zero filled. Percentages are defined by DHS policy. There is an implied decimal between the third and fourth bytes, counting from the right.

The default is 0000. This field is accessed when claims are billed with a Professional Component or Technical Component modifier. CA-MMIS Table 0384 controls modifiers.

36) Diagnostic Error No. (1521):

Depicts the error number assigned by the Change Support unit if the diagnostic ranges (DE 1517 and 1518 - fields 43 and 44) are violated. Right-justified, zero filled to the left.

The default is 0000. The most commonly related Error Codes are 0418, 0444, and 0478, however any error code number entered in this field would be assigned to the claim.

37) Indicator Specific Date (1523):

The Date of Service (DOS) for the following indicators (fields 38 through 41): Pend/Deny, ER/POS, TAR, POS. The date format is YYMMDD.

The default is the effective date.

38) Pend/Deny Indicator (1508):

Procedures that should be suspended for manual review or denied as non-covered benefits are flagged with this indicator. The indicator is DOS specific.

Code	Error Code (s)	Description
P	0434	Pend for Medical Review
S	0413	Suspend if billed amount is over calculated file price
D	0431, 0479, 0482	Deny claim - not a covered benefit
*T	0467	Deny - Obsolete code
M	0427	Manual Review (i.e., not Medical Review)
R	0416	X-Over correlation procedures only
U	0409	The code will not be subjected to the automated MAX UVS cutback
0		Default - No suspension or

denial is applicable

*When a code becomes obsolete, enter the effective date the code terminates, then click PF12, to age the entry, leaving the history trail.

39) Emergency Indicator (0579):

Directs the system to the proper Conversion Indicator to use if the Place of Service (POS) is Emergency Room (ER). The indicator is DOS specific.

Code	Description
1	If POS is B or 23 (ER) use ER medicine or Surgical conversion factor; Otherwise use non-ER factor
0	Use non-emergency conversion factor no matter What POS

The default is 0.

40) TAR Indicator (0555):

Indicates procedures requiring a Treatment Authorization Request (TAR), or MEDI reservation. The indicator is DOS specific.

Code	Description
0	No TAR or Medi Service Reservation required
1	Medi Service Reservation or TAR required
2	Medi Service Reservation only required
3	TAR only required
4	Refer to MMIS Table 1355 for TAR/ Medi requirement

The default is 0. The related Error Codes are 0440, 0439, and 0430 for values 1, 2, and 3 respectively. The related Error Codes are 0432, 0433, 0435, 0436, 0441, 0442, and 0446 for value 4, as defined by CA-MMIS Table 1355.

41) POS I/E Indicator (0578):

This seven-byte field shows valid or invalid Place of Service (POS) codes for this procedure. The Procedure Master File can hold a maximum of 105 POS codes at a time. The first byte is an alpha Inclusive/Exclusive indicator, I or E:

I = Inclusive - This procedure is payable only when billed with the POS codes listed in bytes 2 through 7. Claims billing this procedure with POS codes other than those listed suspend under Edit 465.

E = Exclusive -This procedure is not payable when billed with the POS codes listed in bytes 2 through 7. Claims billing this procedure with these POS codes suspend under Edit 465. If procedure is billed with POS codes other than those listed and no other errors are present, the claim is paid automatically.

The related Error Codes are 0465 and 0450.

The next six bytes are the alpha/numeric POS codes that either must be present (I) or cannot be present (E) on the claim. Valid POS codes and their descriptions are listed below.

Code	Description
1	Office
2	Home
3	Inpatient Hospital
4	Skilled Nursing Facility (SNF)
5	Outpatient Hospital
6	Independent laboratory
7	Other
8	Independent Kidney Treatment
9	Clinic
A	Surgery Clinic
B	Emergency Room
C	Intermediate Care Facility (ICF)
D	Extended Care Facility (ECF)
E	Rehabilitation Center
F	Subacute Care Facility
G	ICF-DD
H	ICF-DDH
I	ICF-DDN

Code	Description
11	Office
12	Home
21	Inpatient Hospital
31	Skilled Nursing Facility (SNF)
22	Outpatient Hospital
81	Independent Laboratory
41	Ambulance - Land
42	Ambulance – Air or Water
55	Residential Substance Abuse Treatment Fac.
62	Comprehensive Outpatient

	Rehabilitation Fac.
99	Other
65	End Stage Renal Disease
25	Birthing Center
53	Community Mental Health Center
71	State or Local Public Health
72	Rural Health Clinic
24	Surgery Clinic
23	Emergency Clinic
32	ICF
91	Subacute
92	ICF-DD
93	ICF-DDH
54	Intermediate Care Facility-Nursing/Mentally Retarded

3.1.3 Procedure Update Diagnosis Screen (RFS585)

This subsection describes the fields on the Procedure Update Diagnosis Screen (RFS585). When the user presses PF6 on the Procedure Update Main Detail Screen (RFS582), Screen RFS585 displays.

The occurrence fields carry the Include/Exclude indicator for the diagnosis codes, the beginning diagnosis range, and ending diagnosis range. The maximum number of occurs is 70.

For an example and a complete description of Screen RFS585, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen RFS585 Field Descriptions:

1) Diagnosis Range Indicator (1516):

This field is required if diagnosis range is entered. Values are space, 'I' Include diagnosis, and 'E' Exclude diagnosis range.

The ranges defined by Data Elements (DE) 1517 and 1518 (fields 2 and 3, respectively) are defined either as Inclusive or Exclusive. Inclusive indicates Medi-Cal pays this procedure only when billed with a diagnosis within the ranges defined by DE 1517 and DE 1518. Exclusive indicates Medi-Cal pays this procedure when billed with any diagnosis except those defined by DE 1517 and DE 1518. DE 1517 and DE 1518 require a range indicator.

Up to 70 diagnosis ranges can be coded. The codes do not need to be entered in consecutive order. Do not leave blank spaces between valid ranges. Blank spaces may cause the system to stop at the first blank space and not see subsequent diagnosis ranges.

Code	Description
I	Inclusive
E	Exclusive

The default is 99999. The related error code(s) are determined by the value present in the Diagnostic Error Number (D.E. 1521).

2) Diagnosis Range From (1517):

The beginning diagnosis code for the particular range, entered left-justified, blank filled to the right. The decimal is not coded and zeroes and spaces are significant.

The default is blank.

3) Diagnosis Range Thru (1518):

The ending diagnosis code for the particular range, entered left justified, blank filled to the right. The decimal is not coded and zeroes and spaces are significant.

The default is blank. Because spaces are significant, the system will read the diagnosis range only as far as the ending diagnosis has been entered. It will not assume a four-digit diagnosis code is intended to extend to the fifth digit. For example:

Range on File	653 - 6561	V726 – V726	409- 40999	250 - 2500
Code Included in Range	653, 6530, 65300, 6561	V726	409, 4091, 4092, 40990, 40999	250, 2500
Code **Not** Included in Range	65299, 65610, 65619, 6562	V725, V7261, V7269	408, 410	2501, 25000, 25001

3.1.4 Procedure Update Occurrences Screen (RFS584)

This subsection describes the fields on the Procedure Update Occurrences Screen (RFS584). The occurrence fields carry pricing dates, units, and prices for dates of service previous to the most current price data (found on the Procedure Update Main Detail Screen), Pend/Deny indicators, and fees associated with rental of the item, Lab codes, and Specialty indicators. The word required next to any field description means the information must be entered to complete the associated field--there is no default value.

For an example and a complete description of Screen RFS584, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen RFS584 Field Descriptions:

1) Procedure Type (1503):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

2) Procedure code (0500):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

3) Medicare Code (0532):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

4) Last Activity Date (0552):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

5) Procedure Name (0510):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

6) Effective Date (0551):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited.

7) Ending Date (0528):

This field is carried over from the procedure Update Main Detail Screen (RFS582). Input is inhibited.

8) Conversion Indicator (1552)--*Required*

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen.

Directs the system to the proper method for calculating the payable amount for the procedure. Refer to CA-MMIS Table 0215 (Provider Specialty And Type Restrictions) for associated procedure codes. (Request Report RF-O-401 through the online report-request option to obtain a listing of this table.)

Refer to Section 3.1.2, for a list of conversion indicators and descriptions.

9) Unit Date From (1500)--*Required*:

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen.

Date the procedure unit value is effective. The system can store up to seven occurrences for Unit Date From.

The default is the effective date.

10) Unit Date To (1501)--*Required*:

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen.

Date the procedure unit value ceases to be effective. Up to seven Unit Date-To occurrences are kept on file. Date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

11) Basic Unit Value (1502):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen.

Contains the unit value or fixed-price amount for the procedure code and is used in conjunction with the conversion indicator unit value displayed in field 15 to determine the payable amount for the procedure. Multipliers defined in the conversion indicator determine pricing calculations.

The amount is entered right-justified, zero filled to the left. There is an implied decimal between the second and third bytes, counting from the right.

Example: Unit value 5.83 would be entered as:

BYTE# 7 6 5 4 3 2 1

0 0 0 0 5 8 3

12) Price (1505):

This field is system generated. Input is inhibited. It defines the Medi-Cal allowed amount for the procedure. It is determined by multiplying the dollar conversion defined in DE 1522 (conversion indicator - field 20) times the Basic Unit Value (DE 1502 - field 23).

13) Conversion Type (1522):

This field's initial value is carried over from the Procedure Update Main Detail Screen (RFS582). The field's value can be changed for inquiry purposes: Fields 14 and 15 will display the Conversion Dates From and Unit Values corresponding to the conversion type entered. This option is an inquiry option only; the procedure record is not modified when a different conversion type is entered in field 13.

14) Conversion Date From (1500):

This field's initial value is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited. Field 14 displays the Conversion Date from corresponding to the conversion type displayed or entered in field 13.

15) Unit Value (1502):

This field's initial value is carried over from the Procedure Update Main Detail Screen (RFS582). Input is inhibited. Field 15 displays the Unit Value corresponding to the conversion type displayed or entered in field 13. There is an implied decimal between the second and third bytes, counting from the right.

16) Rental Date From (1511):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen. It contains the beginning effective date of the rental amount. Date format is YYMMDD.

17) Rental Date to (1512):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). This field can be updated at the occurrences screen. It contains the ending effective date of the associated rental amount. Date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

18) Rental Pend/Deny Indicator (1555): (not in use)

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrence screen.

Rental Pend/Deny indicators are associated with durable medical equipment (DME).

Code	Description
S	Suspend if billed amount is over calculated file price
D	Deny claim - not a covered benefit
M	Manual review (such as, not medical review)
O	Default - no suspension or denial is applicable

19) Rental Price (1513):

This field is carried over from the Procedure Update Main Detail Screen (RFS582). The field can be updated at the occurrences screen.

Rental fees reside in Title 22 and are associated with durable medical equipment (DME) and prosthetics and orthotics (P&O). Rental rates are fixed-priced and entered right justified, zero filled to the left. An implied decimal resides between the second and third bytes, counting from the right.

Example: Rental rate $20.21 would be entered as:

BYTE# 7 6 5 4 3 2 1

0 0 0 2 0 2 1

20) Lab Codes (1510):

The lab number for procedures related to certified labs. Lab number is coded right-justified, zero filled to the left.

21) Provider Specialty Ranges (0553):

Not currently used. Up to seven specialty ranges may exist on the file.

3.2 Procedure Code Master File (RF-F-070) Controls

The Procedure Code Master File (RF-F-070) control process begins with verification of all transactions that will be applied to the Procedure Code Master File (RF-F-070). Stringent data control procedures are applied to all data input to the update screens. The system edits all input before updating the Procedure Code Master File (RF-F-070). If any errors are present, they are highlighted, and the file is not updated. CS personnel review update audit reports to ensure that the correct data was applied to the File RF-F-070.

3.3 Procedure Code Master File (RF-F-070) Multiplier Update Procedures

The Procedure Code Master File (RF-F-070) Multiplier Update Transaction Process begins with sources obtained from DHS OILs, SDNs, or Change Orders. The process ends when the appropriate transactions are applied to the Multiplier (conversion) Table and verified through control Report RF-O-05A .

Updates to the Procedure Code Master File (RF-F-070) Multiplier Table are controlled by the Procedure Update Multiplier Table Screen (RFS590). This screen is not an inquiry option and should not be used for that purpose. An inquiry screen that displays the same information as the update screen, but which inhibits input, is available for inquiry purposes. When a Multiplier Table update is run, it should be the only Procedure Code Master File (RF-F-070) update run on that cycle.

Stringent data control procedures are applied to all data input to the update screen. The system edits all input before updating the Multiplier Table. If any errors are present, they are highlighted and the table is not updated. CS personnel review Report RF-O-05A daily to ensure that the correct data was applied to the Multiplier Table.

When the Procedure Code Master File (RF-F-070) Multiplier Table is updated through Screen RFS590, the system adjusts every Procedure Code Master File record that contains a conversion indicator present on the updated multiplier records. The procedure records are modified to conform to the unit value and price entered on the modified multiplier records when the next daily Procedure Master File Batch Update is run.

3.3.1 Procedure Update Multiplier Table Screen (RFS590)

This subsection describes the fields on the Procedure Update Multiplier Table Screen (RFS590).

For an example and a complete description of Screen RFS590, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen RFS590 Field Descriptions:

1) Conversion Indicator:

This field's value is written to the screen from the Procedure Code Master File (RF-F-070). Input is inhibited.

These indicators are used in conjunction with CA-MMIS Table 0215 to calculate reimbursement for specific provider types.

2) Title/Procedure Range:

This field's value is hard coded in the screen program. Input is inhibited. The field displays an English narrative of the procedure code ranges and the provider types applicable.

3) Multiplier:

This field contains the multiplier value associated with the conversion indicator, which is used to determine the payable amount for procedures. Procedure pricing calculations are determined by the procedure unit value and the multiplier defined by the conversion indicator. The system stores up to and displays seven occurrences. Only the field's first occurrence can be modified.

The amount is entered right-justified, zero filled to the left. There is an implied decimal between the second and third bytes, counting from the right.

Example: Multiplier value 2.00 would be entered as:

BYTE# - 7 6 5 4 3 2 1

0 0 0 0 2 0 0

4) Date:

This field contains the date the multiplier value became effective. The system stores up to and displays seven occurrences. Only the field's first occurrences can be modified. Format is YYMMDD.

The RFS590 screen allows the most current multiplier occurrence to be changed, or allows the addition of a new multiplier occurrence.

To change the current occurrence, type over the multiplier value and/or the effective date and press Enter. If the changes are satisfactory, and after they have been cross verified, press PF10 to request an update to all procedure codes that have this conversion indicator.

To add a new occurrence, type over the multiplier value and effective date. DO NOT PRESS Enter. Instead, press PF12 to age the occurrences. Aging the occurrences causes the existing occurrences to move down one line, and inserts the new occurrence as the most current.

3.4 Procedure Code Master File (RF-F-070) Update Form

This subsection describes the fields on the Procedure Code Master File (RF-F-070) Update Form. An asterisk (*) next to any field description means that the information must be entered to complete the field for Adds--there is no default value.

Left marginal numbers, enclosed by parenthesis, refer to circled numbers on the Procedure Code Master File (RF-F-070) Update Form (Figure 3.2) header portion. The line number on the form identifies the fields on the detail portion of the form. DHS uses this form to transmit desired Procedure Code Master File (RF-F-070) updates to the Contractor through an OIL. Entering the field's current-value (from the Procedure Code Master File (RF-F-070) and the field's new (proposed) value complete most fields.

HEADER FIELDS

1) Transaction Type *:

Change:

Used only for those procedure codes already on file where existing information is to be changed. In addition to transaction code, procedure code and procedure type, only the field(s) to be changed need be entered on the form.

Add:

Used only for those procedure codes that are being added to the Procedure Code Master File (RF-F-070). When add is used, all required fields on this update form must be coded. If a required field is not present, the DHS contact must be consulted to determine the correct value.

Delete:

The delete transaction is used to delete records from the Procedure Code Master File (RF-F-070). This is a physical deletion. Any record found to have been deleted in error requires an add transaction to update the file.

2) Effective Date (0551):

The effective date of the procedure or change. Format is YYMMDD.

3) End Date:

(Not currently used.)

4) Procedure Code (0500):

There are five types of procedure codes. Refer to Section 3.1.2 for a detailed discussion of these types. This field is required for all transaction types: adds, changes, and deletes.

5) Description (Procedure Name DE 0510):

A free-form, 40-byte, alpha field containing a description of the procedure. The procedure name reflects the description in the CPT/CSN/HCPCS.

6) Taxable box:

This box is checked only for those procedures subject to California State Sales Tax. When this box is checked, CA-MMS Table 1560 needs to be updated.

DETAIL (LINE) FIELDS

1. Procedure Type (1503):

This field classifies procedures into distinct procedure groups. Valid procedure types and their descriptions can be found in Section 3.1.2. This field is required for all transaction types: adds, changes, and deletes.

2. Sex Code (0524):

Indicates sex restrictions.

Code	Description
M	Restricted to males
F	Restricted to females
B	No restrictions

The default is B.

3. Minimum Age (0525):

Establishes the minimum age of a beneficiary upon whom the procedure is performed. Input as a whole figure equivalent within the range 01 to 98.

The default is 00.

4. Maximum Age (0537):

Specifies the maximum age of a beneficiary upon whom the procedure is performed. Input as a whole figure equivalent within the range 01 to 99. The maximum age restriction may not be less than the minimum age. Codes 00 and 99 for the minimum and maximum ages (respectively) indicate there are no age restrictions. A claim for a recipient who is 100 or more years old will suspend for Error Code 0426, which will be overridden by the examiners.

The default is 99.

5. Asterisk (*) Indicator (1514):

Indicates those procedures defined in the CPT/CSN as a star or asterisk procedure.

Code	Description
*	Is an asterisk procedure

The default is blank.

6. Admit Type (1519):

Defines a procedure as to the type of admission.

Code	Description
1	Emergency
2	Elective
3	Delivery
4	Newborn

The default is blank.

7. Tort Liability (0585):

Third Party Liability indicator.

Code	Description
Y	Procedure is defined as third party by DHS
N	Not third party

The default is N.

8. EPSDT (0588):

Indicates which procedures are defined as Early/Periodic, Screening, Diagnosis and Treatment (EPSDT).

Code	Description
Y	Procedure is defined as EPSDT related by DHS
N	Not EPSDT

The default is N.

9. Family Planning (0589):

DHS defines some procedure codes as family-planning related.

Code	Description
Y	Family planning related
N	Not family planning related

The default is N.

10. 80 Percent Cutback Indicator (0580):

This field indicates cutbacks to certain procedures, determined by the place where service was rendered (80% reimbursement for common office procedures).

Code	Description
1	80% cutback if POS is B (Emergency Room) or 5 (Outpatient Hospital)
0	100% reimbursement

The default is 0.

11. NMP Indicator (1524):

Indicates whether a non-medical practitioner may perform the procedures.

Code	Description
Y	May be performed by a non-medical practitioner
N	Not available to a non-medical practitioner

The default is N.

12. Max Period (0571), Maximum UVS (0566):

The period of time for maximum units.

Code	Description
D, O, 9	Daily (Default value)
W	Weekly
M	Monthly
S	Single Service (cannot be block billed)
G	Global Services (must be block billed)

Maximum Units (UVS).

The maximum number of units, visits, or studies per UVS period that may be billed under the particular procedure. Values range from 00 to 99.

The default is 99.

13. Conversion Indicator (1552):

Directs the system to the proper method for calculating the payable amount for the procedure. Refer to CA-MMIS Table 0215 (Provider Specialty and Type Restrictions) for associated procedure codes. (Request Report RF-O-401 through the online report-request option for a listing of this table.)

Refer to Section 3.1.2, Item 20, for a complete listing of conversion indicators.

Conversion indicator 30 should be entered only on injection records that are eligible for administration fees. The initial administration fee for injection should be added to the Unit Price on file. The system will calculate reimbursement and cut back the administration fees when the quantity has been exceeded.

14. Unit Date From (1500)*:

Date the procedure unit value is effective.

15. Unit Date To (1501):

Date the procedure unit value ceases to be effective. Date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

16. Basic Unit Value (1502) *:

Contains the unit value or fixed-price amount, which determines the payable amount for the procedure. Multipliers defined in the conversion indicator determine pricing calculations.

The amount is entered right-justified, zero filled to the left. There is an implied decimal between the second and third bytes, counting from the right.

Example Unit value 5.83 would be entered as:

BYTE # 7 6 5 4 3 2 1

0 0 0 0 5 8 3

17. Price

This is assigned by the system.

18. Rental Date From (1511):

The beginning effective date of the rental amount. Date format is YYMMDD.

The default is the effective date.

19. Rental Date To (1512):

The ending effective date of the associated rental amount. Date format is YYMMDD.

The default is 691231. Note: Due to year 2000, the default end-date of December 31, 2069 has been established.

20. Rental Pend/Deny Indicator (1551):

Rental Pend/Deny indicators are associated with durable medical equipment (DME) and prosthetics and orthotics (P&O).

Code	Description
S	Suspend if billed amount is over calculated file price

D	Deny claim - not a covered benefit
M	Manual review (such as, not medical review)
O	Default - No suspension or denial is applicable

21. Rental Fee (1513):

Rental fees reside in Title 22 and are associated with durable medical equipment (DME) and prosthetics and orthotics (P&O).

Rental rates are fixed-priced and entered right justified, zero filled to the left. An implied decimal resides between the second and third bytes, counting from the right.

Example: Unit value 5.83 would be entered as:

BYTE # 7 6 5 4 3 2 1

0 0 0 0 5 8 3

SERVICE LIMITS:

22. Dates:

(Not currently used.)

23. Period (0562):

(Not currently used.)

24. Frequency (0563):

(Not currently used.)

25. Limit

(Not currently used.)

26. Service Error

Used for information only.

27. Follow-Up Days

Number of follow-up days included in procedure.

28. Split Bill

Percentage of procedure price allowed for professional component.

29. Diagnosis Error

CS personnel assign this field; however, the DHS contact will enter it if known.

30. Indicator Specific Date (1523):

The Date of Service (DOS) the following indicators became effective: Pend/Deny, ER/POS, TAR, POS. The format is YYMMDD.

The default is the effective date.

31. Pend/Deny Indicator (1508):

Procedures that should be suspended for manual review or denied as non-covered benefits are flagged with this indicator. The indicator is DOS specific.

Refer to Section 3.1.1.2 for a list of Pend/Deny Indicators.

32. Emergency Indicator (0579):

Directs the system to the proper conversion factor to use if the Place of Service (POS) is Emergency Room (ER). The indicator is DOS specific.

Code	Description
1	If POS B (ER) use ER medicine or surgical conversion factors otherwise use non-ER factor
0	Use non-emergency conversion factor no matter what POS

The default is 0.

33. TAR Indicator (0555):

Indicates procedures requiring a treatment authorization request (TAR). The indicator is DOS specific.

Code	Description
0	No TAR or Medi label required
1	Medi label or TAR required
2	Medi label only required
3	TAR only required
4	Refer to MMIS Table 1355 for TAR/Medi requirement

The default is 0.

34. POS I/E Indicator (0578), POS Ranges:

This seven-byte field shows valid or invalid place of service (POS) codes for this procedure. The first byte is an alpha inclusive/exclusive indicator, I or E.

I = Inclusive:This procedure is payable only when billed with the POS codes listed in bytes two through seven. Claims billing this procedure with POS codes other than those listed suspend under edit 465 and are worked according to the edit/audit criteria in the suspense processing manuals.

E = Exclusive: This procedure is not payable when billed with the POS codes listed in bytes two through seven. Claims billing this procedure with these POS codes suspend under edit 465 and are worked according to the edit/audit criteria in the suspense processing manuals. If procedure is billed with POS codes other than those listed and no other errors are present, the claim is paid automatically.

The next six bytes are the alphanumeric POS codes that either must be present (I) or cannot be present (E) on the claim. Valid POS codes and their descriptions are listed in Section 3.1.1.2.

35. Diagnosis Range Indicator (1516):

The ranges defined by data elements 1517 and 1518 are defined either as inclusive or exclusive. Inclusive indicates Medi-Cal pays this procedure only when billed with a

diagnosis within the range defined by DE 1517 and DE 1518. Exclusive indicates Medi-Cal pays this procedure when billed with any diagnosis except those defined by DE 1517 and DE 1518. A range indicator is required if DE 1517 and DE 1518 are non-blank. Up to 10 diagnosis ranges can be coded.

Code	Description
I	Inclusive
E	Exclusive

The default is blank.

36. Diagnosis Range From (1517):

The beginning diagnosis code for the particular range, entered left-justified, blank filled to the right. The decimal is not coded and zeroes and spaces are significant.

The default is blank.

37. Diagnosis Range Thru (1518):

The ending diagnosis code for the particular range, entered left-justified, blank filled to the right. The decimal is not coded and zeroes and spaces are significant.

The default is blank.

Refer to Section 3.1.2 for a chart depicting examples of diagnosis ranges.

38. Lab Codes:

The lab number for procedures related to certified labs.

The default is 000.

39. Provider Specialty Ranges (0553):

Not currently used. Up to seven specialty ranges may exist on the file.

3.5 Child Health and Disability Prevention (CHDP) Rate Table

The CHDP Procedure Online Inquiry/Update Application allows CS data file analysts to update the CHDP Procedure Code File (CH-F-022) by adding a procedure code, changing age range or rate information for a procedure code, or deleting a procedure code. All transactions keyed through the CHDP Procedure Online Inquiry/Update Application are applied to the File CH-F-022 immediately. DHS must request all changes to the age range or rate information for a CHDP procedure code through an OIL.

Procedure codes must have a corresponding Other Shot/Test Code. If a procedure code needs to be added or deleted from the File CH-F-022, and it does not have a corresponding Other Shot/Test Code, the change requires an SDN. The change involves internal modifications to the CHDP batch system in addition to the changes keyed through the CHDP Procedure Online Inquiry/Update Application.

Procedure codes that do have a corresponding Other Shot/Test code can be added or deleted through an OIL, and an SDN is not required. Within the CHDP Batch System, certain limits exist pertaining to the number of procedure codes that can be added without a programming change. As of 8/31/92, there are 34 procedure codes on the file and 17 of them have corresponding Other Shot/Test codes. The limit for procedure codes is 45; if there are corresponding Other Shot/Test codes, the limit is 30. After future

additions, if the number of procedure codes added is reaching either of these limits, notify the CHDP Systems personnel.

3.5.1 Input Transactions

Two screens control updates to File CH-F-022. The Procedure Screen (CHS650) allows the user to add procedure records, change records already on file, or delete records, depending on the selection chosen. The Rate Screen (CHS651) allows the user to view or update rate information for a particular age range for a procedure code. The user accesses this screen through the Procedure Screen.

File CH-F-022 is updated with information that comes from the CHDP Procedure Code Update Form (refer to Figure 3.7), which contains changes and additions to the information on the file. Data on this form is obtained from state directives transmitted through an OIL.

All data entered is edited before updating the file. If any errors are detected, the fields are highlighted and the file is not updated. CS personnel review update audit reports to ensure the correct data was applied to File CH-F-022.

CHDP PROCEDURE CODE UPDATE
FOR MODIFICATIONS TO AGE RANGES
AND RATE INFORMATION

PROCEDURE CODE _____

DESCRIPTION _____

_____

OTHER SHOT/TEST CODE _____ SEX _____

AGE RANGE FROM (YEAR MONTH) ____ ____ AGE RANGE THROUGH (YEAR MONTH) ____ ____ NEW AGE RANGE ____ ____ MODIFIED AGE RANGE ____

EFFECTIVE DATE FROM ____/____/____ EFFECTIVE DATE THROUGH ____/____/____

CHDP COMPREHENSIVE CARE RATE	CHDP SCREENING ONLY RATE	MEDI-CAL COMPREHENSIVE CARE RATE	MEDI-CAL SCREENING ONLY RATE
$_____._____	$_____._____	$_____._____	$_____._____

AGE RANGE FROM (YEAR MONTH) ____ ____ AGE RANGE THROUGH (YEAR MONTH) ____ ____ NEW AGE RANGE ____ ____ MODIFIED AGE RANGE ____

EFFECTIVE DATE FROM ____/____/____ EFFECTIVE DATE THROUGH ____/____/____

CHDP COMPREHENSIVE CARE RATE	CHDP SCREENING ONLY RATE	MEDI-CAL COMPREHENSIVE CARE RATE	MEDI-CAL SCREENING ONLY RATE
$_____._____	$_____._____	$_____._____	$_____._____

AGE RANGE FROM (YEAR MONTH) ____ ____ AGE RANGE THROUGH (YEAR MONTH) ____ ____ NEW AGE RANGE ____ MODIFIED AGE RANGE ____

EFFECTIVE DATE FROM ____/____/____ EFFECTIVE DATE THROUGH ____/____/____

CHDP COMPREHENSIVE CARE RATE	CHDP SCREENING ONLY RATE	MEDI-CAL COMPREHENSIVE CARE RATE	MEDI-CAL SCREENING ONLY RATE
$_____._____	$_____._____	$_____._____	$_____._____

Figure 3.3 – CHDP Procedure Code Update for Modifications to Age Ranges and Rate Information

3.5.2 CHDP Procedure Screen (CHS650)

This section describes the fields on the CHDP Procedure Screen (CHS650). All information must be entered on this screen manually since there is no default value for any of the fields.

For an example and a complete description of Screen CHS650, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen CHS650 Field Descriptions:

1) Procedure Type:

This field must be an alphanumeric character. Refer to Section 3.1.2 of this manual for a complete list of the valid procedure types and their descriptions.

2) Procedure Code:

This field must contain five alphanumeric characters. Refer to Section 3.1.2 of this manual for a description of the different types of procedure codes.

3) Other Shot/Test Code:

This field must contain two numeric characters. If the new procedure code being entered does not have a corresponding Other Shot/Test code, the value 00 must be entered in this field.

4) Sex:

This field must contain the allowable sex for the procedure code. Only three characters may be entered: M - Male, F - Female, or B - Both.

5) Description:

A free-form alpha field containing a description of the procedure. This field must not be blank.

For other shots and other tests, only the first 12 bytes of this field are used for a description on Provider Correction Requests (PCRs). When entering a description for a procedure code with a corresponding other shot or other test code (such as, a value other than 00), spaces should be entered after the initial description to reach a required 12 character total. This ensures incomplete descriptions are not printed on PCRs (for example, Chlamydia Culture -three spaces are entered after the word chlamydia, for a 12 character total).

There are no restrictions on descriptions for procedure codes without corresponding other shot or other test codes.

6) Age Range (Year):

This field must have a value in the 00 through 20 range. This field defines age limitations in terms of years of age.

7) Age Range (Month):

This field must have a value in the 00 through 11 range. This field defines age limitations in terms of months of age.

For example, an age entry (YYMM) of 20 11 is read 20 years, 11 months.

Other Criteria for Age Changes:

An age From/Through range must be defined so the Age Range From value is less than the Age Range Through value.

The age ranges must cover the ages 00 00 through 20 11. In order to meet this criteria, the From value of the first age range must contain 00 00 and the Through value of the last age range must contain 20 11.

The age ranges must not contain gaps between one another or overlap one another. The difference between age ranges must always be one month.

Example:

(1)	00 00	00 11	(2)	01 00	04 11
(3)	05 00	07 06	(4)	07 07	09 11
(5)	10 00	12 06	(6)	12 07	14 11
(7)	15 00	17 06	(8)	17 07	20 11
(9)			(10)		
(11)			(12)		
(13)			(14)		
(15)			(16)		

3.5.3 CHDP Rate Screen (CHS651)

This section describes the fields on the CHDP Rate Screen (CHS651). All information must be entered on this screen manually since there is no default value for any of the fields.

For an example and a complete description of Screen CHS651, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

Screen CHS651 Field Descriptions:

1) Procedure Type and Code:

Refer to Section 3.5.2, numbers 1 and 2.

2) Description:

See section 3.5.2, number 5.

3) Other Shot/Test Code:

See section 3.5.2, number 3.

4) Sex:

See section 3.5.2, number 4.

5) Age Range - From:

The beginning age range for the procedure code. Format is YY MM.

6) Age Range - Through:

The ending age range for the procedure code. Format is YY MM.

7) Effective Date - From:

The date the price becomes effective. Must be a valid date and in the MM DD YY format.

8) Effective Date - Through:

The last date the price is effective. Must be a valid date and in the MM DD YY format.

9) CHDP Comprehensive Care, CHDP Screening Only, Medi-Cal Comprehensive Care, and Medi-Cal Screening Only:

Each of these columns contains a price field for the type of procedure. The fields must contain values in the range of 00000 through 09999 (such as if a rate of $16.98 needs to be keyed, it should be entered as 01698).

Other Criteria for Date Ranges:

An effective date range must contain a From date that is less than its Through date.

The effective date ranges must not contain gaps between one another or overlap one another. The difference between effective date ranges must always be one day.

An effective date range must apply to each age range for a particular code even though a rate may not be assigned to that age range.

Section 4 - Report Descriptions

The Change Support unit receives the following reports from the automated system:

- Procedure Master File Listing (RF-O-03P)
- Procedure Update Audit Listing (RF-O-0lA)
- Procedure Audit Trail and Control (RF-O-04A)
- Multiplier Table Listing (RF-O-05A)
- CHDP Procedure Code Listing (CH-O-605)
- CHDP Procedure Transaction Audit Report (CH-O-606)

Change Support personnel monitors reports to verify the timely and efficient functioning of the Procedure Code Master File (RF-F-070) updates. The CS personnel who are responsible for timely follow-up and distribution generate all report requests. Audit trail reports are logged in the batch entry log for strict control.

Additionally, the Contractor supplies the Procedure Code Master File (RF-F-070) to DHS on microfiche, on a quarterly basis.

For an example and a complete description of these reports, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Reports User Manual-Reference Subsystem and CHDP Subsystem, where all report documentation is stored.

4.1 Procedure Master File Listing (RF-O-03P)

The Procedure Master File Listing (RF-O-03P) is a display of the entire Procedure Code Master File (RF-F-070). It is sorted by procedure type within procedure code. The Contractor produces the report on a quarterly basis and delivers it to the CS Unit and DHS personnel on microfiche.

The Procedure Master File extract that is produced quarterly is also sent to DHS/Rate Development Branch. Program MFR720, Procedure Master File Extractor, creates the extract. The report dataset name is PMCAL.MRFAT.EQRFFX, and is sent on CD ROM.

4.2 Procedure Update Audit Listing (RF-O-01A)

The Procedure Update Audit Listing (RF-O-0lA) reports all procedure update transactions applied to the Procedure Code Master File (RF-F-070) since the report's last generation. The Contractor produces the report and distributes it with the Procedure Audit Trail and Control Report (RF-O-04A). Similar to Report RF-O-04A, the Procedure Update Audit Listing (RF-O-0lA) specifies the kind of transaction that was applied to each record listed:

* Procedure record was added
* Procedure record was modified
* Procedure record was changed
* Procedure record was deleted

Unlike Report RF-O-04A, the Procedure Update Audit Listing does not report what the updated field's values were before the updates were applied. RF-O-0lA also lists the entire procedure record rather than just the fields that were updated.

4.3 Procedure Audit Trail and Control (RF-O-04A)

The Procedure Audit Trail and Control Report (RF-O-04A) lists all the updates applied to the File RF-F-070 since the report's last generation. For each updated record the report shows the following information: the record's procedure type and code; the Medicare (HCPCS) equivalent of the code; the last activity date, and the operator ID associated with the person who made the update; the effective and ending dates; the procedure name; the update type; and the fields that were updated. The report does not list the entire procedure record. The report is generated through Program MFD580, Procedure Master Batch Update, which updates the Procedure Master Backup File (RF-F-72P). It is produced and distributed with Reports RF-O-0lA and the Procedure Multiplier Table Listing (RF-O-05A).

The report indicates the kind of update as follows:

* Procedure record was added
* Procedure record was modified
* Procedure record was changed
* Procedure record was deleted

Modified procedure records are those adjusted automatically during the batch update (Program MFD580) following online multiplier-table updates. Changed refers to procedure records altered manually online. For changed and modified records, the report lists the modified fields' names (or an abbreviation) and what the fields' values were changed from and to.

4.4 Procedure Multiplier Table Listing (RF-O-05A)

The Procedure Multiplier Table Listing (RF-O-05A) reports all occurrences (seven) of each conversion type's multiplier and each occurrence's effective date. Report RF-O-05A is produced and distributed with Reports RF-O-0lA and RF-O-04A.

4.5 Procedure Code Master File (RF-F-070) Select Criteria Report (RF-O-133)

The Procedure Inquiry Entry Selection Screen (RFS570) provides users with the capability of viewing and/or requesting a report of selected procedure code records. This screen prompts the user to enter selection criteria to specify which Procedure Code Master File (RF-F-070) records are to be viewed and/or reported. The user may select a specific procedure record by entering a complete procedure key (Procedure type and code) or may define a class of procedure codes by specifying field values (for example, procedure type = 1 and Pend/Deny indicator = P).

The P/S/B (Print/Screen/Both) indicator field in the right-hand corner of the screen allows the selected criteria to be printed, displayed on the screen, or both printed and displayed. The indicator defaults to S for screen only. A report can be selected by entering a P or B in the field. When a P or B is selected, a print destination must be entered; the destination must be the three-digit identifier assigned to the requester for purposes of report delivery (these identifiers are listed on CA-MMIS Table 2200). All reports produced off the screen are identified as RF-O-133. Refer to Section 5-Report and Screen Examples, of this manual for an example and description of this report.

Section 5 contains information found in the Reports User Manual-Reference Subsystem and CHDP Subsystem, where all report documentation is stored.

To activate the report, enter RF-O-133 on the Provider Report Request Screen (PSS909). A single entry on this screen will activate <u>all</u> reports requested through the RFS570 screen, regardless of the initial requester.

For an example and a complete description of Screen RFS570, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the

Cathode Ray Tube (CRT) User Reference Manual where all CA-MMIS screen documentation is stored.

4.6 CHDP Procedure Code Listing (CH-O-605)

This report contains all of the CHDP procedure codes currently on file. The report shows the following:

- Procedure Type and Code
- Sex
- Other Shot/Test Code
- Description
- Operator I.D.
- Date of the Last Update
- Each Age Range and corresponding Effective Dates and Rates

The total number of age ranges for the procedure code is listed following the information for each code. A summary containing the total number of age ranges on file and the total number of procedure codes on file is printed at the bottom of the report. Refer to the CHDP Subsystem Report Users Manual for a description and example of this report.

The Contractor prints and distributes four copies of this report to Change Support. Change Support forwards three copies to DHS and keeps one for their records.

4.7 CHDP Procedure Transaction Audit Report (CH-O-606)

This report lists all the transactions applied to the CHDP Procedure Code File (CH-F-022) since the last time the job was run. The transactions are grouped by procedure code and are listed from the least to the most recent. Four types of transactions exist: ADD, CHGP, CHGR, and DEL.

An ADD transaction shows information about a code that was added to the file. The information for this transaction includes the procedure type and code, the transaction date and time, the transaction type (ADD), the Operator I.D., the description of the code, the number of ages ranges for the code, and the age ranges keyed for the new code.

A CHGP transaction is created when the description or age range information for an existing procedure code is changed. This transaction lists the procedure type and code, the transaction date and time, the transaction type (CHGP), the Operator I.D., the description of the code before and after the transaction was applied, and the age ranges before and after the transaction was applied.

A CHGR transaction is created when the rate information for an age range is changed. This transaction lists the procedure type and code, the transaction date and time, the transaction type (CHGR), the Operator I.D., the age range, and the rate information before and after the transaction was applied.

A DEL transaction is created when a procedure code is deleted from the file. This transaction lists the procedure type and code, the transaction date and time, the transaction type (DEL), and the total transactions.

At the end of the report, the total number of transactions is printed. The Contractor prints and distributes four copies of this report to Change Support. Change Support forwards three copies to DHS and keeps one for their records.

For an example and a complete description of these reports, refer to Section 5-Report and Screen Examples, of this manual. Section 5 contains information found in the Reports User Manual-Reference Subsystem and CHDP Subsystem, where all report documentation is stored.

Appendix A - Conversion/Multiplier Table

The Conversion/Multiplier Table provides the values for DE 1552 (Conversion Indicator) used in determining the allowed reimbursement rate for a specific procedure carried on the Procedure Cod Master File (RF-F-070). The values for a given procedure code are multiplied by the units on File RF-F-070, resulting in the procedure's price.

For example:

- Calculations:

  Sample Procedure File entry –

	Units	Price	Conv. Ind.
Code: 11040	.73	27.18	4

The Conversion Table lists Conversion Indicator 4 as $37.23

Calculation: $37.23 X .73 = $27.18

Note: All procedure codes require a conversion indicator in order to be placed on the procedure file. However, to place a code on file without a pre-determined price, use an entry of zeroes in the units field.

The Conversion/Multiplier Table is accessed in CA-MMIS through Screen RFS590. Change Support maintains the table through the automated Procedure File Update process. It is used in conjunction with CA-MMIS Table 0215, Provider Specialty and Type Restrictions, to calculate reimbursement for billed procedures.

Since the Procedure Code Master File (RFF070) has room for only one conversion indicator per procedure code, Table 0215 supplements the File RFF070 entries by providing the capability to define additional conversion indicators for a single procedure code.

CA-MMIS Table 0215 identifies conversion indicators (factors) for specific ranges of procedure codes for specific provider types (defined in Title 22, Section 51509, and as defined by OILs). This capability allows payment for a given procedure code to be calculated based on provider type; in essence, paying different providers different amounts for the same procedure.

For example:

Procedure Code	Conversion Indicator on PMF	Unit Value on PMF	Conversion Indicator (CI) on 215 Table
90761	1	40.00	31 (for provider types 5,15,22,26,61) 32 (for provider types 40, 41, 48) 33 (for provider types 34, 42-47, 50)
CI 31 = factor of $1.01 32 = factor of $1.25 33 = factor of $1.07			$1.01 X 40.00 = $40.40 $1.25 X 40.00 = $50.00 $1.07 X 40.00 = $42.80

The Conversion / Multiplier Table is available online.

Where Information is Obtained

The information contained on the Conversion/Multiplier Table and CA-MMIS Table 0215 is obtained from OILs.

Who Updates the Table and When

Change Support maintains the table upon receipt of an OIL requesting updates to the multiplier table/conversion indicator prices.

When the description area (procedure code listings) for a conversion indicator is changed, the online screen also requires updating. An SDN is required to do the online change to Screen RFS590.