# CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

## 837 INSTITUTIONAL ENCOUNTER DATA TRANSACTION

## CAL MEDICONNECT MEDICAID ENCOUNTER (837I)

### STANDARD COMPANION GUIDE TRANSACTION INFORMATION

### INSTRUCTIONS RELATED TO TRANSACTIONS BASED ON ASC X12 IMPLEMENTATION GUIDES, VERSION 005010

**COMPANION GUIDE VERSION 2.6**

**MAY 2022**

# Document History (Version Control)

| Version | Date | Author | Brief Description of Modifications |
|---|---|---|---|
| 0.1 | 08/05/2014 | Greg Dawson | Created |
| 1.0 | 12/30/2014 | Greg Dawson | Incorporate CMS comments and CPO Indicator |
| 1.1 | 01/30/2015 | Greg Dawson | Incorporate plan comments |
| 1.2 | 03/13/2015 | Greg Dawson | Update duplicate logic to include Admission Date/Hour and Discharge Hour |
| 1.3 | 05/20/2015 | Greg Dawson | Correct reference for 1000B NM102. Correct reference to HICN in section 3.12 |
| 1.4 | 08/05/2015 | Greg Dawson | Include 340B information and NPI definition, remove HCP from EVR filename |
| 1.5 | 04/05/2016 | Greg Dawson | Update references to CN1 and paid amount balancing. Clarify use of 2010CA Patient Loop |
| 1.51 | 10/17/2017 | Jeff Jennings | Updated BHT03 requirement wording (Section 3.24) |
| 1.6 | 02/12/2018 | Jeff Jennings | Added Sec. 3.23 - EPSDT reporting guidance |
| 1.7 | 04/13/2018 | Bilochan Sainju | Added clarification that Denied Void and Denied Replacement Encounters cannot be acted on |
| 1.71 | 05/22/2018 | Wendy Ng | Updated as per EDQU suggestions<br>• Updated formatting in section 3.21 |

| | | | |
|---|---|---|---|
| | | | • Clarified verbiage in section 3.21 regarding representative scenarios<br>• Clarified verbiage in the Note column in Appendix B.4<br>• Clarified verbiage on the reason scenario in Appendix B.4 for Encounter ID 0091234 cannot be corrected |
| 1.8 | 08/27/2019 | Sravan Bojja | Under section 3.7, Added Attending Provider to the duplicate check, added NDC requirement for PADs to Section 3.22 |
| 1.9 | 12/.3/2019 | Bilochan Sainju | Updated references from "HICN" to "Medicare ID Number" in Appendix A |
| 2.0 | 2/6/2020 | Jeff Jennings | Added line to Section 3.18 – PACES accepts both MS-DRG & APR-DRG numbers |
| 2.1 | 3/16/2020 | Jeff Jennings | Updated Section 3.7 to reflect use of MBI for duplicate check. Updated Sec. 3.12 to highlight instructions on where to place the CIN |
| 2.2 | 06/03/2020 | Bilochan Sainju | Updated notes on encounter submission types in section 3.21, Correcting a Submitted Encounter |
| 2.3 | 09/15/2020 | Sravan Bojja | Updated logic regarding newborn reporting in section 3.7 Duplicate Encounters |
| 2.4 | 01/14/2022 | Sharmila Chandrakanth | Added new section 3.19, for Crossover Encounters<br>Updated information about MS-DRG and Medi-Cal APR DRG in section 3.20<br>Added explanations for PAD/HCPCS validations related to the NDC in section 3.24 |

| | | | |
|---|---|---|---|
| 2.5 | 02/15/2022 | Srikanth Krishnamurthy | Added new section 3.26 Discharge Hour<br><br>Updated information about Discharge Hour |
| 2.6 | 05/05/2022 | Sharmila Chandrakanth | Added new section 3.27 Encounter with Community Supports Housing Services |

# Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

# Table of Contents

**1 TI Introduction ..... 8**

1.1 Overview of HIPAA Legislation ..... 8
1.2 Compliance according to ASC X12 ..... 9
1.3 Intended Use ..... 9

**2 Included ASC X12 Implementation Guides ..... 9**

**3 Instruction Tables ..... 10**

3.1 Transaction Submission ..... 10
3.2 Available Transaction Responses ..... 10
3.3 Transaction Components ..... 11
3.4 File Contents ..... 11
3.5 Submitted Encounter File Naming Conventions ..... 11
3.6 Response File Naming Conventions ..... 11
3.7 Duplicate Encounters ..... 12
3.8 MSSP Encounter Guidance ..... 14
3.9 ISA/IEA ..... 15
3.10 GS/GE ..... 16
3.11 ST/SE ..... 17
3.12 Member Identifiers ..... 17
3.13 Provider Identifiers ..... 18
3.14 Provider Specialty ..... 20
3.15 National Coding Standards ..... 20
3.16 ICD-10 Diagnosis Codes ..... 21
3.17 Payment Information ..... 21
3.18 Paid Amount Balancing ..... 21
3.19 Crossover Encounters ..... 21
3.20 Diagnosis Related Group (DRG) ..... 22
3.21 Medi-Cal Specific Information ..... 22
3.22 Encounter Identification ..... 22
3.23 Correcting a Submitted Encounter ..... 23
3.24 Physician Administered Drugs (PADs) ..... 24
3.25 Early & Periodic Screening, Diagnosis and Treatment (EPSDT) ..... 25
3.26 Discharge Hour - 2300 DTP*096 DTP03 ..... 25
3.27 Encounters with Community Supports Housing Services ..... 25
3.28 BHT ..... 26
3.29 Header ..... 26

3.30 Billing Provider ..... 27
3.31 Pay-To Plan Name ..... 27
3.32 Subscriber Detail ..... 28
3.33 Payer Name ..... 29
3.34 Patient Detail ..... 29
3.35 Claim Level Detail ..... 30
3.36 Service Line Detail ..... 34

**4 TI Additional Information ..... 36**

**Appendix A – Medi-Cal Data Definitions ..... 37**

A.1 CIN Number ..... 37
A.2 MEDS ID ..... 37
A.3 Service Facility Location County ..... 38
A.4 Care Plan Option Indicator ..... 39

**Appendix B – Void and Replacement Scenarios ..... 40**

B.1 Void of an Accepted Encounter ..... 40
B.2 Void of a Denied Encounter ..... 41
B.3 Replacement of an Encounter ..... 42
B.4 Encounters that can NOT be corrected ..... 44

# Transaction Instruction (TI)

## 1 TI Introduction

### 1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs
- Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).

- Change the meaning or intent of the standard's implementation specification(s).

### 1.2 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

### 1.3 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

# 2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

| Unique ID | Name |
|---|---|
| 005010X223A1 | Health Care Claim: Institutional (837) |

# 3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

| Legend |
|---|
| SHADED rows represent "segments" in the X12N implementation guide. |
| NON-SHADED rows represent "data elements" in the X12N implementation guide. |

Only those elements that require specific explanation are included in these tables. The underlying TR3 document for this transaction is available at http://store.x12.org.

## 3.1 Transaction Submission

Participating Cal MediConnect plans are required to separate Medicare and Medicaid encounters into two data streams. Both sets of data are submitted to CMS. Plans should refer to CSSC Operations for details on how this data must be submitted and the certification process involved.

Once CMS has accepted a submitted Medicaid encounter transaction, the data will be forwarded to California Department of Health Care Services (DHCS) for processing.

## 3.2 Available Transaction Responses

Plans should refer to CSSC Operations for information on transaction responses that they would receive when a Cal MediConnect Medicaid encounter data file is submitted and initially processed by CMS.

Once the Medicaid encounter data is received by DHCS, the Post-Adjudicated Claims and Encounters System (PACES) validates the encounters.

Post-processing, plans receive an Encounter Validation Response (EVR) file – custom XML error report detailing the result of edits applied to each encounter.

EVR files are uploaded to the Response SFTP folder for a specific plan.

A 277 response file will not be sent due to the format of the received data from CMS.

### 3.3 Transaction Components

DHCS requests that plans use the following components within submitted files:

- Data element separator: **"*"**
- Segment terminator: **"~"**

### 3.4 File Contents

Files should be comprised of only 837I (institutional) transactions. Up to 50 ST-SEs are allowed, each ST-SE can have up to 5,000 instances of the 2300 loop.

### 3.5 Submitted Encounter File Naming Conventions

Plans should refer to CSSC Operations for information on file naming conventions for submitted encounter data files.

### 3.6 Response File Naming Conventions

DHCS processes the submitted encounters and responds with an EVR file, using the following naming convention:

**XXXXX—X_837I_CMC_YYYYMMDD_NNNNN_RESP.xml**

Where:

XXXXX-X is the first node of the file name and is the name of the health plan as specified by the plan and approved by DHCS.

837I_CMC is a constant designating the file as a response to an 837 Institutional Cal MediConnect submission.

YYYYMMDD is the date of the response.

NNNNN is a unique numeric transaction identifier used to differentiate between response files sent on the same day.

RESP indicates this is a PACES generated custom response file (EVR).

Example:

**MYHEALTHPLAN_837I_CMC_20120930_00001_RESP.xml**

### 3.7 Duplicate Encounters

Encounters are evaluated for duplicates at the service line level. If a service line is found to be a duplicate of a previously submitted service line, the entire encounter is denied.

For the purposes of an 837 Institutional service line, a duplicate would have the same following values as a previously submitted service line:

- Medicare ID Number (MBI) – 2010BA NM109
- Date(s) of Service – 2400 DTP*472 DTP03 (can be a range)
- Admission Date/Hour - 2300 DTP*435 DTP03 (can be a date or a date/time)
- Discharge Hour - 2300 DTP*096 DTP03
- Attending Provider - can be sourced from a variety of places – see section 3.13. The valued stored for purposes of duplicate validation is the value derived for attending provider at the service line level. This derived value may have been submitted at a higher level where no other identifier was submitted at either the claim or service line. This derived value may also be either a Medi-Cal Provider ID or State License number depending upon the presence of an NPI. If no NPI is submitted because the provider is atypical, a submitted secondary identifier is used. The order of priority for secondary identifiers is Medi-Cal Provider ID first and State License Number second.

- Rendering Provider – can be sourced from a variety of places – see section 3.13. The valued stored for purposes of duplicate validation is the value derived for rendering provider at the service line level. This derived value may have been submitted at a higher level where no other identifier was submitted at either the claim or service line. This derived value may also be either a Medi-Cal Provider ID or State License number depending upon the presence of an NPI. If no NPI is submitted because the provider is atypical, a submitted secondary identifier is used. The order of priority for secondary identifiers is Medi-Cal Provider ID first and State License Number second.

- Revenue Code – 2400 SV201

- Procedure Code – 2400 SV201-2

- Procedure Modifier(s) – 2400 SV201-3,4,5,6

- Diagnosis Code - (ICM-10 CM) Z38.30-Z38.8 (Only for multiple newborns)

- Drug code – 2410 LIN03 – Drug code is used when it is present.

Conditional usage of Drug Code - When a submitted encounter is compared to previously submitted encounters and all other key fields match but one of the encounters has a drug code and the other does not – this situation is still identified as a duplicate. If all other key fields match and the drug codes are different, the situation is not a duplicate.

In order to appropriately represent encounters for the same service that can be performed multiple times in a day, usage of modifiers: 59, 76, 77 and XS over-rides the duplicate validation logic. The use of these modifiers is strictly monitored.

To report the same service that was performed for the mother and the baby or babies, use modifiers: 25, XE, XP, and XU to over-ride the duplicate validation logic. Services for babies with no CIN should be reported under the mother's CIN. Please refer to the

DHCS-PACES Encounter Data Mother-Newborn Encounter Reporting-v.1.0guidance document for detail on reporting standards and examples.

**Please note:** Appropriate use of modifiers requires accompanying procedure codes for valid use.

### 3.8 MSSP Encounter Guidance

Multipurpose Senior Services Program (MSSP) Encounters must only be submitted using the 837 Institutional transaction, NOT the 837 Professional.

MSSP encounters must use national standard procedure and revenue codes, and must include the NPI of the MSSP site.

Temporary local code crosswalks and NPI crosswalks have been made available by the Long Term Care Division of DHCS.

### 3.9 ISA/IEA

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| ISA | | Interchange Control Header | | |
| | ISA01 | Authorization Information Qualifier | 00 | |
| | ISA02 | Authorization Information | | 10 blanks |
| | ISA03 | Security Information Qualifier | 00 | |
| | ISA04 | Security Information | | 10 blanks |
| | ISA05 | Interchange ID Qualifier | ZZ | |
| | ISA06 | Interchange Sender ID | | Submitter ID assigned by Palmetto GBA |
| | ISA07 | Interchange ID Qualifier | ZZ | This ID qualifies the Receiver in ISA08 |
| | ISA08 | Interchange Receiver ID | 80891 | |
| | ISA11 | Repetition Separator | ^ | |
| | ISA13 | Interchange Control Number | | Must be a fixed length with nine (9) characters and match IEA02.<br>Used to identify file level duplicate collectively with GS06, ST02 and BHT03 |
| | ISA14 | Acknowledgement Requested | 0 | Interchange Acknowledgement Requested (TA1).<br>A TA1 is sent if the file is syntactically incorrect, otherwise only a 999 is sent |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | ISA16 | Component Element Separator | : | |
| IEA | | Interchange Control Trailer | | |
| | IEA02 | Interchange Control Number | | Must match the value in ISA13 |

### 3.10 GS/GE

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| GS | | Functional Group Header | | |
| | GS01 | Functional Identifier Code | HC | |
| | GS02 | Application Sender's Code | | Submitter ID assigned by Palmetto GBA.<br>This value must match the value in ISA06 |
| | GS03 | Application Receiver's Code | 80891 | |
| | GS06 | Group Control Number | | This must match the value in GE02 |
| | GS08 | Version / Release / Industry Identifier Code | 005010X223A2 | |
| GS | | Functional Group Header | | |
| | GE02 | Group Control Number | | This must match the value in GS06 |

### 3.11 ST/SE

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| ST | | Transaction Set Header | | |
| | ST01 | Transaction Set Identifier Code | 837 | |
| | ST02 | Transaction Set Control Number | | This value must match the value in SE02.<br>Used to identify file level duplicates collectively with ISA13, GS06, and BHT03 |
| | ST03 | Implementation Convention Reference | 005010X223A2 | |
| SE | | Transaction Set Trailer | | |
| | SE01 | Number of Included Segments | | Transaction Segment Count |
| | SE02 | Transaction Set Control Number | | This value must match the value in ST02 |

### 3.12 Member Identifiers

The subscriber's Medicare ID Number (MBI number) must be used in 2010BA NM1*IL NM109, each member must be identified in the Subscriber loop (2010BA), the Patient loop (2010CA) must not be sent. Please refer to CMS guidelines for using HIC number instead of MBI as Medicare ID Number. **The Medi-Cal Client Identification Number (CIN) must be present in 2300 NTE02 as defined below.**

### 3.13 Provider Identifiers

Medi-Cal Managed Care requires the submission of the National Provider Identifier (NPI) on all submitted encounters, with the sole exception being for atypical providers.

On the 837I, there are eight main values where a provider identifier may be supplied:

| | **Billing Provider Level** | |
|---|---|---|
| **Billing Provider** | **2010AA – NM1*85**<br><br>Required | |
| | **Pay-To Provider Level** | |
| **Pay-To Provider** | **Not used** | |
| | **Claim Level** | **Service Level** |
| **Attending** | **2310A NM1*71**<br><br>Required when the claim contains any services other than non-scheduled transportation. | N/A |

| | | |
|---|---|---|
| **Operating** | **2310B NM1*72**<br><br>Required when a surgical procedure is listed on the claim. | **2420A NM1*72**<br><br>Required when a surgical procedure is listed on the service line and the operating physician on this line is different from the operating physician at the claim level. |
| | **Claim Level** | **Service Level** |
| **Other Operating** | **2310C NM1*ZZ**<br><br>Required when another operating physician is involved. | **2420B NM1*ZZ**<br><br>Required when another operating physician is involved and the other operating physician for this line is different from the other operating physician at the claim level. |
| **Rendering** | **2310D NM1*82**<br><br>Required when the rendering provider is different than the attending provider | **2420C NM1*82**<br><br>Required when different from the attending provider and when different from the rendering provider at the claim level. |
| **Service Facility** | **2310E NM1*77**<br><br>Required if different than the Billing Provider | **N/A**. |

| | | |
|---|---|---|
| **Referring** | **2310F NM1*DN**<br><br>Required on an outpatient claim when the referring provider is different from the attending provider. | **2420D NM1*DN**<br><br>Required when different from the attending provider and when different from the referring provider at the claim level. |

Only the Billing Provider NPI and the Service Facility Location can be an organizational NPI, the rest must be individual NPIs.

In addition to the NPI, encounter data submitters are requested to provide both the State License Number (REF*0B) and the Medi-Cal Provider Number (REF*G2) as applicable. Multiple instances of the Secondary Provider Information segment are permissible.

Atypical providers should be identified by leaving both NM108 and NM109 unpopulated and entering whatever identification numbers are appropriate in the secondary identifier segment. A Social Security Number should NOT be used as an identifier.

### 3.14 Provider Specialty

Submitters are requested to provide provider specialty information for each applicable provider identifier.

### 3.15 National Coding Standards

Submitters must adhere to national coding standards when providing procedure and diagnostic codes. Local codes will not be accepted.

### 3.16 ICD-10 Diagnosis Codes

Submitters must adhere to the ICD-10 compliance date, any encounters submitted for a date of service on or after October 1st 2015 must use ICD-10 diagnosis codes. Use of any other code results in the encounter being denied.

### 3.17 Payment Information

Submitters are required to provide actual payment information using the established structure in the 837IP.

The type of arrangement used to pay the encounter must be described in the CN1 segment in the 2300 loop – CN101 Contract Type Code. When the encounter has been paid on a fee-for-service basis, CN102 should be populated with the amount paid. DHCS requires that 2300 CN1 be provided, and requests the 2400 CN1 segment to be included.

Any payments made to other health insurance carriers must be included in the relevant coordination of benefits segments.

### 3.18 Paid Amount Balancing

Balancing of paid amounts reported in CN102, AMT*D and SVD02 occurs whenever 2300 CN101 equals 02, 03, 04, or 06. In this situation, CN102 must equal AMT*D for a prior payer with SBR09 = "MC". Additionally, AMT*D must equal the sum of all applicable SVD02 amounts for the same payer.

When CN101 equals "01" (DRG) a corresponding DRG code must also be present.

### 3.19 Crossover Encounters

DHCS defines a crossover encounter to be an encounter for a recipient who is eligible for both Medicare and Medi-Cal, where Medicare is responsible for a portion of the encounter and Medi-Cal is responsible for any remaining coverage. For the purposes of

encounter data validation, PACES identifies crossover encounters as those in which the Claim Filing Indicator SBR09 = MA, MB, or 16 in either loop 2000B, loop 2320, or both.

### 3.20 Diagnosis Related Group (DRG)

Medi-Cal APR DRG is 4 digit code, MS-DRG is a 3 digit code which is used to classify cases according to certain groups. DRG codes can be added in:

- Loop 2300 – HI*DR
- Loop 2300 – HCP06
- Loop 2400 – HCP06

The usage of MS-DRG vs. Medi-Cal APR DRG codes is dependent on whether the encounter is a crossover or not. When an encounter is a crossover then any reported DRG codes must be a MS-DRG code, and when an encounter is not a crossover then any reported DRG code must be a Medi-Cal APR DRG code.

Please see section 3.19 for the definition of crossover encounters.

### 3.21 Medi-Cal Specific Information

There are a number of Medi-Cal specific data elements that have been historically provided on proprietary encounter data submissions. These data elements do not have corresponding positions on the 837I layout. Since Medi-Cal still needs these data elements in order to accurately process submitted encounters, they have been positioned in the NTE segment.

### 3.22 Encounter Identification

In accordance with X12 837 Institutional data specification rules, unless the encounter is a void or replacement, CLM01 must be unique, a submitted encounter that has the same value in CLM01 as a previously submitted encounter is denied. To aid in encounter identification, plans must use the HCP number of the plan that the

beneficiary was enrolled in at the time of the encounter as the first three characters of CLM01.

During DHCS processing, each encounter is assigned a unique identification number. This number is provided back to the submitter in both the 277 and the EVR file. When attempting to correct a previously submitted encounter, plans must use this Encounter-ID, as defined below.

### 3.23 Correcting a Submitted Encounter

Submitted encounters are either accepted or denied by DHCS. When DHCS denies a submitted encounter, the reasons for the denial are reported on the available EVR file.

Submitted encounters can be subsequently corrected by either a void or a replacement action.

When a submitter needs to correct an encounter, the following data must be provided:

- The submitter of the correcting encounter must be the same as the submitter of the encounter being corrected.
- CLM01 must equal the value of CLM01 on the encounter being replaced or voided.
- The Encounter-ID (from either 277 or EVR) of the encounter to be corrected must be placed in the Payer Claim Control Number REF segment in the 2300 loop (REF*F8).
- A value of either "7" (replacement) or "8" (void) must be placed in the Claim Frequency Code in CLM05-03.

Representative scenarios for both void and replacement are included in Appendix B.

There are a number of situations which cannot be corrected through this process.

- Denied Void and Denied Replacement encounters cannot be acted on.
- If an encounter is voided, and then a subsequent replacement or void request is received, this subsequent encounter is denied. This denied encounter record is not correctable and remains in a denied status; however, the "encounter" has been correctly voided.
- If the original submission of an encounter is not referenced as an original (CLM05-3 = "1") – it is denied. This specific denied encounter record is not correctable. The originally submitted encounter remains in a voided status.

Representative scenarios for non-correctable situations are also included in Appendix B.

Use of the term "denied" in this narrative does NOT refer to a claim or an encounter that was denied by a plan prior to submission to DHCS as an encounter. DHCS requests that previously denied claims NOT be submitted as encounters.

**Note:** Encounters submitted with a Claim Frequency Type Code other than 1 or 7 cannot be voided or replaced and are considered uncorrectable.

### 3.24 Physician Administered Drugs (PADs)

For non-crossover encounters, service lines which report a HCPCS/CPT code for a physician administered drug (PAD), including 340B PADs, must include the NDC for that drug in 2410 LIN03.

For service lines reporting a HCPCS/CPT code for a 340B PAD, it is further required that the "UD" modifier must be included in one of the four available modifier positions in the service line (2400 SV202 – 3, 4, 5, or 6) whether the encounter is a crossover encounter or not.

Please see section 3.19 for the definition of crossover encounters.

### 3.25 Early & Periodic Screening, Diagnosis and Treatment (EPSDT)

When submitting encounters for EPSDT services, follow the instructions in the Implementation Guide for the 837I:

- In the 2300 loop (claim level), use the CRC segment ("Conditions Indicator") to indicate whether an EPSDT referral was given for diagnostic or corrective treatment.
- The CRC segment should indicate the referral only, not the actual diagnostic or corrective treatment. The CRC referenced diagnostic or corrective treatment should be included on a separate encounter submission.

Encounters for EPSDT Diagnostic or corrective treatments are submitted differently:

Identify EPSDT Diagnostic or corrective treatments by utilizing the **EP** modifier with the appropriate CPT code(s) for services rendered.

### 3.26 Discharge Hour - 2300 DTP*096 DTP03

Discharge Hour is mandatory for Inpatient 837I encounters when the CL103 value (Patient Status Code) indicates the patient was discharged.

The patient is discharged when one of the following values is reported in CL103:

01, 02, 03, 04, 05, 06, 07, 09, 20, 21, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 69, 70, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95.

Encounters will be denied if the Discharge Hour is missing when the patient is discharged.

### 3.27 Encounters with Community Supports Housing Services

Reporting of fractional units for service lines with procedure code H0044 and procedure modifier U2 or U3 is not allowed. When these procedure code and modifier combinations are used, the value reported in SV205 must be a whole number or the encounter will be denied.

Similarly, when procedure code H0044 is used with procedure modifier U2 or U3, only units are allowed to be reported for that service line. If the service line reports 'DA' in SV204, the encounter will be denied.

### 3.28 BHT

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | BHT | Beginning of Hierarchical Transaction | | |
| | BHT03 | Originator Application Transaction Identifier | | Must be a unique identifier across all files, as well as across all transactions within a file.<br>Used to identify file level duplicates collectively with ISA13, GS06, and BHT03 |
| | BHT06 | Claim Identifier | CH | Chargeable |

### 3.29 Header

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 1000A | NM1 | Submitter Name | | |
| | NM102 | Entity Type Qualifier | 2 | Non-person Entity |
| | NM109 | Submitter Identifier | | Submitter ID assigned by Palmetto GBA |
| 1000B | NM1 | Receiver Name | | |
| | NM102 | Entity Type Qualifier | 2 | Non-person Entity |
| | NM103 | Receiver Name | MMEDSCMS | |
| | NM109 | Identification Code | 80891 | |

### 3.30 Billing Provider

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000A | PRV | Billing Provider Specialty | | Requested |
| | PRV01 | Provider Code | BI | |
| 2010AA | NM1 | Billing Provider Name | | Required |
| | NM101 | Entity Identifier Code | 85 | |
| | NM109 | Billing Provider Identifier | | Use the NPI of the entity who submitted the claim or encounter to the reporting managed care plan– this is validated against the NPPES file |

### 3.31 Pay-To Plan Name

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010AC | NM1 | Pay-To Plan Name | | Not used |

### 3.32 Subscriber Detail

Medi-Cal views each beneficiary as an individual subscriber.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2000B | SBR | Subscriber Information | | |
| | SBR01 | Payer Responsibility Number Code | S | MMEDSCMS is considered the destination (secondary) payer |
| | SBR09 | Claim Filing Indicator Code | MC | Medicaid |
| 2010BA | NM1 | Subscriber Name | | |
| | NM108 | Identifier Code Qualifier | MI | |
| | NM109 | Subscriber Primary Identifier | | This is the subscriber's Medicare ID Number which is Medicare Beneficiary Identifier (MBI) number. Must match the value in Loop 2330A, NM109 |

### 3.33 Payer Name

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010BB | NM1 | Payer Name | | |
| | NM101 | Entity Identifier Code | PR | |
| | NM103 | Payer Name | MMEDSCMS | |
| | NM108 | Identifier Code Qualifier | PI | |
| | NM109 | Identification Code | 80891 | |
| 2010BB | REF | Billing Provider Secondary Identifier | | |
| | REF01 | Medicaid Subscriber ID Identifier | G2 | |
| | REF02 | Medicaid Subscriber ID Number | | Medicaid State Assigned Identification Number – CIN – this is the same value sent in 2300 NTE |

### 3.34 Patient Detail

Submissions that include a Patient loop (2010CA) will cause discrepancies in the total number of encounters recorded per transaction and no Encounter ID will be returned for Encounters submitted within a 2010CA loop.

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2010CA | | Patient Name | | Since Medi-Cal views each patient as the subscriber, information in the Patient loop is not accessed |

### 3.35 Claim Level Detail

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2300 | CLM | Claim Information | | |
| | CLM01 | Claim Control Number | | Must be a unique number when Claim Frequency Code = '1'.<br>The first three characters must be the Medi-Cal HCP number of the plan the beneficiary was enrolled in at the time of the encounter |
| | CLM05-3 | Claim Frequency Code | | Use "1" for an original encounter submission;<br>Use "7" for a replacement submission;<br>Use "8" for a void submission |
| 2300 | CN1 | Contract Information | | Supply information as to how the encounter was paid for. |
| | CN102 | Contract Amount (for capitated encounters), or Paid Amount | | This is the amount paid by the plan as a part of their contract with Medi-Cal. This amount would equal the AMT*D amount for a payer designated with an SBR09 value of "MC".<br>Required when CN101 = 01, 02, 03, 04, and 06. Enter the amount paid for this encounter. This value may be zero |
| | CN104 | Reference Identification | | Enter the HCP Number of the plan this beneficiary is enrolled in |
| | REF | Payer Claim Control Number | | Used only if 2300 CLM CLM05-3 indicates that this encounter is a replacement or a void of a previous encounter |
| | REF01 | Reference Identification Qualifier | F8 | |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | REF02 | Payer Claim Control Number | | Previously submitted Claim Control Number of an encounter that is being replaced or voided |
| | NTE | Billing Note | | |
| | NTE01 | Note Reference Code | ADD | |
| | NTE02 | Description | | Enter the following Medi-Cal specific data separated by a semi-colon"<br>Medi-Cal CIN Number;<br>MEDS-ID;<br>Service Facility Location County;<br>Care Plan Option Indicator<br>See Appendix A for definitions |
| 2310A | NM1 | Attending Provider Name | | Required when the encounter contains any services other than non-scheduled transportation |
| | NM101 | Entity Identifier Code | 71 | Attending Physician |
| | NM109 | Attending Provider Identifier | | NPI – this is validated against the NPPES file |
| | PRV | Attending Provider Specialty Information | | Requested. |
| | REF | Attending Provider Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2310B | NM1 | Operating Physician Name | | Required when a surgical procedure code is listed on the encounter |
| | NM101 | Entity Identifier Code | 72 | Operating Physician |
| | NM109 | Operating Physician Identifier | | NPI – this is validated against the NPPES file |
| | REF | Operating Physician Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2310C | NM1 | Other Operating Physician Name | | Required when a surgical procedure code is listed on the encounter |
| | NM101 | Entity Identifier Code | ZZ | Other Operating Physician |
| | NM109 | Other Operating Physician Identifier | | NPI – this is validated against the NPPES file |
| | REF | Other Operating Physician Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2310D | NM1 | Rendering Provider Name | | Required if the rendering provider is different than the attending provider |
| | NM101 | Entity Identifier Code | 82 | Rendering Provider |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | NM109 | Rendering Provider Identifier | | NPI – this is validated against the NPPES file |
| | REF | Rendering Provider Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2310E | NM1 | Service Facility Name | | Required when the location is different than the billing provider |
| | NM101 | Entity Identifier Code | 77 | Service Location |
| | NM109 | Service Facility Primary Identifier | | NPI – this is validated against the NPPES file |
| | REF | Service Facility Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, G2, LU | Use "0B" for State License Number, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2310F | NM1 | Referring Provider Name | | Required on an outpatient encounter when different from the attending provider |
| | NM101 | Entity Identifier Code | DN | Referring Provider |
| | NM109 | Referring Provider Identifier | | NPI – this is validated against the NPPES file |
| | REF | Referring Provider Secondary Identification | | Multiple instances of this segment are expected |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2 | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number |
| 2330B | REF | Other Payer Secondary Identifier | | Plans are advised to not use this segment |
| | REF01 | Reference Identification Qualifier | FY | Claim Office Number |
| | REF02 | Other Payer Secondary Identifier | | Any data submitted in this data element will be over-ridden by CMS during encounter processing |

### 3.36 Service Line Detail

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| 2400 | REF | Line Item Control Number | | |
| | REF02 | Line Item Control Number | | Must be a unique number |
| 2410 | REF | Prescription or Compound Drug Association Number | | Required when a prescription number is available |
| 2420A | NM1 | Operating Physician Name | | Required when a surgical procedure code is listed on the encounter and the operating physician is different than at the claim level |
| | NM101 | Entity Identifier Code | 72 | Operating Physician |
| | NM109 | Operating Physician Identifier | | NPI – this is validated against the NPPES file |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | REF | Operating Physician Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2420B | NM1 | Other Operating Physician Name | | Required when another operating physician is involved and the other operating physician is different than at the claim level |
| | NM109 | Other Operating Physician Identifier | | NPI – this is validated against the NPPES file |
| | REF | Other Operating Physician Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2420C | NM1 | Rendering Provider Name | | Required if the rendering provider is different than the attending provider at the claim level, and when the rendering provider is different than at the claim level |
| | NM101 | Entity Identifier Code | 82 | Rendering Provider |
| | NM109 | Rendering Provider Identifier | | NPI – this is validated against the NPPES file |
| | REF | Rendering Provider Secondary Identification | | Multiple instances of this segment are expected |

| Loop ID | Reference | Name | Codes | Notes/Comments |
|---|---|---|---|---|
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2, LU | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number, use "LU" for location number |
| 2420D | NM1 | Referring Provider Name | | Required on an outpatient encounter when different from the attending provider, and, the referring provider is different than that at the claim level |
| | NM101 | Entity Identifier Code | DN | Referring Provider |
| | NM109 | Referring Provider Identifier | | NPI – this is validated against the NPPES file |
| | REF | Referring Provider Secondary Identification | | Multiple instances of this segment are expected |
| | REF01 | Reference Identification Qualifier | 0B, 1G, G2 | Use "0B" for State License Number, "1G" for Provider UPIN, use "G2" for the Medi-Cal Provider Number |

# 4 TI Additional Information

None at this time

# Appendix A – Medi-Cal Data Definitions

## A.1 CIN Number

This is the Client Index Number assigned by Medi-Cal to the beneficiary.

The CIN number is a nine byte alphanumeric field.

## A.2 MEDS ID

A supplemental beneficiary identification number sometimes used as a key within MEDS.

The MEDS ID is a nine byte alphanumeric field.

### A.3 Service Facility Location County

This field identifies the California county within which the service facility is located.

This is a two-byte numeric field, and is defined by the following table:

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

### A.4 Care Plan Option Indicator

This indicator is used to identify Care Plan Option (CPO) services. CPO services are defined in DHCS Dual Plan Letter 13-006:

**http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-006.pdf**

The Care Plan Option Indicator is a one byte alphanumeric field. Populate with "Y" if the services provided can be identified as Care Plan Option services. Otherwise populate this indicator with either "N" or null.

# Appendix B – Void and Replacement Scenarios

## B.1 Void of an Accepted Encounter

The value in CLM01 is used as a short representation – appropriate format requirements are described earlier in this document.

This scenario shows the related fields used to void a previously submitted encounter that was accepted. The first table shows the original encounter submission after processing:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 03/01 | A1234 | 1 | n/a | 0091234 | Accepted | |

A void is submitted. The following table shows both encounters after processing of the void on 03/26 has completed:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 03/26 | A1234 | 1 | n/a | 0091234 | Voided | Original encounter has been voided |
| 03/26 | A1234 | 8 | 0091234 | 0091245 | Void Processed | |

An attempt to replace this encounter once it has been voided would result in a denial, as follows:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| | A1234 | 1 | n/a | 0091234 | Voided | No change |
| | A1234 | 8 | 0091234 | 0091245 | Void Processed | No change |
| 03/27 | A1234 | 7 | 0091234 | 0091256 | Denied | Once an encounter has been voided no further action can be taken |

## B.2 Void of a Denied Encounter

This scenario shows the related fields used to void a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 04/01 | B2234 | 1 | n/a | 0081234 | Denied | Rendering NPI was invalid |

The submitted void was incorrectly formatted. The following table shows both encounters after processing of a void on 04/26 has been completed:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| | B2234 | 1 | n/a | 0081234 | Denied | Unchanged |
| 04/26 | B2235 | 8 | 0081234 | 0081245 | Denied | Invalid reference in CLM01 |

Another void is submitted on 04/27.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| | B2234 | 1 | n/a | 0081234 | Voided | Voided on 4/27 |
| | B2235 | 8 | 0081234 | 0081245 | Denied | Invalid reference in CLM01 |
| 04/27 | B2234 | 8 | 0081234 | 0081256 | Void Processed | |

### B.3 Replacement of an Encounter

This scenario shows the related fields used to replace a previously submitted encounter that was initially denied. The first table shows the original encounter submission after processing:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 05/01 | C3234 | 1 | n/a | 0071234 | Denied | Rendering NPI was invalid |

A replacement transaction is submitted but is also denied for a different reason. The following table shows both encounters after processing of the replacement has been completed:

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| | C2234 | 1 | n/a | 0071234 | Denied | Unchanged |
| 05/16 | C2234 | 7 | 0071234 | 0071245 | Denied | Service Facility NPI was invalid |

Another replacement is submitted on 05/27.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 05/27 | C2234 | 1 | n/a | 0071234 | Replaced | Original encounter was replaced |
| | C2234 | 7 | 0071234 | 0071245 | Denied | Unchanged |
| 05/27 | C2234 | 7 | 0071234 | 0071256 | Accepted | |

In the previous table take special note of the fact that since there was no accepted encounter in the history of this submission, the value supplied in REF*F8 was the Encounter-ID for **the earliest denied encounter.**

Another replacement is submitted on 05/29.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| | C2234 | 1 | n/a | 0071234 | Replaced | Unchanged |
| | C2234 | 7 | 0071234 | 0071245 | Denied | Unchanged |
| 05/29 | C2234 | 7 | 0071234 | 0071256 | Replaced | |
| 05/29 | C2234 | 7 | 0071256 | 0071267 | Accepted | |

In the previous table take special note of the fact that the value supplied in REF*F8 was the Encounter-ID for **the latest accepted encounter** "0071256 **NOT** the Encounter-ID for the original submission "0071234".

### B.4 Encounters that can NOT be corrected

This scenario shows an encounter that has been successfully voided.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 03/01 | D2234 | 1 | n/a | 0081234 | Voided | |
| 03/15 | D2234 | 8 | 0081234 | 0081245 | Void Processed | Original encounter was voided |

A subsequent replacement is submitted. This is denied.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 03/01 | D2234 | 1 | n/a | 0081234 | Voided | |
| 03/15 | D2234 | 8 | 0081234 | 0081245 | Void Processed | Original encounter (0081234) was voided |
| 03/18 | D2234 | 7 | 0081234 | 0081267 | Denied | Once an encounter has been voided, no further action can be taken |
| 03/20 | D2234 | 7 | 0081267 | 0081288 | Denied | No action can be taken on denied Replacement |
| 03/25 | D2234 | 8 | 0081267 | 0081299 | Denied | No action can be taken on denied Void |

Denied Replacement Encounter with encounter ID 0081267 cannot be corrected.

**Denied Void and Denied Replacement encounters cannot be acted on.**

This scenario shows an encounter that has been submitted and denied, because although it is an original submission to DHCS it is not coded as an original encounter – CLM05-3 should be equal to '1' and REF8F8 should be blank on original submissions.

| Date | CLM01 | CLM05-3 | REF8F8 | DHCS Encounter ID | Internal DHCS Status | Note |
|---|---|---|---|---|---|---|
| 03/01 | E2234 | 7 | 0099345 | 0091234 | Denied | Not an original encounter |

Encounter ID 0091234 cannot be corrected.