

SHORT-DOYLE/MEDI-CAL SYSTEM
EOB FILE RECORD LAYOUT (Revised December 1, 2005)

FIELD NAME	DESCRIPTION	EOB Extract	Data Type
CLAIM ID Claim Type Provider Code Claim Serial Number	ADP: A - Electronic file, D - Paper DMH: H - Electronic file, M - Paper This is a 5 digit sequential number within each provider code (each provider code has its own series). The Claim ID's Provider Code sub-field is not used in the system provider edits. After 99999 has been reached it can be set again to 00001. This insures that duplicates do not occur during a short time period and make the claim appear a duplicate to the system.	Claim_ID_I	Text
		Claimid_ClmType	Text
		Claimid_ProvCode	Text
		Claimid_ClmSerNum	Text
PROVIDER CODE	Must be non-blank. All alphabetic characters must be in UPPER CASE to match the Provider Master File.	ProviderCode	
CLAIM SUBMISSION DATE ^(a) Year Month	Must be equal to or after the month and year of service.	ClaimSubmissionDate	Text
		ClmSubmitDt	date
PROGRAM CODE	01 – DMH, Mental Health Services 20 – ADP, Drug Services 25 – ADP, Perinatal Services	ProgramCode	
MODE OF SERVICE (MEDI-CAL)	<u>DMH ONLY</u> 05 – Psychiatric Health Facility, Adult Crisis Residential, or Adult Residential 07 – Inpatient Hospital Services 08 – Psychiatric Hospital (Inpatient) – Under 21 09 – Psychiatric Hospital (Inpatient) – 65 or Over 18 – Non-Residential Rehabilitative Treatment <u>DMH AND ADP</u> 12 – Outpatient Hospital Services <u>ADP ONLY</u> 17 – Clinic Services	ModeOfService	
PATIENT NAME	See field notes.	PatientName	

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PATIENT RECORD NUMBER	County's client number ADP: Client record/chart number assigned by provider.	PatientRecordNum	
BENEFICIARY ID (See field notes)	The beneficiary ID may be formatted in any of the following ways: County code, aid code, case, FBU, person number, Example: 193R0686666011(19-3R-068666-0-11) or County code, aid code, "9", followed by SSN when the aid code= 10,20 or 60. Example: 11609563600020 (11-60-9-563600020) or County code, aid code, "M", followed by MEDS ID or Pseudo MEDS ID Example: 1330M87940123P (13-30-M-87940123P) or County code, aid code, "C" followed by the CIN, Example 2930C9863005A (29-30-C-98630052A) or SSN/MEDS ID or CIN followed by 5 blanks (not valid for HFP Claiming), Example: 136729153 (SSN) or 91298347A (CIN) (See Field Notes for clarification.) For Healthy Families: County code, aid code "9H", "9", followed by the CIN, Example: 399H998630052A (39-9H-9-98630052A).	BeneficiaryID	
YEAR OF BIRTH ^(a)	Year of Birth (YYYY) must be numeric.	YrOfBirth	
GENDER CODE	M – Male, F – Female, U – Unknown, blank – Unknown	GenderCode	
RACE / ETHNICITY CODE	1 – White 2 – Hispanic 3 – Black 4 - Asian/Pacific 5 - American Indian or Alaskan Native 7 - Filipino 8 - Other Blank – For 837 transactions see position 330 on the EOB record layout.	RaceEthCode	
DIAGNOSTIC CODE	Must be non-blank; codes are defined in the American Psychiatric Diagnostic and Statistical Manual IV-TR (DSM-IV-TR) for DMH claims and in the National Center for Health Statistics (NCHS) International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), ADP claims must use Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV.	DiagnosticCode	
SERVICE YEAR AND	Year and month that service is provided must be non-blank & numeric. The claim must be received by DMH within the sixth month following the end of	ServiceYrMon	text

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MONTH Year Month	the Service Year and Month.	ServiceMon	
TREATMENT (SERVICE) DATES ^(a) First Day Last Day	Treatment (Service) dates 01 through 31 01 through 31	TrmtFirstDt	text
		SvcFirstDt	date
		TrmtLastDt	text
		SvcLastDt	date
DISCHARGED CODE	1 or blank 1 – indicates that the patient has been formally discharged from 24 hour care services		
SERVICE FUNCTION	<p>ADP – one of the following codes</p> <p>20 through 22 – Outpatient Methadone Maintenance 23 through 25 – LAAM Maintenance ^(b) 26 through 27 – NTP – Individual Counseling 28 through 29 – NTP – Group Counseling 30 through 39 – Day Care Habilitative (counseling included) 40 through 49 – Residential Care (counseling included)^(c) 50 through 59 – Naltrexone Treatment (NAL)^(d) 80 through 84 – Outpatient Drug Free – Individual Counseling 85 through 89 – Outpatient Drug Free – Group Counseling</p> <p>DMH – one of the following codes</p> <p><u>24 Hour Services (Cost Reporting Mode 05, M/C Mode 05,07,08,09)</u></p> <p>10 through 18 - Local Hospital Inpatient 19 - Hospital Administrative Days 20 through 29 - Psychiatric Health Facility 40 through 49 - Adult Crisis Residential 65 through 79 - Adult Residential</p> <p><u>Day Services (Cost Reporting Mode 10, M/C Modes 12 or 18))</u></p> <p>20 through 24 - Crisis Stabilization – Emergency Room 25 through 29 - Crisis Stabilization – Urgent Care 81 through 84 - Day Treatment Intensive – Half Day 85 through 89 - Day Treatment Intensive – Full Day 91 through 94 - Day Rehabilitation – Half Day</p>	ServiceFunction	

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	95 through 99 - Day Rehabilitation – Full Day <u>Outpatient Services (Cost Reporting Mode 15, M/C Modes 12 or 18)</u> 01 through 09 - Case Management/Brokerage 10 through 18 - Mental Health Service (MHS) 19 - MHS Professional Inpatient Visit 30 through 38 - Mental Health Service 39 - MHS Professional Inpatient Visit 40 through 48 - Mental Health Service 49 - MHS Professional Inpatient visit 50 through 57 - Mental Health Service 58 - Therapeutic Behavioral Services (TBS) 59 - MHS Professional Inpatient Visit 60 through 68 - Medication Support 69 - Medication Support Professional Inpatient visit 70 through 78 - Crisis Intervention (CI) 79 - Crisis Intervention Professional Inpatient Visit		
UNITS OF TIME (Mainframe format, see field notes)	ADP: units-of-time is not required, zero filled. DMH: units-of-time must be numeric. See field notes for values.		
UNITS OF SERVICE (Mainframe format, see field notes)	Must be numeric. See field notes for values.		
NET BILLED AMOUNT (Mainframe format)	Must be numeric and greater than zero. The net billed amount is the actual service cost minus any payments by other sources.		
APPROVED AMOUNT	Indicates the total amount approved for payment.		
DATE CLAIM RECEIVED ^(a) Year Month Day	The earlier of the dates the claim file (via ITWS) or Medi-Cal certification form (via fax) are received by DMH or ADP. For paper claims, the DHS Key Data Entry staff obtain this date from the batch transmittal/cover using the upper right hand box that says "Date Received" by DMH or ADP.	ClaimRecievedDate	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
		CImRecvdDt	date
DENIED REASON CODE	(When sort key field = 'D', this code is used to indicate the denial reason) C – Unprocessable, invalid claim ID D – Unprocessable, duplicate claim ID F – Failed Edits, ("Approve/Deny" County option) N – Deny claim with non-Title XIX/HFP/XIX determination O – Unprocessable, invalid override code R – Unprocessable, receipt date error S – Unprocessable, duplicate claim ID on suspense T – Deny claim with tape submission error X – County requested denial of claim on suspense Blank – claim denied because it was on the suspense file more than 97 days (also see Days on Suspense field)		
ELIGIBILITY OVERRIDE CODE (See field notes)	W – Override eligibility edit (ECR only, ADP only) blank – Do not override eligibility edit		
LATE BILLING OVERRIDE CODE (See field notes)	A – Patient or legal representative's failure to present Medi-Cal identification B – Billing involving other coverage including, but not limited to Medicare, CHAMPUS, etc. (see TPL/OHC Ind.) C – Circumstances beyond the control of the local program/provider regarding delay or error in the certification of the Medi-Cal eligibility of the beneficiary by state or county. D – Circumstances beyond the control of the local program/provider regarding delays caused by natural disaster, willful acts by an employee, delays in provider certification, or other circumstances that have been reported to the appropriate law enforcement or fire agency, when applicable. E – Special circumstances that caused a billing delay such as a court decision or fair hearing decision. F – Initiation of legal proceedings to obtain payment of a liable third party pursuant to Section 14115 of the Welfare and Institutions Code (WIC). Blank – Do not override late billing	LateBillingOverrideCode	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
DUPLICATE PAYMENT OVERRIDE CODE (See field notes)	Y – Override duplicate billing edit (from submitted claim record or Duplicate ECR) Blank – Do not override duplicate billing edit	DupPymntOverrideCode	
DATE CLAIM WAS APPROVED, SUSPENDED OR DENIED ^(a) YEAR MONTH DAY	Approved and denied claims use the process cutoff date. Suspended claims use the run date. (also known as Adjudication Date)	ClmDecisionDate	
		ClmDispDt	date
COUNTY CODE (See field notes)	Set to correct county (01-58, 65, 66, 93 or 99) According to a county table in program MSD110		
FEDERAL / NON FEDERAL CODE	Indicates whether or not the beneficiary is eligible for Federal Financial Participation (FFP). N - Non – Federal (Not Eligible) F - Federal (Eligible) Blank - Not determined	FedNonfedCode	
CLAIM ORIGIN	D – ADP M – DMH The system checks the program code first to set this field; otherwise it checks the claim type.	ClmOrigin	
BATCH NUMBER County code Year of claim Month of claim Batch sequence Claim Media / Claim Submission Type	DMH: CC County code from file name and ITWS upload interface YYYY Service year from the MH1982A claim form. MM Service month from the MH1982A claim form. NN Sequence number for files within a particular service month, for example, 01 for original, 02 for the first supplemental, 03 for the second supplemental, etc. ITWS determines the sequence number using a batch number history table. "01" Literal: for electronic claims, "PC" - for paper claims (manual assignment process) ADP: CCYYYYMM 133 to 140 same as DMH NNN 141 to 143 Batch Sequence N 144 to 144 Claim Submission Type 1=original, 2=supplemental, 3=resubmission	BatchNum	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
SSN / MEDS-ID	If claim only has SSN in Bene ID field, then that SSN is moved here, or if CIN is in Bene ID's last 9 characters, then SSN is from CIN XREF, or if a 14 character Bene ID used for billing, then the SSN is from the MEDS County XREF file.	SSN	
DUPLICATE MATCH ID	This contains the SSN/MEDS-ID followed by four spaces if a SSN/MEDS-ID is found. The duplicate match ID field is equal to space when the SSN/MEDS-ID field is equal to spaces.	DupMatchID	
COUNTY USE FIELD	Passed from Claim to EOB without modification or edit.	CountyUse	
MAXIMUM ALLOWED AMOUNT	Schedule of Maximum Allowable Rate. Allowance or reimbursement rate by type of service. May change on a yearly basis.	MaxAllowedAmt	
		MaxAllowedAmt2	
ADMISSION DATE ^(a) Year Month Day	24 hour care claims (use only for DMH Inpatient Claims)	AdmitDate	
ERROR FIELD INDICATORS	(occurs 20 times) (See below for error code description)		
DUPLICATE ERROR INDICATOR		DupErr	
CROSSOVER ERROR INDICATOR ^(e)		CrossoverErr	
WELFARE ID ERROR INDICATOR	Error indicator for either SSN or Beneficiary ID	WelfareIDErr	
GENDER ERROR INDICATOR		GenderErr	
YEAR OF BIRTH ERROR INDICATOR		YOBErr	
SERVICE YYMM ERROR INDICATOR		ServiceYYMMErr	
PROVIDER ERROR INDICATOR		ProviderErr	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
MODE OF SERVICE ERROR INDICATOR		ModeOfServiceErr	
PROGRAM CODE ERROR INDICATOR		ProgramCodeErr	
SERVICE FUNCTION CODE ERROR INDICATOR		ServiceFuncCodeErr	
UNITS OF TIME/COUNSELOR'S INITIALS ERROR INDICATOR	For DMH units of time error. For ADP Counselor's initials error.	UnitOfTimeCounsInitErr	
UNITS OF SERVICE ERROR INDICATOR		UnitOfServiceErr	
TOTAL BILLED AMOUNT ERROR INDICATOR		TotalBilledAmtErr	
CLAIM SUBMISSION DATE ERROR INDICATOR		ClaimForErr	
NAME ERROR INDICATOR		NameErr	
ADMISSION DATE ERROR INDICATOR		AdmitDateErr	
RACE ERROR INDICATOR		RaceErr	
TREATMENT (SERVICE) DATE ERROR INDICATOR		TrmntDateErr	
DISCHARGE CODE ERROR INDICATOR		DischCodeErr	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
DIAGNOSIS CODE ERROR INDICATOR		DiagCodeErr	
SORT KEY (See field notes)	A – Approved claim D – Denied claim G – Aged suspended claim S – Suspended claim	SortKey	
DAYS ON SUSPENSE	Blank – If not on Suspense file or Blank – If on the Suspense file under 45 days Numeric – Claim has been on the Suspense file greater than 45 days	DaysOnSuspense	
CROSSOVER INDICATOR ^(e)	Blank – No Medicare or other health coverage H - Non-Medicare certified provider N - Medicare covered recipient, however either Medicare denied the claim or the claim is for services that Medicare does not cover P - Other health coverage X - Medicare coverage	Crossover	
THIRD PARTY LIABILITY (TPL) INDICATOR ^(e) (See field notes)	See field notes for TPL indicator values	ThirdPartyLiability	
HEALTH INSURANCE CLAIM NUMBER ^(e)	This field is from MEDS	HealthInsClnNum	
UNITS OF TIME (Text format, see field notes)	ADP: units-of-time is not required, zero filled. DMH: units-of-time must be numeric. See field notes for values.	Units_Of_Time	
UNITS OF SERVICE (Text format, see field notes)	Must be numeric. See field notes for values.	Units_Of_Service	
TOTAL BILLED AMOUNT (Text format)	Must be numeric and greater than zero. The total billed amount is the actual service cost minus any payments by other sources.	TotalBilledAmt	
TOTAL APPROVED ADJUSTED AMOUNT (Text format)	Indicates the total amount approved for payment.	TotalApprvAdjAmt	

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
TOTAL SERVICE CHARGE ^(e)	Total service charge is the total cost for the service. This is typically the posted / listed service rate. Passed from Claim to EOB without modification or edit.	TotalServiceCharge	
MEDICARE/OTHER COVERAGE AMOUNT ^(e)	Amount Medicare or other third party paid on the claim. Passed from Claim to EOB without modification or edit. Medi-Cal Oversight and Audits use this information.	MedicareOtherCoverageAr	
		MedicareOtherCoverageAr	
APPROVED AID CODE ^(c)	The aid code found on MEDS for which the claim was approved.	ApprvAidCode	
FFP APPROVED AMOUNT ^(f)	The amount of FFP approved for reimbursement. This field has a value only on <u>approved</u> claims. It is calculated using date of service, not when the claim is processed, for example, a claim with a date of service of 9-30-01 would have an aid code FFP rate from <u>federal fiscal year</u> 2000-2001. The <u>federal</u> fiscal year runs from October 1 through September 30.	FFPApprvAmt	
CLIENT INDEX NUMBER (CIN) ^(f)	This field is from MEDS	ClientIndexNum	
BIRTH MONTH AND DAY ^(f)	This field is from MEDS.	BirthMonthDay	
COUNSELOR'S INITIALS (ADP ONLY) ^(f)	Counselor's Initials (for ADP claims only). Must be 5 numbers, such as 00123 or 56789, or a 3 character left justified all UPPER-CASE alpha ID, such as KAM. This is in first name, middle initial and last name order. If no middle initial, then format with a dash (-) in between, such as K-M. If using the alpha version, the last 2 of 5 characters must be space filled. The edit is performed if the Service Function codes are '26' THRU '29' or '80' THRU '89'.		
MEDS ETHNICITY CODE ^(g)	See MEDS Quick Reference Guide		
MEDS SPOKEN LANGUAGE CODE ^(g)	See MEDS Quick Reference Guide		
COUNTY USE FIELD 2 ^(f)	Passed from Claim to EOB without modification or edit.	CountyUse2	
CARD ISSUE DATE ^(f)	This field is from MEDS.		
BUY-IN PART B EFFECTIVE DATE ^(f)	This field is from MEDS.		

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FIELD NAME	DESCRIPTION	EOB Extract	Data Type
STATE USE ONLY - HIPAA ENTITY CODE ^(h) (See field notes)	Must be space filled on input Claim records. On the system-created Proprietary claim and EOB, which originated from an 837 transaction, the translator populates this field with a HIPAA Entity Code.	HippaEntity	

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Footnotes

- (a) - This field is modified effective March 20, 1998 for Y2K
- (b) - LAAM is not valid for Program Code 25 (Perinatal Services)
- (c) - Residential is not valid for Program Code 20
- (d) - NAL is not valid for Program Code 25
 NTP – Narcotic Treatment Program
 SF codes 20–25 can only use counseling SF codes 26-29
- (e) - This field is either new or modified effective February 1995.
- (f) - This field is new effective May 14, 1999.
- (g) - This field is new effective August 8, 2003.
- (h) - This field is new effective October 17, 2003.

Data Formats

- X(nn) = Alphanumeric
 (nn) = field length
- N(nn) = Numeric
 (nn) = field length
- S9(nn)V99 = Signed Numeric (mainframe format)
 (nn) = field length
 V99 = implied decimal point with two decimal places
- N(nn).99S = Numeric (text format)
 (nn) = field length
 .99 = implied decimal point with two decimal places
 S = Explicit sign (“+” or “-“)

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ERROR CODE DESCRIPTIONS	
ERROR CODE	ERROR MESSAGE
01	BLANK
02	NOT VALID DATE
03	INVALID CODE This error code is currently set for many situations where an invalid code is encountered such as invalid gender code, invalid CIN, invalid SSN, etc. For Healthy Families this code will also be set if the aid code is equal to '9H' and the CIN is not a valid format. Valid format for a CIN is 9 digits, 9 in the first position and an alphabetic character other than 'P' in the 9 th position. It is also set if the aid code is equal to '9H' and no county is entered.
04	LATE SUBMISSION
05	NOT A VALID DAY
06	NOT NUMERIC
07	ZERO CLAIMED
08	MODE NOT AUTHORIZED
09	INELIGIBLE IN MO/YR This error code is currently set for the following reasons: 1) If no FFP aid code is found for the date of service. 2) If the Eligibility Status Code is not less than 500 for the primary segment or the Special Programs Segments 1,2, 3, or 4 but the ID is found on MEDS. For Healthy Families this code will also be set for the following reasons: 1) HFP Date of Service (or service date range for Inpatient) is not within the HFP eligibility period. 2) No HFP or Medi-Cal eligibility was found for the Date of Service but the ID is found on MEDS. 3) The HFP Date of Service shows the Eligibility Status Code on MEDS has a '5' or '7' in the second character.
10	CONFLICTS WITH ELIGIBILITY FILE
11	NOT ON ELIGIBILITY FILE
12	NOT ON PROVIDER FILE
13	PROGRAM NOT AUTHORIZED
14	MODE NOT AUTHORIZED IN MO/ YR
15	NO SECONDARY MATCH
16	MO/YR OF SERVICE GREATER THAN RECEIPT DATE
17	CLAIM HELD FOR THE HFP HOLD PERIOD Will be set for any HFP claim that comes in and the difference between the Current Date and Date of Service is less than the specified HFP Hold Period (currently 90 days).

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ERROR CODE DESCRIPTIONS	
ERROR CODE	ERROR MESSAGE
18	CLAIM TOO OLD FOR ELIGIBILITY CHECK BY SSN
19	INVALID SERVICE FUNCTION CODE
20	UNITS OF SERVICE ARE NOT LESS THAN OR EQUAL TO UNITS OF TIME
21	INVALID DRUG CODE
22	DATE RANGE NOT ALLOWED
23	UNITS > ALLOWED
24	UNITS> FROM DAY
25	UNITS NOT EQUAL TO DAYS
26	DUPLICATE SERVICE –NO OVERRIDE
27	MULTIPLE SERVICE –OVERRIDE OK
28	GREATER THAN TWO OUTPATIENT SERVICES
29	SERVICE FUNCTION NOT AUTHORIZED
30	SERVICE FUNCTION NOT AUTHORIZED IN MO/YR
31	MEDICARE COVERAGE PART, HIC #
32	OTHER COVERAGE IND
33	CLAIMS GREATER THAN 2 DAYS LAAM DOSE (ADP ONLY)
34	AMOUNT GREATER THAN ALLOWED
35	2 DOSES IN 1 DAY NOT ALLOWED (ADP ONLY)

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FIELD NOTES

Patient Name

The patient name field is not reformatted from the Claim file to the EOB.

HIPAA Transactions are fixed formatted with the Last Name X(11) and the First Name X(3). Older, non-HIPAA transactions will retain the format as assigned by the provider or county, but must start with the LAST NAME.

The Name must be UPPER CASE to match to MEDS.

Beneficiary ID

If the provider sends in only an SSN, MEDS ID, or CIN then the edit program, MSD110, builds a 14 character Beneficiary ID that has 0000 in the county and aid code plus the options of M, 9, or C and the other fields as described in the Beneficiary ID field. Then program MSD125 goes against MEDS looking for eligibility. If the SSN, MEDS ID, or CIN is not found then the zeros remain in the county and aid code. If there is no eligibility found on MEDS, the county and aid code displayed is blank, so the Suspended or Denied record will also have no values in them. The claim is denied with a "09" error code in Beneficiary ID (201-202) indicator and Service Month and Year Error (207-208) indicator if the person was "INELIGIBLE IN MO/YR".

Healthy Family Program claims must have the following information to be a valid Beneficiary ID: County of Responsibility Code (2 characters), the aid code "9H", the number "9", and the CIN. For example, a Beneficiary ID of "019H997862781A", would represent an HFP claim for Alameda county (01), followed by the aid code (9H), the digit 9, and the CIN of 97862781A

MEDS Pseudo IDs are system generated 9 character IDs. They always start with an '8' or a '9' and end with a 'P'.

Client Index Number (CIN) is a system generated 9 character ID. They are defined as 9NNNNNNNA. It always starts with a '9' has 7 numeric digits and ends with an alpha character of: A, C thru H, M, N, S thru Y. These characters are invalid endings for CINs: B, I, J, K, L, O, P, Q, R, or Z. Note that CINs never end with a 'P' and therefore cannot be confused with pseudo MEDS IDs. CINs are cross-referenced to MEDS IDs in the MEDS system.

The new BIC card (as of January 2005) has a 14 character ID. The first 9 are the CIN followed by a check digit and a four-digit Julian date that matches the date of issue on the BIC. The CIN from the BIC may be placed in the Beneficiary ID, followed by 5 spaces. For example, when the BIC ID is 90000000A95001, 90000000A is the CIN, 9 is the check digit, and 5001 is the 4-digit Julian date for January 1, 2005. In this instance, the Beneficiary ID is "90000000A ". **Remember that the BIC ID and the Beneficiary ID are different formats.**

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SD/MC Verification of Eligibility with MEDS

The SD/MC system matches the claim against MEDS to verify eligibility. The match is on Beneficiary ID, Name, Date of Birth, Gender, and Date of Service.

County Code

65 is Berkeley, 66 is Tri City and 93 is Stanislaus. 99 is an error code that means the county code in the provider number is not valid or numeric. ADP and DMH have so many providers that they ran out of provider numbers for big counties like SF and LA. In LA's case, they have provider numbers that start with 70-79, instead of 19. The batch number's county code must equal the provider number's first 2 characters when it is used as a subscript to do the county number look up on the county table in program MSD110. This table will set the county code to 19, when it finds a provider code starting with one of the seventies.

Duplicate Payment Override Code

ADP will only allow the override to work for: Error Code 27 (Multiple Service – Override Ok)

DMH will only allow the override to work for: Error Code 27 (Multiple Service – Override Ok) and
Error Code 28 (Greater Than Two Outpatient Services)

The purpose of the suspense is to allow for correction of data that may have been entered in error (e.g. date of service). If the data was correct, multiple/duplicate units of service will be permitted only with a certified override. Override code 'Y' in the override field on the Duplicate Error Correction Report (DUPECR) will remove the claim from suspense and allow approval of the claim. The Duplicate ECR contains a certification that the use of the 'Y' code is predicated on the review of client records by a licensed clinician and that the services were appropriate and medically necessary. Any combination of more than two outpatient services on the same day will be permitted only with a certified override.

Eligibility Override Code

This override process can only be done using the ECR report. As of January 17, 2003, DMH cannot use the W Override code. The program that applied the override using ECRs now errors out the correction transaction. The claim will stay on the suspense file unless other errors are corrected (incorrect DOB, incorrect SSN, incorrect name, etc).

HIPAA Entity Code

A HIPAA translator at the Health and Human Services Data Center (HHSDC) is used to convert HIPAA transactions into the proprietary 157-character records the system uses. The following five fields are used to create a unique identifier to link the input data from the 837 transaction to the 350-character EOB to create an 835 transaction: Claim ID (1-10), Date Claim Received (109-116), County Use (167-181), County Use 2 (332-334), and HIPAA Entity Code (349-350). The translator populates the HIPAA Entity Code field from the entity code received from the ITWS.

Late Billing Override Code

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(Code is used to indicate the denial reason). For DMH, there is a 1 year and one month limit to bill. If the claim is over the limit, '04' (Late Submittal) code is moved into the Service YYYYMM error indicator field. ADP does not have that limit.

Sort Key

A – Approved claim

D – (MSD120/125 sets when non-FFP aid code found and MSD 140 sets when the claim ages off or a correction transaction comes with a deny override code of 'X').

G – This is for ADP. DMH does not get aged EOB records. (MSD140 sets when a claim has been on suspense more than 45 days. The cutoff date vs. the suspend/approve date is used to make the calculation. The claims are written to a separate file and then added with all the denied, approved and suspense records to make the EOB file. That means for counties that get their EOBs just once a month it is possible to have the same record marked as aged 4 times since each new cutoff period a newly aged suspense record for the EOB).

S – (MSD 130 for the ECR process and MSD 170 sets 'S' for duplicate errors)

Third Party Liability

Other Health Care (OHC) from MEDS except Medicare definitions (*, #, or \$) which are then assigned by SD/MC (MSD 120/125)

PAY AND CHASE

A ANY CARRIER (includes multiple coverage)

COST AVOIDANCE

C CHAMPUST Prime HMO

F Medicare HMO

K Kaiser

L Dental only policies

P PHP/HMOs or EPO (Exclusive Provider Option)

V Variable-Any carrier other than the above, includes multiple coverage

9 Healthy Families Program

Other Health Coverage Definitions

' NONE ADP definition NO TPL/OHC

' NONE DMH definition NO MEDICARE and NO TPL/OHC

N NONE

O OVERRIDE

Medicare Definitions

* PART A ONLY

PART B ONLY

\$ PART A AND PART B

@ PART D ONLY

% PART A AND PART D

& PART B AND PART D

! PART A AND PART B AND PART D

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DMH Units of Service, Units of Time

Service Mode Description	M/C Modes of Service	Service Function	Units of Service	Units of Time
Any 24 hours Service	05, 07, 08, 09	Any	Number of Days	Zero (always)
Any Day Service *	12, 18	20-29	"1" (always)	Number of hours
		81-84 & 91-94	"1" (always)	"1" (always) half day
		85-89 & 95-99	"1" (always)	"1" (always) full day
Any Outpatient Service*	12,18	Any	"1" or "0" **	Number of minutes

* Non-24 services may not be aggregated. These services must be claimed separately.

**For outpatient services, the units of service may be equal to zero if there is no contact with a client or support person.