ELMR

Electronic Management of Records

Substance Abuse Program

Provider Connect

Training Manual

(v.2.0)

~~March~~ 2013

Table of Contents

Introduction

Welcome to "Provider Connect", Riverside County Mental Health Department, Substance Abuse's new online system for authorizations and billing. RCMHD is excited to implement our new software system Avatar, a Netsmart product. RCMHD has named our new system ELMR, which stands for **El**ectronic **M**anagement of **R**ecords. The target Go-Live date is July 1, 2011. All authorizations beginning on 7/1/2011 are required in order to enter services and bill through Provider Connect.

The website link is **https://carelink.carenetasp.com/riverside/login.asp**. Each provider will be given their User ID and Password. The new Support line for questions regarding **Provider Connect** is the **ELMR Help Desk at (951) 955-7363 or at ELMRsupport@rcmhd.org**.

Appendix: **Updates from 02/14/2012:**

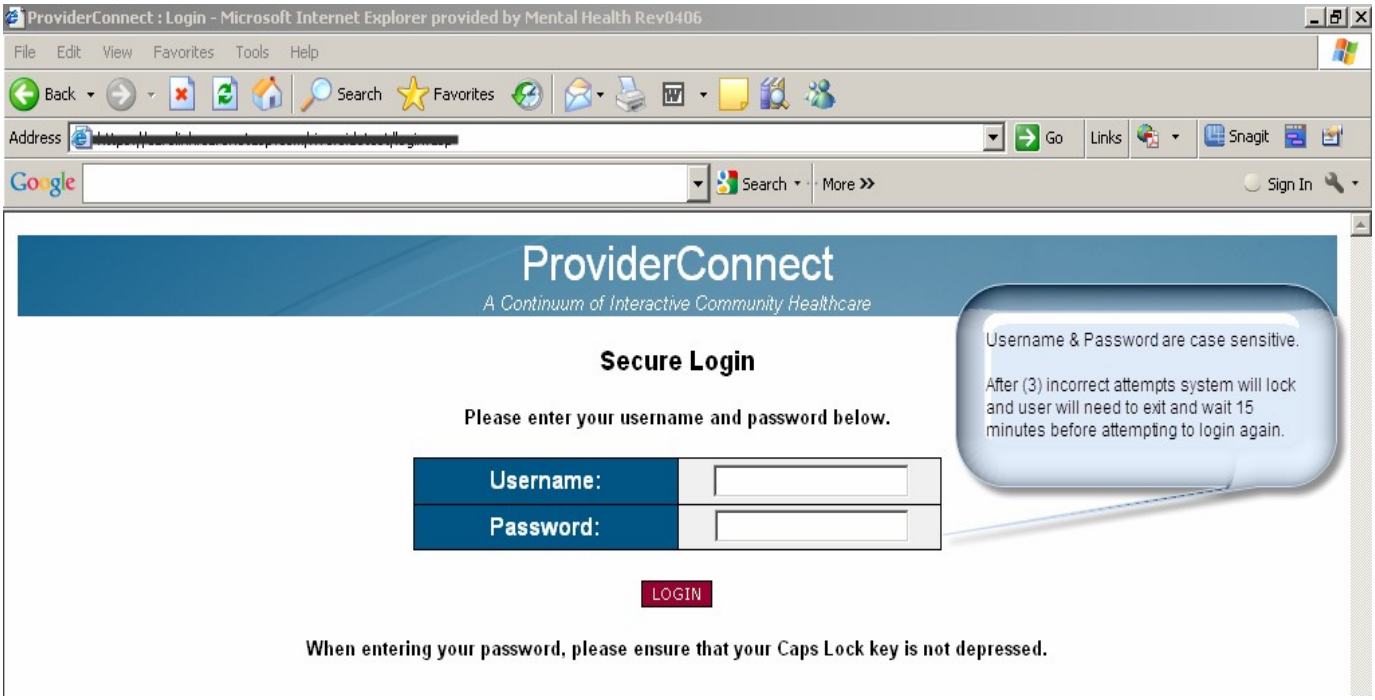
Document identifying changes seen in Provider Connect as well as the billed and unbilled reports. The changes were discussed during the provider meeting held on February 9, 2012.

Appendix: **Billing Reports instructions 4/2012:**

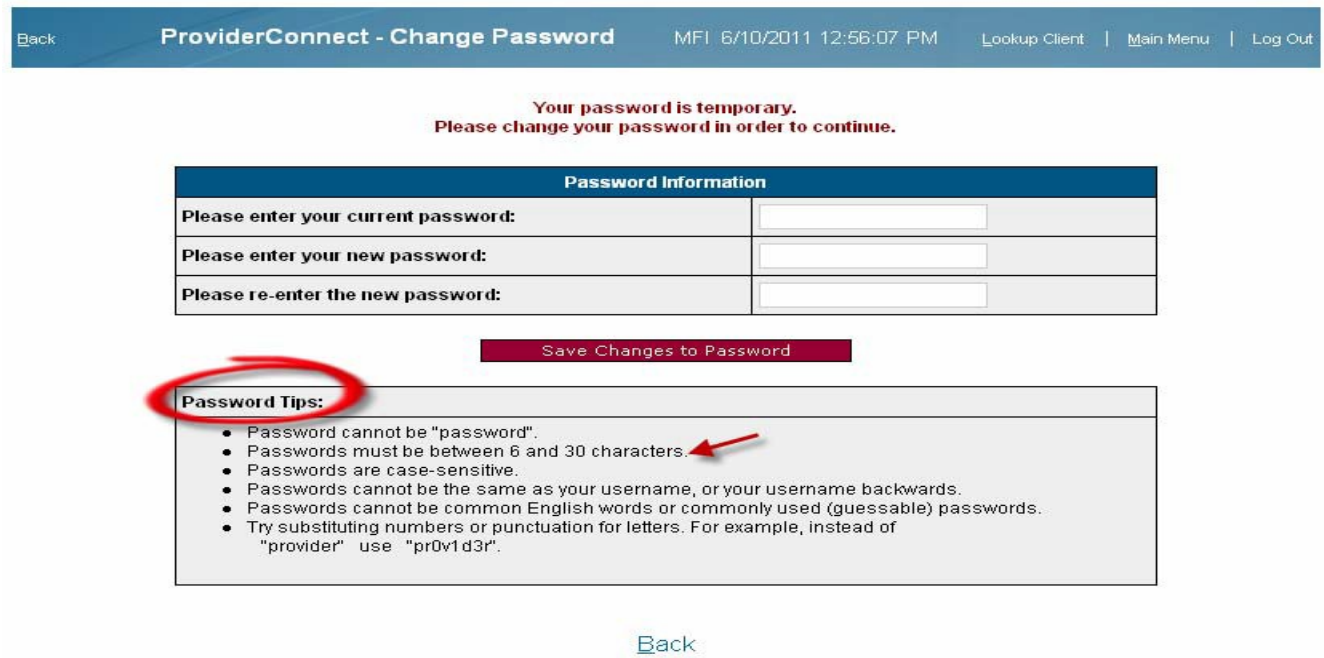
Document for instructions on running billing reports.

Signing On

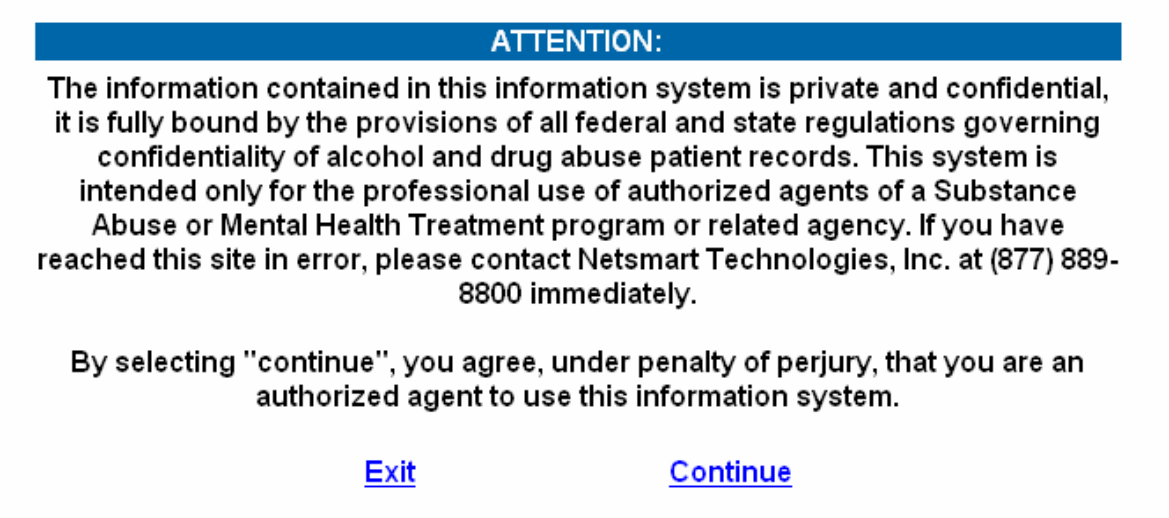
At the login screen, enter username and password. Username and passwords are case sensitive. If an incorrect username and password is entered three (3) times, the system will lock the user account. After 15 minutes, the user can attempt to login again. If your password expires, please contact the ELMR Help Desk through the information provided in the introduction section. After logging in, the user will see the security page. Continue through this page.



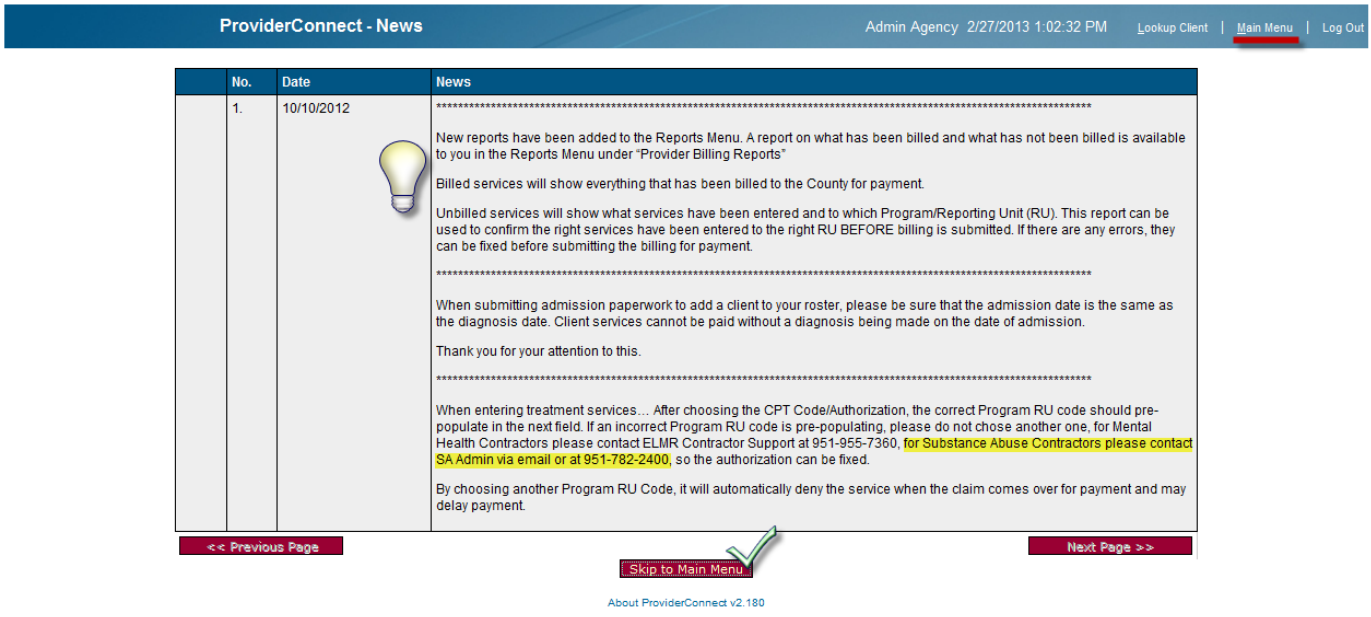
System will prompt user to enter a new password. Follow the instructions in the '**Password Tips**' when creating new password. Once new password is selected and entered in the corresponding fields, click on '**Save Changes to Password**' command button.



System displays the "**Security Page**" confidentiality message screen, click '**Continue**'.

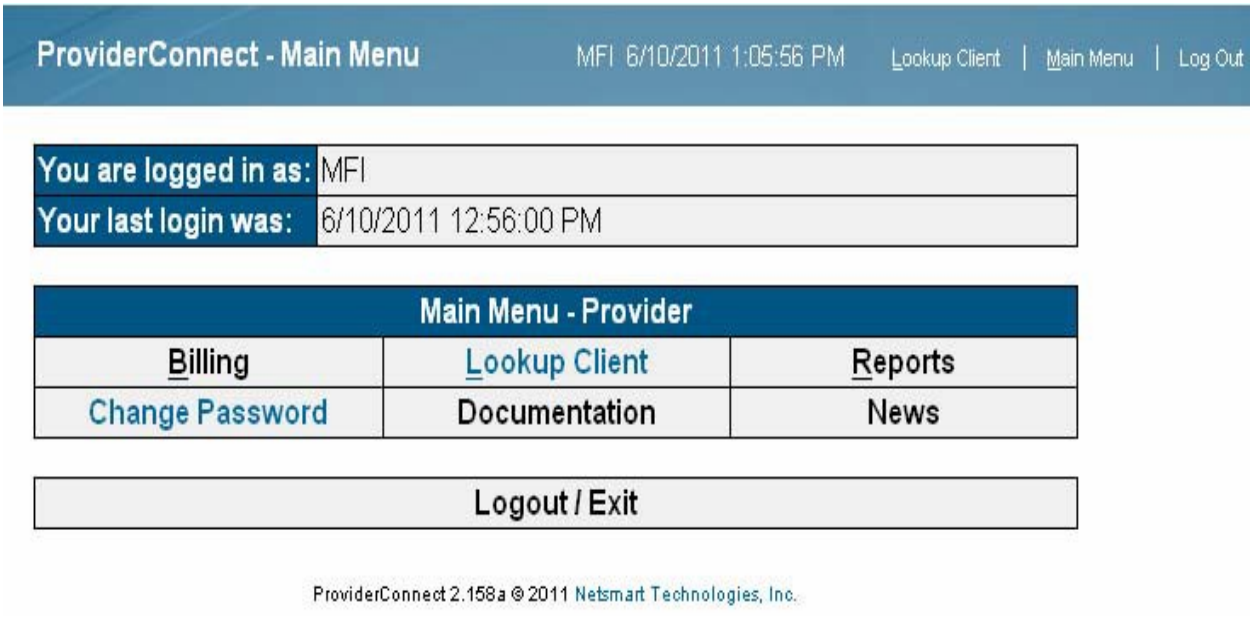


The '**News**' screen will appear next. Click on "**Skip to Main Menu**" command button to proceed to the next screen. News is shared between both the Mental Health and Substance Abuse departments. Information intended for one department will be identified as such. Substance Abuse Administration will also follow-up with an email to each Contracted agency.



NAVIGATING IN PROVIDER

CONNECT Main Menu



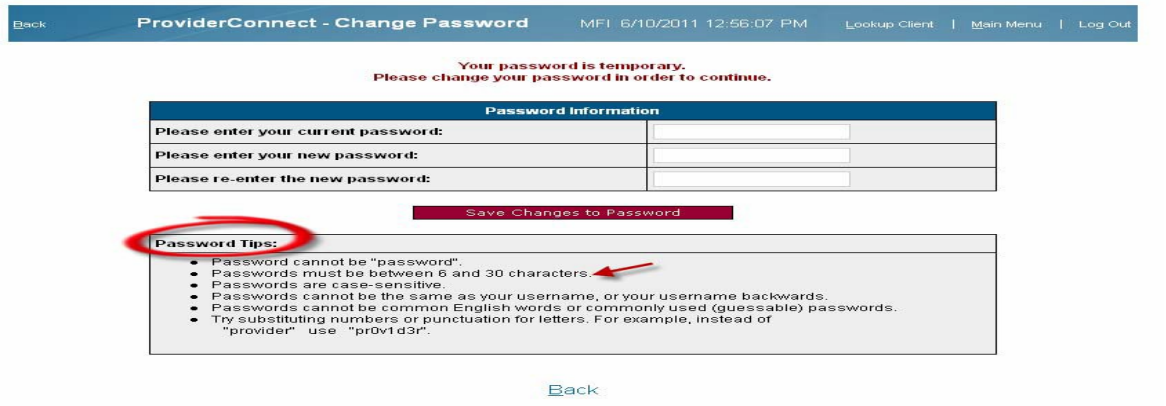
Navigating the Main Menu

This is the main screen. From this screen, there are several options:

- **Billing** – this option takes the user to the screen that will allow the user to generate a bill for all the services that have been entered through Provider Connect. Only one person in your agency needs to be responsible for using this option.
- **Change Password** – this option allows the user to change their password. If there is the potential for a security threat, passwords should always be changed.
- **Look Up Client** – this option allows the user to search for a client that has been assigned to their agency in the system.
- **Documentation** – currently not in use.
- **Reports –** this option takes the user to the screen that allows the user to pull 'billed' or 'unbilled' reports.
- **News** – this option takes the user back to the news page.

Change Password

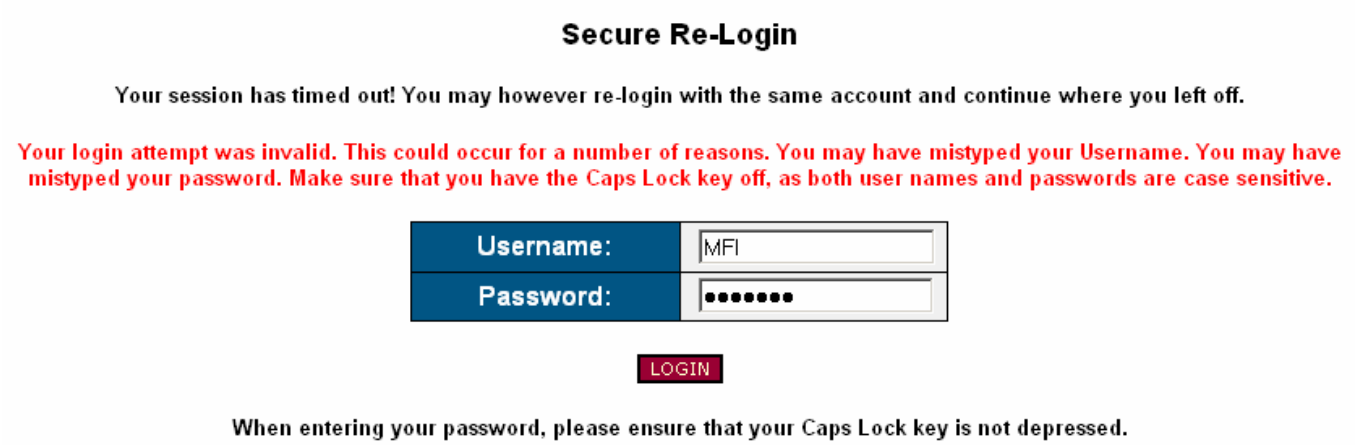
If you need to change your password at any time, click on “Change Password” on the main menu. You will see the screen below. The screen will require your old password followed by the new one. The new password must be entered twice for verification.



IMPORTANT

Provider Connect requires users to change their password every 90 days but users may also change their password at any time. Remember that passwords are case sensitive.

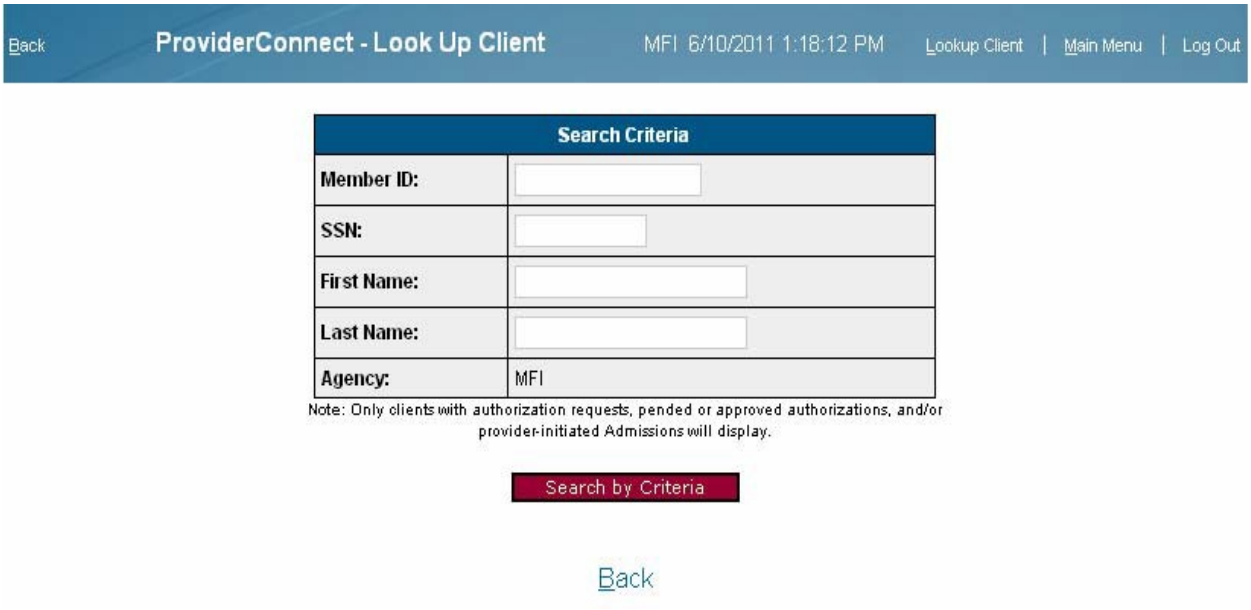
Invalid Login Attempt or Session Timed Out Message

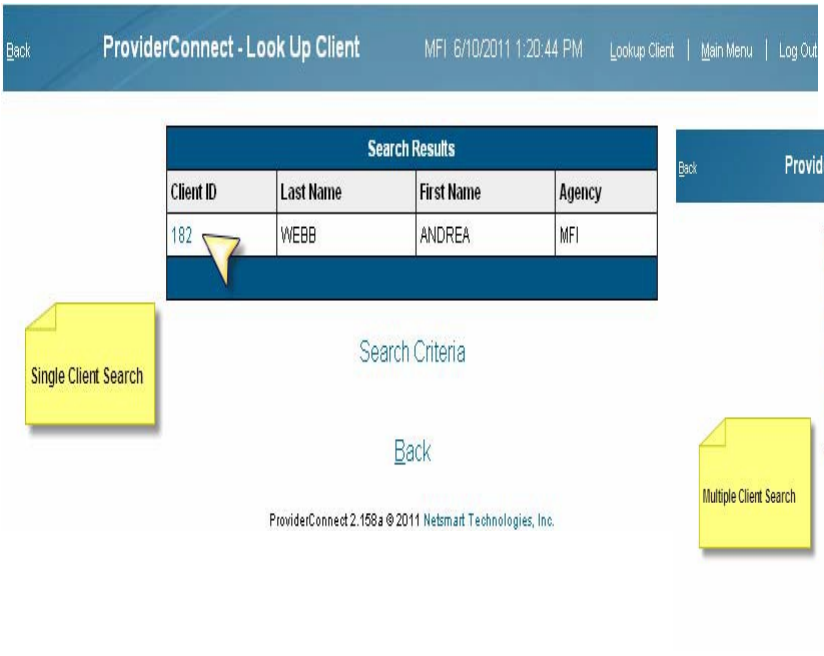


Look Up Client

In order to request authorizations or enter treatment information for a consumer, you will need to work from the consumer's profile screen. In order to access this screen, follow the steps below:

- Choose "Look Up Client" from the main menu.
- You may enter the client's ELMR assigned Client ID number or you may look the consumer up by name. Then click on 'Search by Criteria' command button. Once client is displayed click on 'Client ID' to pull up the client's profile screen.
- If you want to view all the clients you can click on "Search by Criteria" without populating any of the fields above. The system will list all the clients assigned to your agency. You can click on the ELMR assigned Client ID number to pull up the client's profile screen.

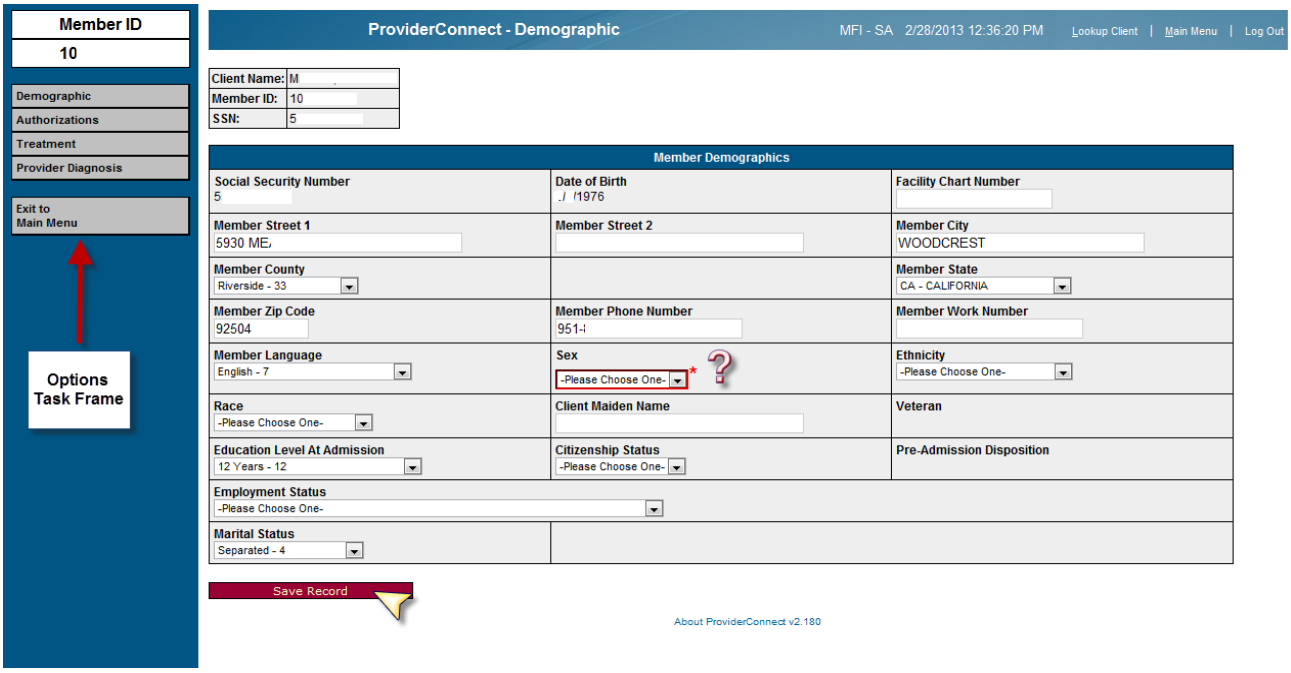




Navigating the Client Profile Screen

On the left side of the Client Profile screen, several options are listed. The profile screen automatically defaults to the demographic page when the client record is accessed.

Demographic

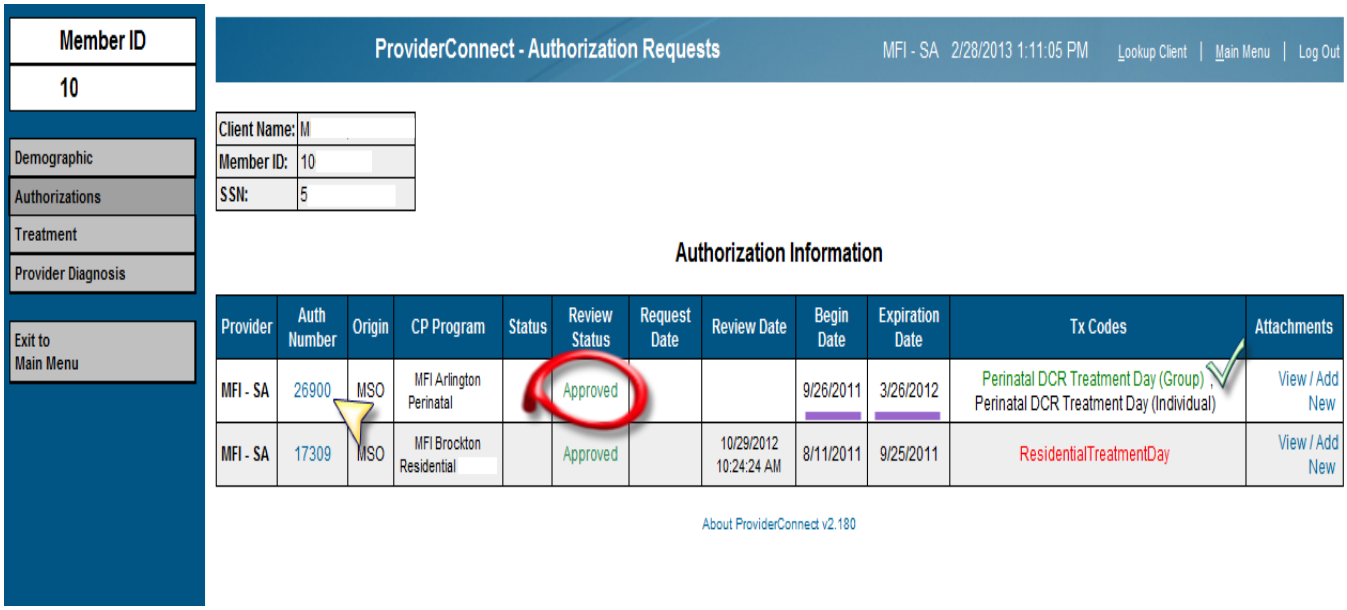


If a field is highlighted in 'red' and has a '*' symbol, this identifies a required field missing. Select appropriate answer to question and then click on, "Save Record" command button. This will transfer the saved data to the County internal ELMR system.

Checking for Approved Authorizations from RCMHD Substance Abuse Administration.

In order to see all Authorized/Approved Admission Requests information that have been sent to the provider by RCMHD Substance Abuse Administration, the user should click on "Authorizations" from the options task frame if client profile is currently in view (Shown Above).

Authorizations



The screen above shows any authorizations approved for the selected client. Substance Abuse Administration is only processing "Approved" authorizations in to Provider Connect. Those Admission Requests that are Pending or Denied will be returned back to the provider with comments and not entered in Provider Connect.

Click the correct "Auth Number" in order to pull up the authorization.

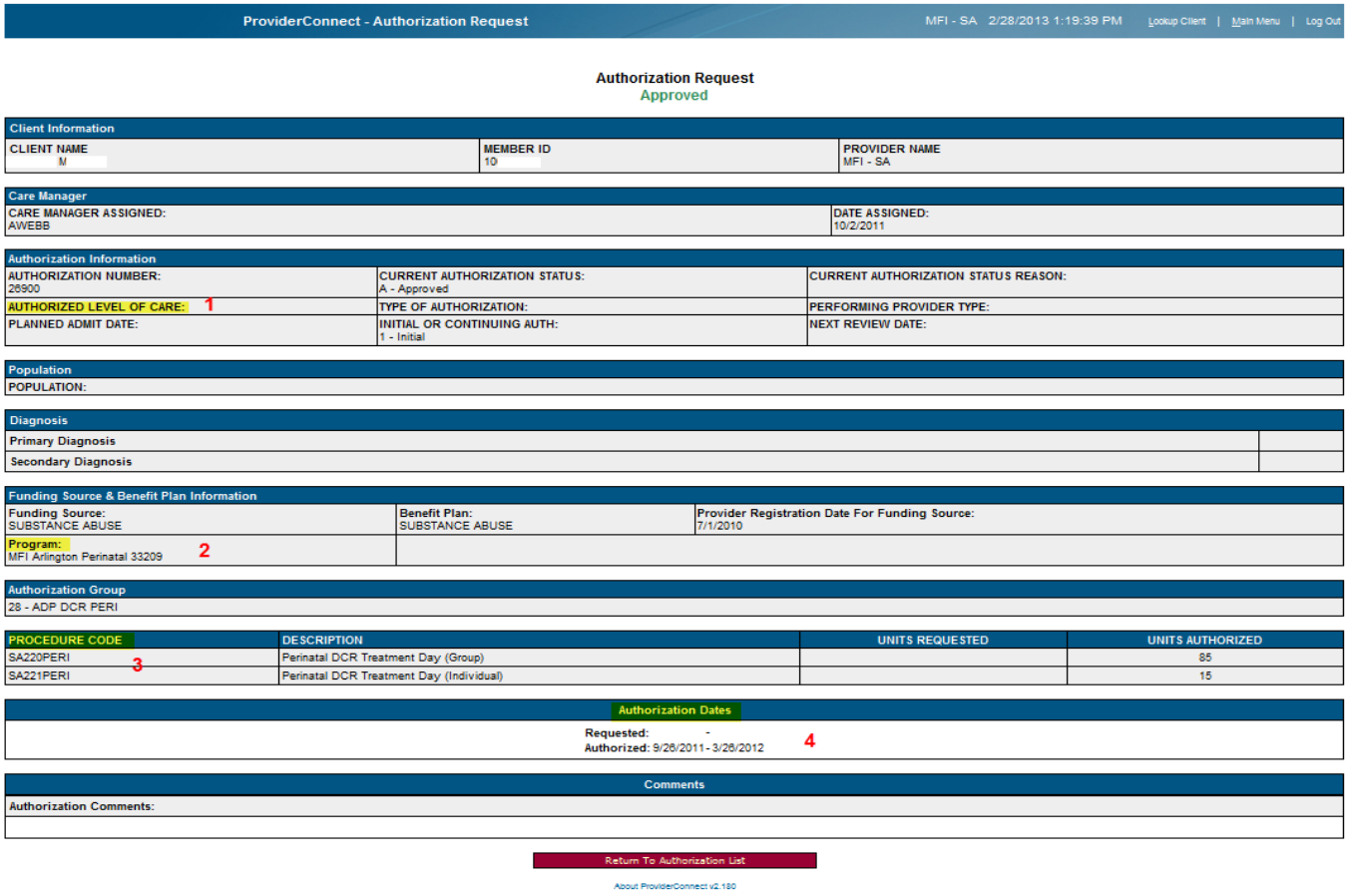
A request can have four (3) different status options: Currently SA Admin is **ONLY** processing "Approved"

- **Approved** – SA Admin has approved your authorization. Please check the start and end dates and the units of your authorization.
- **Pended** – Not in use. All pended requests will be sent back to the provider for with instructions for re-submission.
- **Denied** – Not in use. All denied requests will be sent back to the provider with reason for denial.

If a save disk is present in the attachments column that indicates an attached document by Substance Abuse Administration was uploaded. **TBD** – this may be the new process of forwarding the signed/approved admission request forms.

Substance Abuse Administration will utilize the comments section listed at the bottom of the authorization to communicate with the provider. (See illustration next page)

The following Screen appears after you select the Auth Number from the Authorization Requests screen list. This screen is the actual service authorization, which details the service authorized, date range, units, and any authorization comments.



ProviderConnect - Authorization Request

MFI - SA 2/28/2013 1:19:39 PM Lookup Client | Main Menu | Log Out

Authorization Request
Approved

Client Information

CLIENT NAME	MEMBER ID	PROVIDER NAME
M	10	MFI - SA

Care Manager

CARE MANAGER ASSIGNED:	DATE ASSIGNED:
AWEBB	10/2/2011

Authorization Information

AUTHORIZATION NUMBER:	CURRENT AUTHORIZATION STATUS:	CURRENT AUTHORIZATION STATUS REASON:
26900	A - Approved	
AUTHORIZED LEVEL OF CARE: 1	TYPE OF AUTHORIZATION:	PERFORMING PROVIDER TYPE:
PLANNED ADMIT DATE:	INITIAL OR CONTINUING AUTH: 1 - Initial	NEXT REVIEW DATE:

Population

POPULATION:

Diagnosis

Primary Diagnosis	
Secondary Diagnosis	

Funding Source & Benefit Plan Information

Funding Source:	Benefit Plan:	Provider Registration Date For Funding Source:
SUBSTANCE ABUSE	SUBSTANCE ABUSE	7/1/2010
Program: 2		
MFI Arlington Perinatal 33209		

Authorization Group

28 - ADP DCR PERI

PROCEDURE CODE	DESCRIPTION	UNITS REQUESTED	UNITS AUTHORIZED
SA220PERI 3	Perinatal DCR Treatment Day (Group)		85
SA221PERI	Perinatal DCR Treatment Day (Individual)		15

Authorization Dates

Requested: -
Authorized: 9/26/2011 - 3/26/2012 4

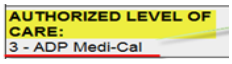
Comments

Authorization Comments:

Return To Authorization List

About ProviderConnect v2.180

1. Authorized Level of Care – review the authorization and make sure that ADP Medi-Cal is assigned here if client is eligible.



2. Program – review the authorization and make sure that the correct program ID has been approved/entered.

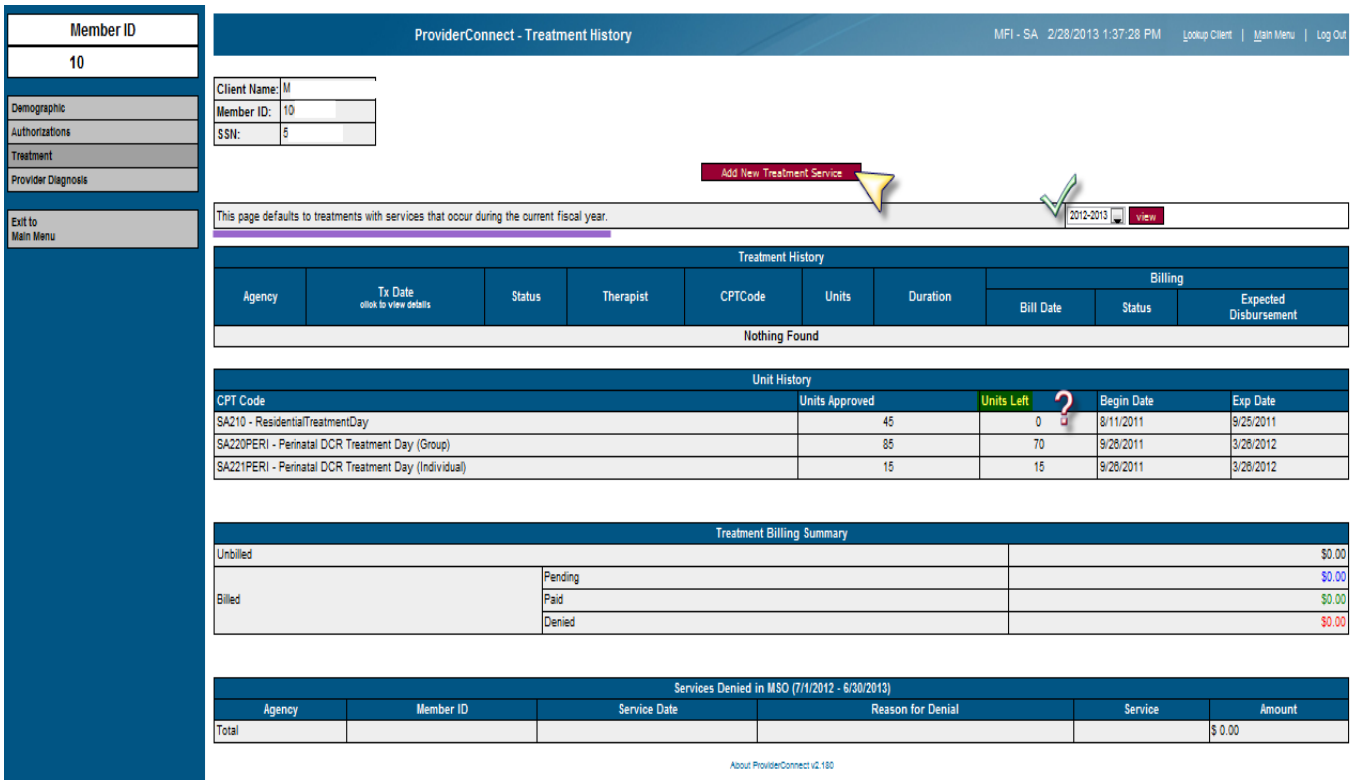
3. Procedure Code – review the authorization and make sure that the service codes approved/entered are correct and correspond to the 'program' authorized.

4. Authorization Dates – review the authorization and make sure that the service date range is correct.

Service Entry for Billing to RCMHD Substance Abuse Administration

All services must be billed through Provider Connect using the following steps:

- Click on the "Treatment' in the options task frame. The user will see past claim history for the client. To add treatment (services) for a client, click on "Add New Treatment Service" command button at the top of the page.



Treatment History – Identifies all services entered in to Provider Connect.

Treatment History

Agency	Tx Date (click to view details)	Status	Therapist	CPTCode	Units	Duration	Billing: Bill Date	Billing: Status	Billing: Expected Disbursement
MFI	6/2/2011	Complete	MOLINA,LISA	SA440	1	60	6/14/2011	Approved	$28.69
MFI	6/1/2011	Complete	MOLINA,LISA	SA421	1	60	6/14/2011	Approved	$60.78
MFI	3/31/2011	Complete	MOLINA,LISA	SA440	1	90	6/10/2011	Denied	$0.00
MFI	3/25/2011	Complete	MOLINA,LISA	SA440	1	90	6/10/2011	Denied	$0.00

- **Tx Date** – can be selected by clicking on date to view sergice entry details.
- **Status (under Treatment History)** – 'blank field' shows the status of unbilled, the word 'Complete' shows the status of billed to County.
- **Therapist** – Clinician identified as rendering the service.
- **CPTCode** – Procedure/Service Code entered for service rendered.
- **Units** – Number of units entered for rendered CPT Code.
- **Duration** – The time in minutes it took for the rendered service. (Reminder that reimbursement is based on contracted CPT Code, Units, and Duration). ODF Individuals are up to 60 minutes, ODF Groups are up to 90 minutes, DCR Groups/Individuals are up to 180 minutes, NTP Groups/Individuals are in 10-minute increments, Detox and Residential are 1440 minutes.
- **Bill Date** – Identifies the date the services line was included in a generated bill to the County.
- **Status (under Billing)** – 'Not Reviewed' states that your agency bill submitted to the County has not been closed for payment processing. This does not mean that your agency bill is not under review. 'Approved' and 'Denied' are status reporting after the County has closed and processed your bill for payment. Reason for denied services are identified at the bottom of the "treatment history" page (shown above).

Unit History – Identifies the number of units authorized for each CPT Code and how many units remain. Provider Connect will not allow service entry if no units remain. This field should be checked monthly in order to verify if additional units authorized are required or if expiration date needs to be extended. Requests are sent via email to the SA Administration designated person.

Unit History				
CPT Code	Units Approved	Units Left	Begin Date	Exp Date
SA210 - ResidentialTreatmentDay	45	0	8/11/2011	9/25/2011
SA220PERI - Perinatal DCR Treatment Day (Group)	85	70	9/26/2011	3/26/2012
SA221PERI - Perinatal DCR Treatment Day (Individual)	15	15	9/26/2011	3/26/2012

Treatment Billing Summary – Identifies the amounts paid or denied for client treatment history based on fiscal year selected at top of page.

Treatment Billing Summary		
Unbilled		$0.00
Billed	Pending	$0.00
	Paid	$89.47
	Denied	$0.00

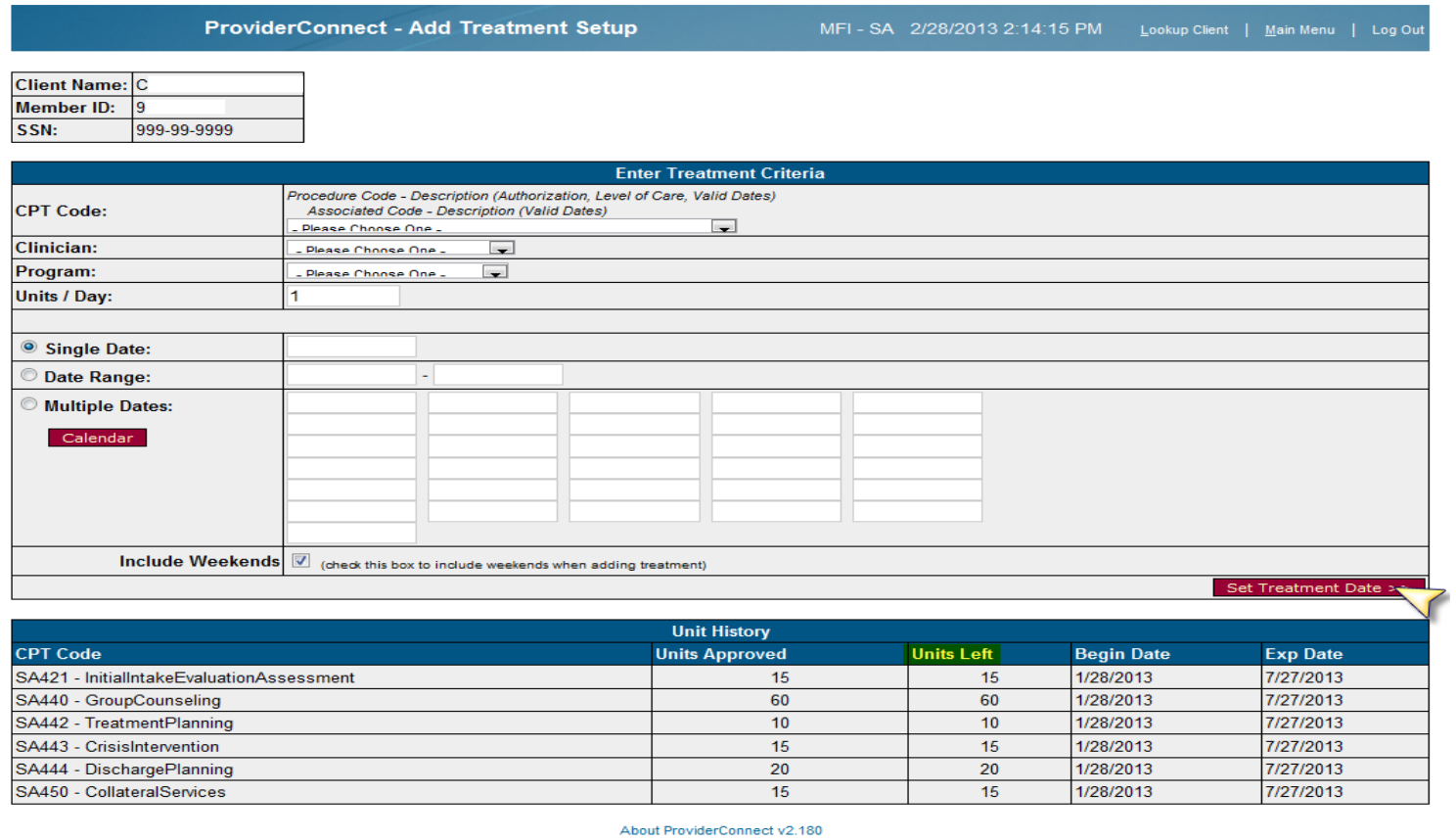
Service Denied in MSO (Fiscal Year Selected) – Provides a history of reason why service was denied for client.

Services Denied in MSO (7/1/2012 - 6/30/2013)					
Agency	Member ID	Service Date	Reason for Denial	Service	Amount
Total					$ 0.00

Entering Treatment Services in Provider Connect

CPT Codes is equivalent to what is currently known as Procedure Codes/Service Codes. Provider is able to enter services as a single, date range, or multiple date entry. History of utilized authorized units is displayed at the end of this screen.

"Add New Treatment Service"



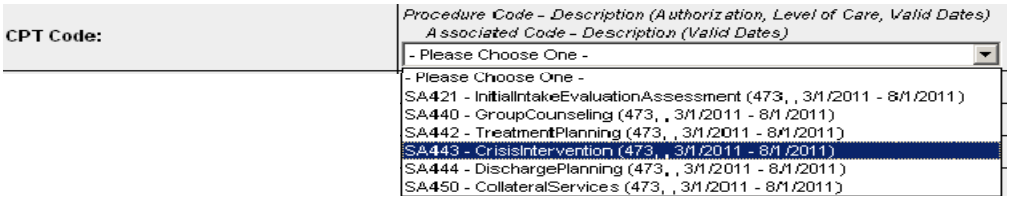
Unit History				
CPT Code	Units Approved	Units Left	Begin Date	Exp Date
SA421 - InitialIntakeEvaluationAssessment	15	15	1/28/2013	7/27/2013
SA440 - GroupCounseling	60	60	1/28/2013	7/27/2013
SA442 - TreatmentPlanning	10	10	1/28/2013	7/27/2013
SA443 - CrisisIntervention	15	15	1/28/2013	7/27/2013
SA444 - DischargePlanning	20	20	1/28/2013	7/27/2013
SA450 - CollateralServices	15	15	1/28/2013	7/27/2013

About ProviderConnect v2.180

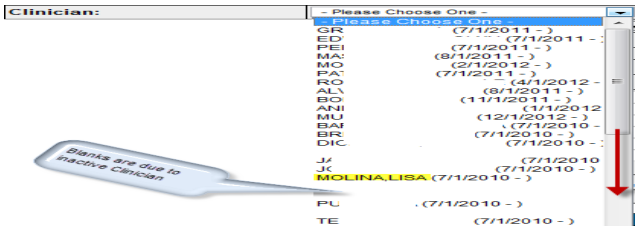
Unit History – Displays the units approved and the remaining amount of units left. When entering services for client pay close attention to 'units left' and 'exp date' as the system will not allow you to enter additional 'unauthorized' units or services past the expiration date.

Data Entry Process

- When entering the treatment/service, first choose the appropriate CPT (Service or Billing) code from the drop down box. Only authorized codes will display and identifies the date range of the authorization.

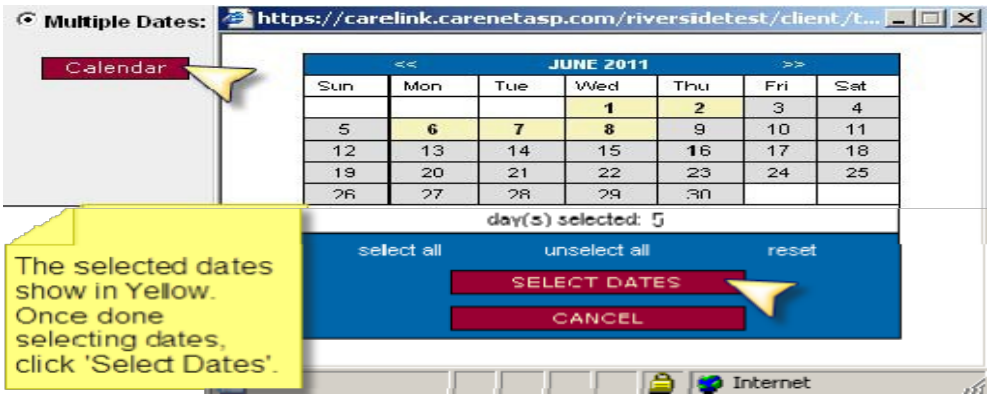


- Enter the correct clinician/agency (attending provider) that rendered the service. You will need to select the appropriate clinician (attending provider) based on the type of service being billed.



- Program pre-populates based on CPT Code selected as the Auth # is identified in the CPT Code line. If the program identified is incorrect "STOP" service entry and verify that the 'Authorization' is correct. Request any corrections via email to Substance Abuse Administration designated person.

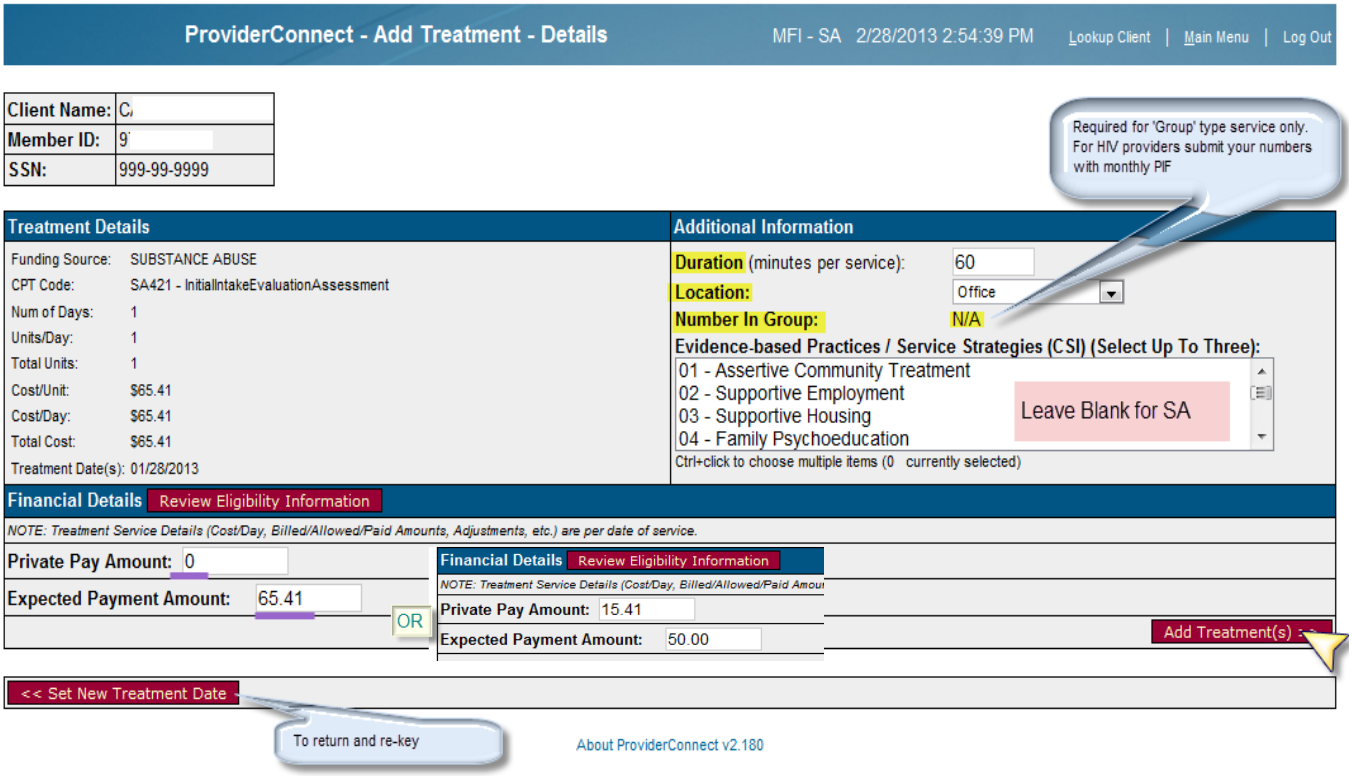
- The number of units is '1' per service entry (exception NTP (group and individual codes) and HIV (education and testing) services).
- Enter the date of service. (**Format: M/D/YYYY**) There are **three ways** to enter the date of service:
  - **Single Date** - This is useful when you have only one date to bill or your have to bill a certain number of units that only pertain to that day.
  - **Date Range** – Field is useful when you have a certain range of dates of service, with no lapse, for the same units. An example of this would be any residential service. If a client is in the home from July 1, 2011 – July 31, 2011 and each day is one unit, the range could be entered. If the client is not in the home at any point during this range, the full range cannot be entered. If the client was not there on July 15, 2009, a treatment can be entered for July 1, 2011 – July 14, 2011 then another new treatment can be entered for July 16, 2011 – July 31, 2011.
  - **Multiple Dates** – This field will work much like the date range in that it is useful if the units and number in group are the same for each date. The calendar feature can be accessed to choose the dates, once selected dates are automatically populated in the Multiple Dates fields.



- Below the entry fields is the 'Units History' table. The user can see past services billed for the consumer as well as the number of units left on the authorization and expiration date. This is another location to identify the need to request for additional units per CPT code. This field should be checked monthly in order to verify if additional units authorized are required or if expiration date needs to be extended. Requests are sent via email to the SA Administration designated person.

When finished, click on "**Set Treatment Date**" to continue. The following screen is displayed.

Add Treatment - Details



Enter '**Duration**', '**Location**', '**Number in Group**', '**Private Pay Amount**' if any, '**Expected Payment Amount**' defaults in based on treatment service code and if amount entered in Private Pay Amount.

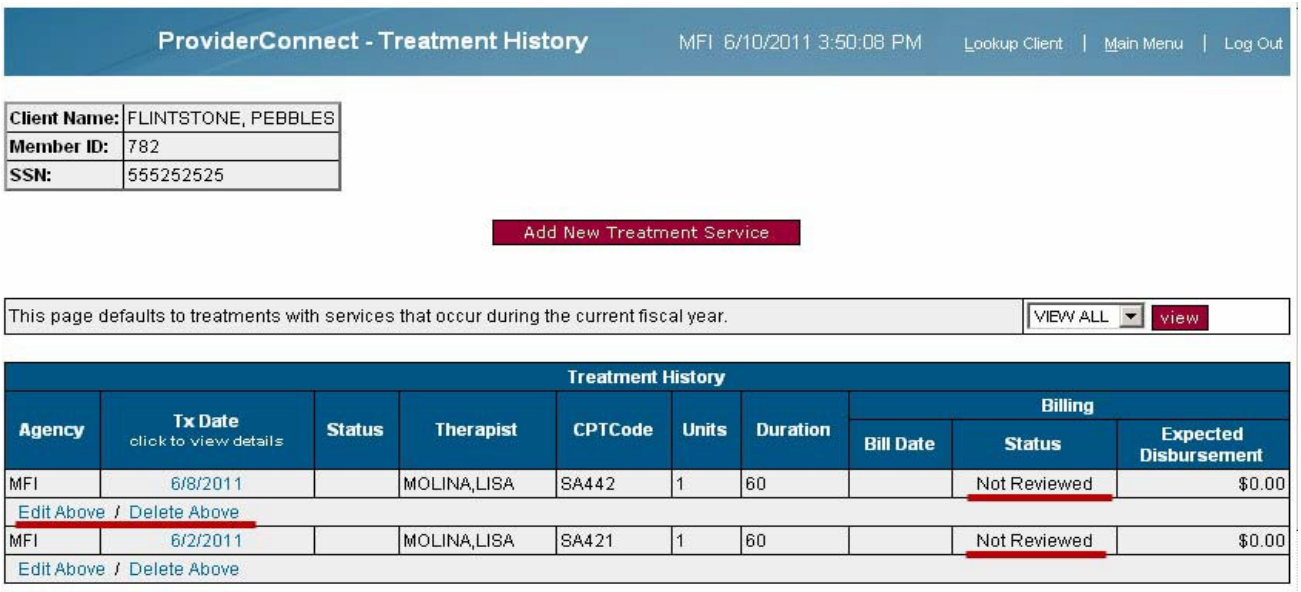
- **Duration** – Is in **minutes**. Previously 60 minutes was entered as 1:00, correct new format is '60' minutes. For a bed day enter '1440' minutes.
- **Location** – Always '**OFFICE**'
- **Number in Group** – Set to only required if service code is a 'Group' type service code. Currently HIV providers must submit to Program Support designated person the Number in Group for both SA766 and SA767 service codes. This can be turned in with monthly PIF.
- **Private Pay Amount** – If any revenue needs to be identified or if client payment to provider was made it is identified in this field.
- **Expected Payment Amount** –
  - If private pay amount is 0.00 then system defaults the treatment service cost based on the provider's Schedule I.
  - If an amount is present in the private pay amount that amount is deducted from the expected payment amount field. Amount populated in the expected payment amount is the amount that is billed to the County.

Click on 'Add Treatment(s)' command button to save entry.

Once the treatment has been added/saved to Provider Connect, it will appear in the Treatment History screen on the Treatment page. At this stage, it still **has not** been billed to the County.

EDIT / DELETE SERVICE

Until the treatment is billed by the provider, the unit of treatment may be edited or deleted by clicking on the "Edit Above/Delete Above" link under the treatment/service date. (Screen illustration below) Once the treatment is billed by the provider, it can no longer be edited or deleted.



- **Edit Above** – This option allows the user to edit the Clinician, Program, Units, Duration, Location, Number in Group, and Private Pay Amount.
- **Delete Above** – If user needs to edit any other field other than those described under 'Edit Above', then the service must be deleted and re-entered.

If the treatment is billed by the provider, the Bill Date column will contain the date on which the treatment was placed on a bill to be sent to the County.

Much like authorizations, the Billing Status column will say "Not Reviewed" until RCMHD determines to pay or deny the treatment. The Expected Disbursement column will remain with $0.00 until the service has been approved or denied for payment.

Treatment History									
Agency	Tx Date click to view details	Status	Therapist	CPTCode	Units	Duration	Billing		
							Bill Date	Status	Expected Disbursement
MFI	6/2/2011	Complete	MOLINA,LISA	SA440	1	60	6/14/2011	Approved	$28.69
MFI	6/1/2011	Complete	MOLINA,LISA	SA421	1	60	6/14/2011	Approved	$60.78
MFI	3/31/2011	Complete	MOLINA,LISA	SA440	1	90	6/10/2011	Denied	$0.00
MFI	3/25/2011	Complete	MOLINA,LISA	SA440	1	90	6/10/2011	Denied	$0.00
MFI	3/24/2011	Complete	MOLINA,LISA	SA440	1	90	6/10/2011	Denied	$0.00

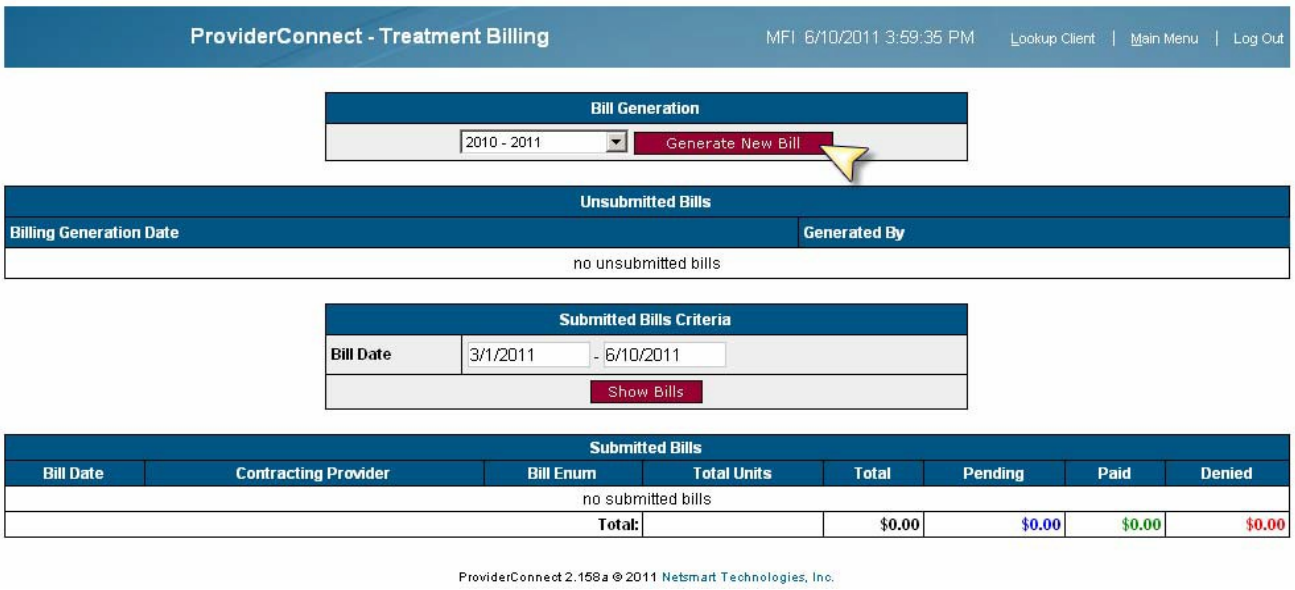
Above is the sample of bills processed by RCMHD and returned to the provider. If Pending is shown that indicates that RCMHD is processing the bill but has not been finalized for payment. Once services are entered for all consumers, the services are saved but not submitted to the County yet. When you are ready to bill, proceed to the Billing Section which can be accessed from the Main Menu. Services should be billed monthly. Services should not be billed daily for ease of processing on both the Provider and Substance Abuse Department side.

Follow the steps below to submit a bill:

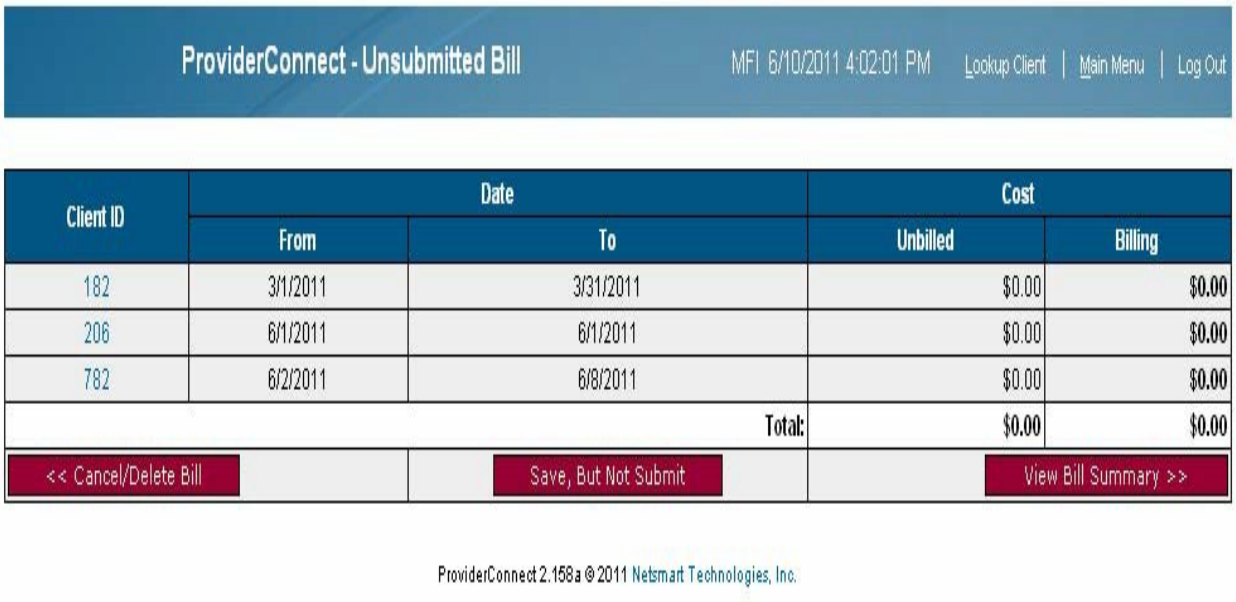
- From the Billing screen, click on "Generate New Bill". This will pull all services that have been added to the system on the Treatment page that have not been associated with a bill. Ensure that the correct fiscal year is selected.

*******Contractor should run the "Provider Billing Reports" first. *******

Run for unbilled services prior to generating a new bill. The report will assist in accurate data being submitted as well as verifying that all services for the month have been entered.*****



System displays the Unsubmitted Bill summary page -

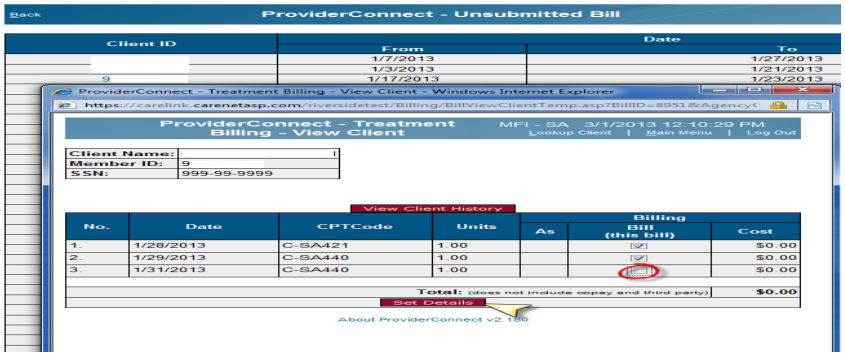


Select an action:

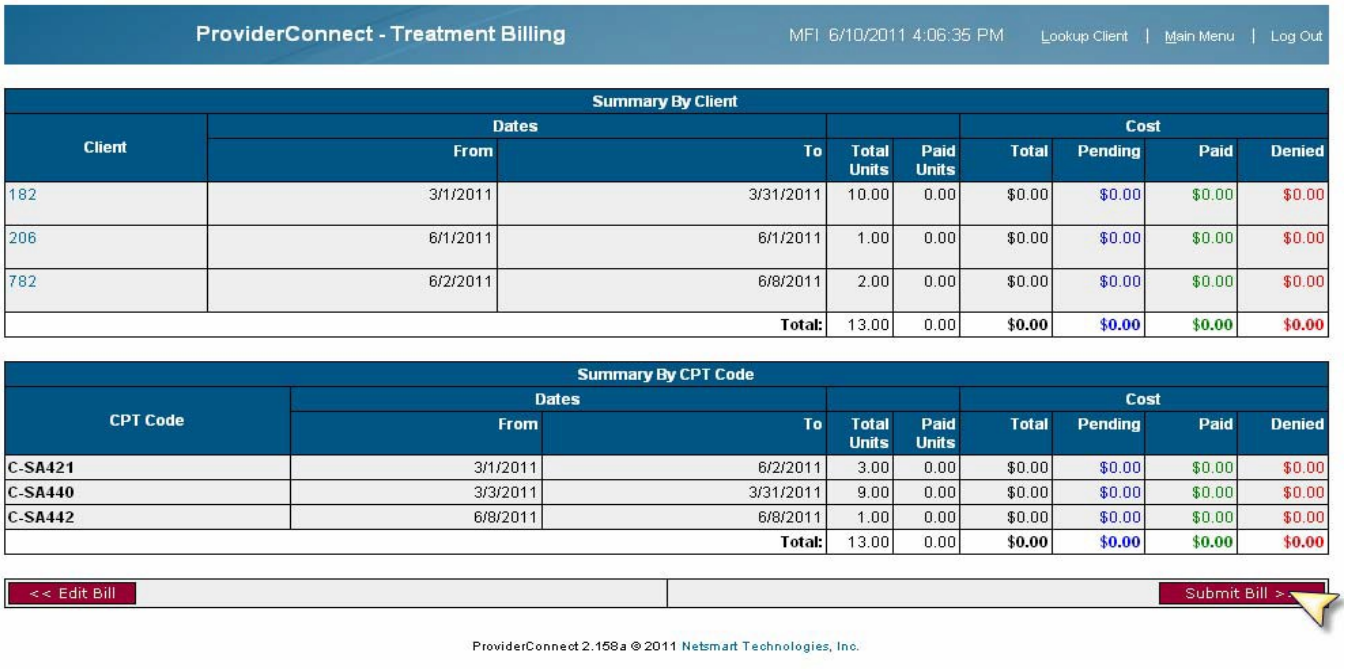
- **Cancel/Delete Bill** – After generating the bill, if the provider decides the bill needs to be removed, the cancel/delete bill function will keep the services listed on the newly generated bill but it will remain in an unbilled status. Once ready click on "Generate New Bill" again.

- **Save, But Not Submit** – This allows the provider to place the bill in a holding status. The provider has not yet submitted the bill to be a part of the batch process that sends the claims to the County for payment. If the provider selects this option, they can view the bill at a later time by clicking the link in the Unsubmitted Bills list. Treatment services associated with bills in the status of "Save But Not Submit" cannot be edited. The provider must choose to Cancel/Delete the bill for the units to be edited or continue to submit the bill. Please make sure to keep this section checked.

- **View Bill Summary** – This is the next step to submit the bill. The provider will be shown a summary of what is being submitted to the County for payment. If they decide to not submit the bill, the provider can select the "Edit bill" option which will take them back to the previous page. In order to finalize the submission of the bill, the provider must choose **"Submit Bill"** option.
- **Client ID –** Click on the client ID to view a detailed list of services. This is where the user can unselect a service line to be excluded from the generated bill. This can be done at the original generated bill page or after selecting 'view bill summary'.



Submit Bill



ProviderConnect - Treatment Billing MFI 6/10/2011 4:06:35 PM Lookup Client | Main Menu | Log Out

Summary By Client

Client	Dates From	Dates To	Total Units	Paid Units	Cost Total	Cost Pending	Cost Paid	Cost Denied
182	3/1/2011	3/31/2011	10.00	0.00	$0.00	$0.00	$0.00	$0.00
206	6/1/2011	6/1/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
782	6/2/2011	6/8/2011	2.00	0.00	$0.00	$0.00	$0.00	$0.00
		Total:	13.00	0.00	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Summary By CPT Code

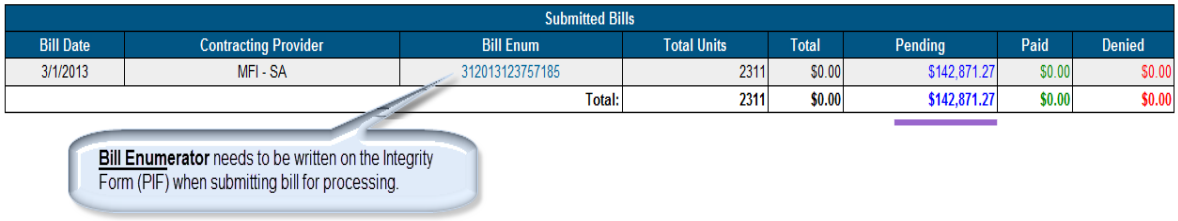
CPT Code	Dates From	Dates To	Total Units	Paid Units	Cost Total	Cost Pending	Cost Paid	Cost Denied
C-SA421	3/1/2011	6/2/2011	3.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA440	3/3/2011	3/31/2011	9.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA442	6/8/2011	6/8/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
		Total:	13.00	0.00	**$0.00**	**$0.00**	**$0.00**	**$0.00**

<< Edit Bill Submit Bill >>

ProviderConnect 2.158a © 2011 Netsmart Technologies, Inc.

Once the provider has submitted the bill, it will appear on the list of Submitted Bills and the billed treatment data is put in the queue to be sent to the County for adjudication. Once the bill has been adjudicated, the status of each service (approved or denied) will be displayed on the billing page and in the client's treatment history record.

By clicking on the 'Bill Enum' number, system opens the bill for review.

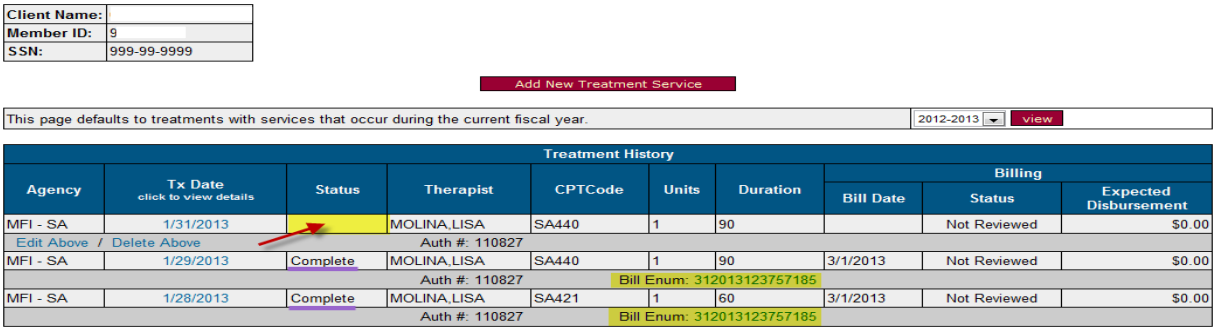


Submitted Bills

Bill Date	Contracting Provider	Bill Enum	Total Units	Total	Pending	Paid	Denied
3/1/2013	MFI - SA	312013123757185	2311	$0.00	$142,871.27	$0.00	$0.00
		Total:	**2311**	**$0.00**	$142,871.27	$0.00	$0.00

Bill Enumerator needs to be written on the Integrity Form (PIF) when submitting bill for processing.

Services removed from generated bill remain in client Treatment History page and not submitted.
Services left on the generated bill and submitted, show a status of 'Complete' and identifies the 'Bill Enum' the service line is assigned to.



Client Name:	
Member ID:	9
SSN:	999-99-9999

Add New Treatment Service

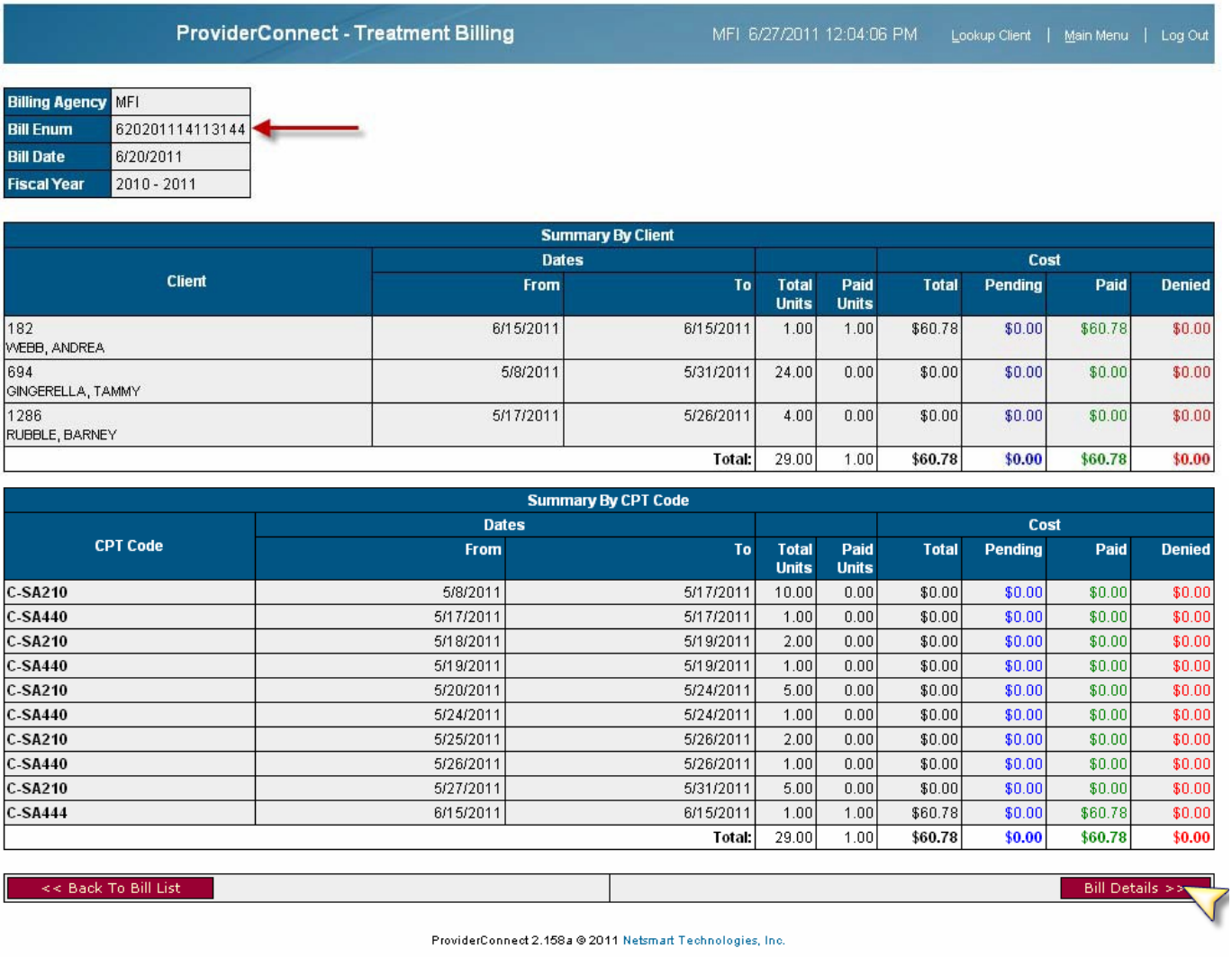
This page defaults to treatments with services that occur during the current fiscal year. 2012-2013 view

Treatment History

Agency	Tx Date (click to view details)	Status	Therapist	CPTCode	Units	Duration	Billing: Bill Date	Billing: Status	Billing: Expected Disbursement
MFI - SA	1/31/2013		MOLINA,LISA	SA440	1	90		Not Reviewed	$0.00
Edit Above / Delete Above			Auth #: 110827						
MFI - SA	1/29/2013	Complete	MOLINA,LISA	SA440	1	90	3/1/2013	Not Reviewed	$0.00
			Auth #: 110827		Bill Enum: 312013123757185				
MFI - SA	1/28/2013	Complete	MOLINA,LISA	SA421	1	60	3/1/2013	Not Reviewed	$0.00
			Auth #: 110827		Bill Enum: 312013123757185				

BILL SUMMARY

Click the Bill Enum to open the submitted bill. In this option provider can review the summary of the bill and view a detail of billed services by client.



ProviderConnect - Treatment Billing MFI 6/27/2011 12:04:06 PM Lookup Client | Main Menu | Log Out

Billing Agency	MFI
Bill Enum	620201114113144
Bill Date	6/20/2011
Fiscal Year	2010 - 2011

Summary By Client

Client	Dates				Cost			
	From	To	Total Units	Paid Units	Total	Pending	Paid	Denied
182 WEBB, ANDREA	6/15/2011	6/15/2011	1.00	1.00	$60.78	$0.00	$60.78	$0.00
694 GINGERELLA, TAMMY	5/8/2011	5/31/2011	24.00	0.00	$0.00	$0.00	$0.00	$0.00
1286 RUBBLE, BARNEY	5/17/2011	5/26/2011	4.00	0.00	$0.00	$0.00	$0.00	$0.00
		Total:	29.00	1.00	**$60.78**	**$0.00**	**$60.78**	**$0.00**

Summary By CPT Code

CPT Code	Dates				Cost			
	From	To	Total Units	Paid Units	Total	Pending	Paid	Denied
C-SA210	5/8/2011	5/17/2011	10.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA440	5/17/2011	5/17/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA210	5/18/2011	5/19/2011	2.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA440	5/19/2011	5/19/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA210	5/20/2011	5/24/2011	5.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA440	5/24/2011	5/24/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA210	5/25/2011	5/26/2011	2.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA440	5/26/2011	5/26/2011	1.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA210	5/27/2011	5/31/2011	5.00	0.00	$0.00	$0.00	$0.00	$0.00
C-SA444	6/15/2011	6/15/2011	1.00	1.00	$60.78	$0.00	$60.78	$0.00
		Total:	29.00	1.00	**$60.78**	**$0.00**	**$60.78**	**$0.00**

<< Back To Bill List Bill Details >>

ProviderConnect 2.158a © 2011 Netsmart Technologies, Inc.

BILL DETAILS

Billing Agency	MFI - SA
Bill Enum	312013123757185
Bill Date	3/1/2013
Fiscal Year	2012 - 2013

Summary By Insurance (YTD)

Insurance (YTD)	Dates				Cost			
	From	To	Total Units	Paid Units	Total	Pending	Paid	Denied
SUBSTANCE ABUSE	1/1/2013	1/29/2013	2,311.00	0.00	$142,871.27	$142,871.27	$0.00	$0.00
		Total:	2,311.00	0.00	**$142,871.27**	**$142,871.27**	**$0.00**	**$0.00**

Bill Details

Member ID	Client Name	Clinician	Treatment Date	CPTCode	X	Quantity	Amount Billed	Billed As	Amount Paid	Check #	Date	Amount
9		MOLINA,LISA	1/1/2013	SA210	X	1.00	$60.00	SUBSTANCE ABUSE	$0.00			
9		MOLINA,LISA	1/2/2013	SA210	X	1.00	$60.00	SUBSTANCE ABUSE	$0.00			

Other Billing Information

- The billing cycle will continue to run on the same timely schedule, from the 1st to the 7th working day of the following month. The cut-off time for bill submission is 6:00 pm on the 7th working day so that RCMHD, Substance Abuse can run a final check for submitted bills from all providers. After the 6:00 pm cut-off submitted bills will be considered late and denied for payment unless prior approval has been granted. View "Processing Schedule" for monthly deadline date.
- Contractor will be able to identify when the submitted bill is in process by RCMHD by the status of 'Pending' and will be finalized when status states 'Approved' or 'Denied'.
- Substance Abuse will continue to fax any State denials to each provider with needed action or comments per denial until a new procedure is determined. Provider will continue to fax in the 5035C Claims Adjustment form for processing.
- **Corrections to Billed Services:** This process will be handled by the County. There is no method in Provider Connect that will allow the Contractor to edit a service after bill is submitted to the County. County Program Support designated person will submit billing error reports to the Contractor for action. Delay in responding to these emails will delay the processing and payment of invoice to Contractor. It is very important that the Contractor run the billing reports prior to generating the bill in order to reduce or eliminate the number of billing errors submitted to the County for review and correction.
- Invoices will still be paid by check. This is handled by the County. No change to current process. Direct Deposit is available if the Contractor meets requirements. Contact your designated Program Support person. Checks can no longer be picked up from the County.

Services Outside of Billing Month

You must request pre-approval via email from Substance Abuse Administration when submitting services for prior month in your monthly billing. All services for current month will be denied and it is the responsibility of the Contractor to re-enter and re-bill. (Ex: January 2013 generated bill had December 2012 services – an approval email is needed prior to processing December 2012 services.) (Ex: January 2013 generated bill had February 2013 services – February 2013 services will be denied by the County. Contractor to re-enter service and include in February 2013 generated bill for processing.)

****************PLEASE DO NOT ENTER DIAGNOSIS***********

Entering diagnosis will potentially cause your claim to deny or cause the claim to deny at the State level. Substance Abuse Administration will already have the diagnosis on file from the opening paperwork your agency submitted.

****************PLEASE DO NOT ENTER DIAGNOSIS***********

Workflow Process

Revised March 2013

Temporary Procedure until enhancements implemented:

Admitting a Client

In order to have access to enter services for an admitted client in Provider Connect the new DAS Contractor Pre-Admission Request form must be submitted via fax to Substance Abuse Administration (951) 683-4904 for approval. The preadmission request form is used to register the client in the ELMR/Avatar county system and enter financial eligibility which is required for billing and payment. Along with the pre-admission 2-page form, the 4-page CalOMS Admission form must be included. Substance Abuse will assign a new client number (if applicable) and then enter the Service Authorization that allows the Contractor to enter services through Provider Connect. Each agency will be able to log in to Provider Connect and view approved admission requests. If your agency has both a Mental Health and Substance Abuse contract, your agency will be assigned a separate logon for each. As a reminder Substance Abuse will not enter pended or denied requests. These will be returned via fax back to the provider with comments. If the requirements can be met the Contractor is to re-submit the pre-admission request form for review.

Other Episode Data Entry

CalOMS Annual Updates, Standard Discharges, CalOMS Youth (or) Detox Standard Discharges, and CalOMS Administrative Discharges will need to be faxed in to Substance Abuse Administration (951) 683-4904 when they occur in order to process in ELMR/Avatar system and end the service authorization.

Service Entry

Services are entered through Provider Connect follow instructions in Section 2 of this manual. Please notify Substance Abuse Administration of any issues that arise with missing practitioners or those that need to be inactive, missing cost/rate for service codes, programs listed for agency, and authorization corrections.

Billing

Billing is submitted through Provider Connect electronically. Follow instructions in Section 2 of this manual. Provider/Agency MUST submit via fax the new Program Integrity Form (PIF) to Substance Abuse Administration (951) 782-9635)or via email to Substance Abuse Administration designated person and Program Support designated person) the same date the generated bill is submitted.

Riverside County Department of Mental Health
Substance Abuse Program

DAS Contractor Pre-Admission (Admission Request Form)

Provide client number if known, if not leave blank. Once request is approved the Client # will be identified.

FAX Admission Request to: Substance Abuse Administration 951-683-4904

Select Client (Search) ADMIN ONLY: *Skip fields on screen **ONLY** if not on this form. **Client ID:** _____

Client Name: (Last) ___DOE_____ (First)___JANE_____ **Gender:** ____F_____
(Male,Female,Other)

Admission Tab (Page 1)

Episode # _____

Write date clearly

Date of Birth: _03_/_06_/_1998__

Preadmit/Admission Date: _03_/_01_/_2013__

Preadmit/Admission Time: _8_:_00__ (am) / pm
(Actual Time) (Circle One)

Program: __NAME ######___
*(Program Name & **ID**)*

Contract Name and Program ID (RU)

Type of Admission: **Pre-Admission**

Admitting Practitioner: __DOE,JOHN_____
(Practitioner Staff # and Name)

Social Security Number: _555_-_55_-_5555_
(Please make every attempt to obtain client's SSN)
***ADMIN ONLY**: (If none **leave blank** in Registration Screen.)*
***ADMIN ONLY**: (Enter **999-99-9999** in Financial Eligibility screen)*

Social Security Number
Pseudo Number
Leave Blank for "NONE"

Demographics Tab (Page 1)

Client's Middle Name: _____

Suffix: ☐ Sr ☐ Jr ☐ III ☐ IV ☐ V ☐ VI

Client's Address: (Street)___123 ABC_____
(Street Number, Name, and Type)
Client's Address: (Line2)_____
(Identify Appt #, Unit #, Floor, etc.)
Client's Address: (Zip Code) __92507_____
*(**DMC Billing**: If Homeless, use Facility Address & Zip Code)*

Address must be provided.
If client is 'Homeless' use facility address.

Client's Primary Phone: _951-_555_-_5555_

Client's Secondary Phone: ____-____-_____

Primary Language: __ENGLISH_____

Marital Status:
☒ Single/Never Married ☐ Now Married
☐ Registered Domestic Partner ☐ Widowed
☐ Divorced/Annulled ☐ Separated

Demographics Tab (Page 2)

Maiden Name_____ Alias 2 _____

Alias 1 _____ Alias 3 _____

Admission Request (ADMIN ONLY: Enter data in Avatar MSO> Care Management > Service Authorization – Comments Tab)

Level of Care Requesting: ☐ Detox (SA110) ☐ DDx Detox (SA110) START Referral ONLY ☐ DC Bed Res (SA209) ☐ FOTP Res (SA211)
☐ Long Term Res (SA210) ☐ Short Term Res (SA212) ☐ Dis. Bed Res (SA215) ☐ Perinatal Res (SA250)
☐ DCR-Adolescent If 18 to 24 years of age is client EPSDT?____ ☐ DCR-Perinatal ☐ DCR-Women w/Children ☒ ODF ☐ ODF/Perinatal ☐ NTP

Must have a 'Level of Care' selected.

Justification to enter treatment: PROVIDE A CLEAR AND THOROUGH JUSTIFICATION AS TRAINED ON BY THE SUBSTANCE ABUSE DESIGNATED MONITOR.
SAMPLES OF CORRECT JUSTIFICATION FORMAT CAN BE PROVIDED TO YOU ON REQUEST.
CONTACT SUBSTANCE ABUSE ADMINISTRATION AT (951) 782-2400.

Information that is required on a justification:
Age, Race, Gender, Pregnancy (if applicable), Length of Use (History), Drug of Choice, Age of 1st Use, & Date of Last Use.

Authorization is found in Provider Connect

---------- **ADMIN USE ONLY** ----------

☐ **Approved (Auth #_____)** ☐ **Denied** ☐ **Pending**

Reason for Denied/Pending: _____

Information will be provided here if the request has been denied or pended for further requirements to be met.

Signature of Substance Abuse Program Manager/Designee:_____ **Date:**_____

Client Name: _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

DIAGNOSIS

Diagnosis Tab (Page 1)

Type of Diagnosis: Admission

Date of Diagnosis: Auto Populates
(Same as Preadmit/Admission Date)

Time of Diagnosis: _8_:_00_ (am) / pm
(Actual Time) (Circle One)

Diagnosing Practitioner: Copy Above
(Same as Admitting Practitioner)

Diagnosis Axis I-1 (Check "ONE")

☐ SA303.90 Alcohol Dependence	☐ SA305.00 Alcohol Abuse
☐ SA304.00 Opioid Dependence	☐ SA305.10 Nicotine Dependence
☐ SA304.10 Barbiturates/Sedatives Depen	☒ SA305.20 Cannabis Abuse
☐ SA304.20 Cocaine Dependence	☐ SA305.30 Hallucinogen Abuse
☐ SA304.30 Cannabis Dependence	☐ SA305.40 Barbiturates/Sedative Abuse
☐ SA304.40 Amphetamine Dependence	☐ SA305.50 Opioid Abuse
☐ SA304.50 Hallucinogen / PCP Depen.	☐ SA305.60 Cocaine Abuse
☐ SA304.60 Inhalant Dependence	☐ SA305.70 Amphetamine Abuse
☐ SA304.80 Polysubstance Dependence	☐ SA305.90 Inhalant/PCP/Polysubstance Abuse
☐ SA304.90 Polysubstance/Psychoactive Substance Dependence	

Only answer for "Problem Gambling" diagnosis.

Does client have a secondary diagnosis of "Problem Gambling"? (Y/N) __N_____
(If Yes, enter Diagnosis Code (312.31 Pathological Gambling) in Diagnosis Axis II-1 field)

Principal Diagnosis *(Use Diagnosis Axis I-1)* ***SUBMIT***

FINANCIAL ELIGIBILITY

Mark all that apply to your Contract and Client.

Guarantor Name / Guarantor Plan
~~(If ADP NNA or ADP Grant client should also have ADP Self Pay)~~

☐ 505 – ADP CalWORKs / (Non-Contract) ADP CalWORKs →

☐ Insurance Co. Name&Code: _____ →
/ (Non-Contract) ADP Commercial

☒ 501 – ADP Medi-Cal/(Non-Contract) ADP Drug Medi-Cal →

☐ 506 – ADP Grant / (Non-Contract) ADP Grant

☐ 502 – ADP NNA / (Non-Contract) ADP NNA

SSN: (As stated above enter 999-99-9999 for NONE)

Arrows identify that further information is required on the box to the right

If ADP CalWORKs Selected:

Worker Name and Location _____

If Insurance Co. Selected:
(Submit 3 Subscriber Forms listed below & Copy of Insurance Card)
(Reminder to submit proof of billing, partial payment, and/or VALID denial when received from Insurance Company)

Policy Number _____

Client's Relationship to Subscriber _____

If ADP Medi-Cal Selected:
(MUST Attach printout of DMC eligibility from State website)

CIN# _91234567A_____ Aid Code _3N____ All (4) answers req.

OHC? (Y/N) _N_ SOC? (Y/N) __N_

Enter Guarantor Insurance Co. Name & Code Policy Number, and Relationship to Subscriber above.

(OHC: Reminder to bill other health coverage and provide proof of billing, partial payment, and/or VALID denial from the OHC in order to authorize DMC billing.)

Client's Relationship to Subscriber __**SELF**____

If Insurance the following forms are on file:

Subscriber Assignment of Benefits: (Y / N) ___Y_____

Subscriber Release of Info: (Y / N) ___Y_____

Subscriber Coordination of Benefits: (Y / N) ___Y_____

Mark 'Y' for all (3) for (501) Guarantor

Riverside County Department of Mental Health
Substance Abuse Program

DAS Contractor
(Extension Request Form)

FAX Extension Request to: Substance Abuse Administration 951-683-4904

Select Client (Search)

Client ID: __912345678_____

Client Name: (Last) __DOE_____ (First)___JANE_____ **Gender:** ____F_____
(Male,Female,Other)

Social Security Number: _555_ - _55_ - _5555__ **Date of Birth**: _03__/_06__/__1998__

Write dates clearly

Service Authorization Tab (ADMIN ONLY - update data in Avatar MSO) Episode # _____

Request Date: _03__/_01__/__2013___

Original Admission Date: _01/_02_/_2013___

Program: ____NAME & ######_____
(Program Name & ID)

Number of Additional Days/Services Requested: _____

_PROVIDE CLEAR AND SPECIFIC REQUEST_____

Additional 45 bed days

Requesting Practitioner: __DOE,JOHN_____
(Practitioner Staff # and Name)

Current Level of Care: ☐ Detox (SA110) ☐ DDx Detox (SA110) ☐ DC Bed Res (SA209) ☐ FOTP Res (SA211)
START Referral ONLY
☒ Long Term Res (SA210) ☐ Short Term Res (SA212) ☐ Dis. Bed Res (SA215) ☐ Perinatal Res (SA250)
☐ DCR-Adolescent ☐ DCR-Perinatal ☐ DCR-Women w/Children ☐ ODF ☐ ODF/Perinatal ☐ NTP
18 y. 24 years of age is client EPSDT? ____

Must have correct 'Level of Care' selected to match the Pre-Admission request.

Reason for Extension: __PROVIDE DETAILED REASON FOR EXTENSION _____

"Client needs more days", is not a detailed reason and extension request will be denied.

Service Authorization Tab

---------- **ADMIN USE ONLY** ----------

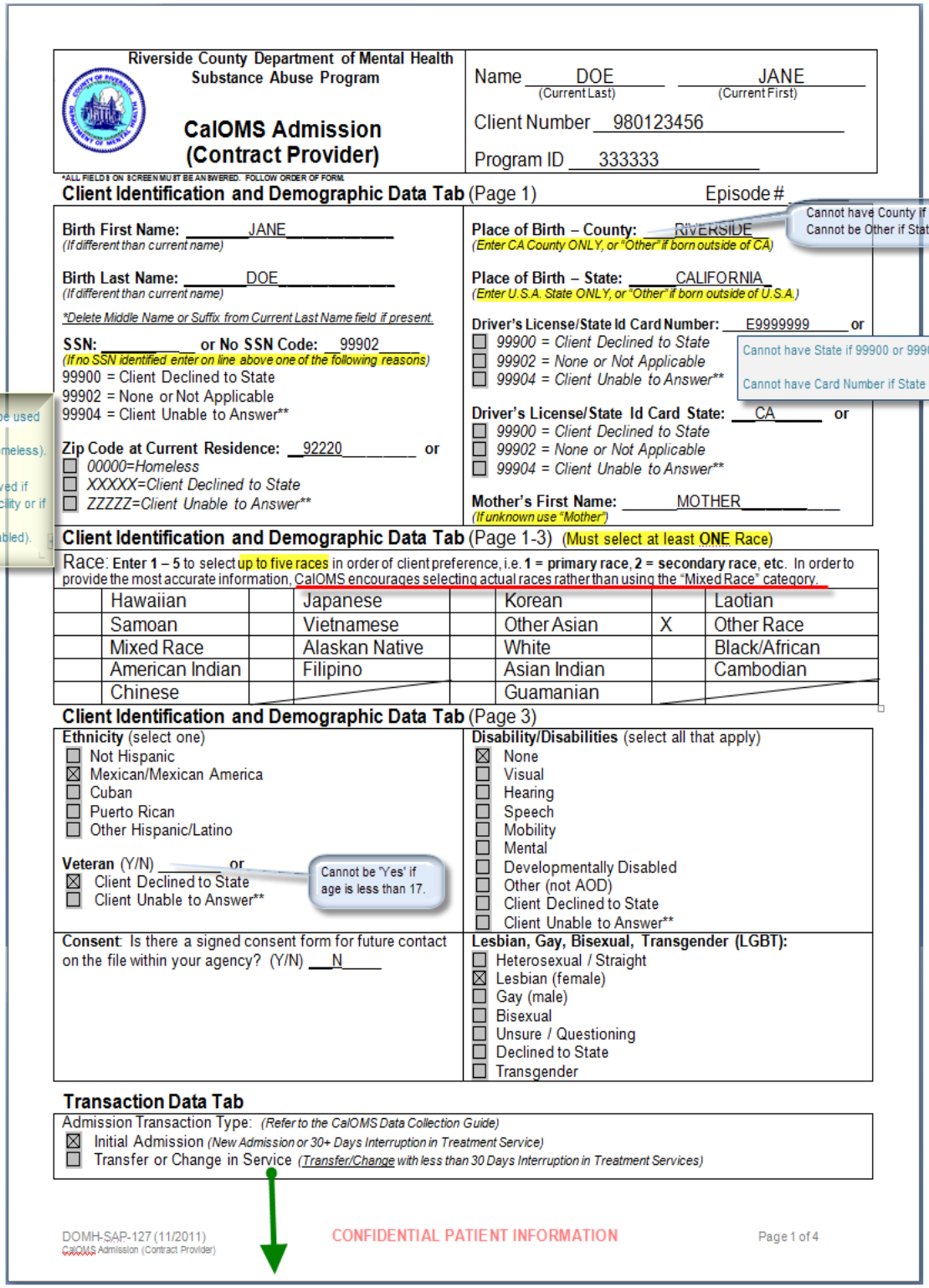
☐ **Approved (Auth #_____)** ☐ **Denied** ☐ **Pending**

Authorization is found in Provider Connect

Reason for Denied/Pending: _____

Information will be provided here if the request has been denied or pended for further requirements to be met.

Signature of Substance Abuse Program Manager/Designee:_____ **Date:**_____



Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Admission (Contract Provider)

Name DOE (Current Last) JANE (Current First)
Client Number 980123456
Program ID 333333

*ALL FIELDS ON SCREEN MUST BE ANSWERED. FOLLOW ORDER OF FORM.

Client Identification and Demographic Data Tab (Page 1) Episode #

Birth First Name: JANE (If different than current name)
Birth Last Name: DOE (If different than current name)
*Delete Middle Name or Suffix from Current Last Name field if present.
SSN: ____ or No SSN Code: 99902
(If no SSN identified enter on line above one of the following reasons)
99900 = Client Declined to State
99902 = None or Not Applicable
99904 = Client Unable to Answer**

Zip Code at Current Residence: 92220 or
☐ 00000=Homeless
☐ XXXXX=Client Declined to State
☐ ZZZZZ=Client Unable to Answer**

Place of Birth – County: RIVERSIDE
(Enter CA County ONLY, or "Other" if born outside of CA)
Cannot have County if State not "CA". Cannot be Other if State is "CA".

Place of Birth – State: CALIFORNIA
(Enter U.S.A. State ONLY, or "Other" if born outside of U.S.A.)

Driver's License/State Id Card Number: E9999999 or
☐ 99900 = Client Declined to State
☐ 99902 = None or Not Applicable
☐ 99904 = Client Unable to Answer**
Cannot have State if 99900 or 99902 selected for Card #.
Cannot have Card Number if State is 99900 or 99902.

Driver's License/State Id Card State: CA or
☐ 99900 = Client Declined to State
☐ 99902 = None or Not Applicable
☐ 99904 = Client Unable to Answer**

Mother's First Name: MOTHER
(If unknown use "Mother")

(00000) must ONLY be used if "Current Living Arrangements" is (homeless).
(ZZZZZ) is only allowed if client is in a Detox facility or if "Disability" includes (developmentally disabled).

Client Identification and Demographic Data Tab (Page 1-3) (Must select at least ONE Race)

Race: **Enter 1 – 5** to select up to five races in order of client preference, i.e. **1 = primary race, 2 = secondary race, etc.** In order to provide the most accurate information, CalOMS encourages selecting actual races rather than using the "Mixed Race" category.

	Hawaiian		Japanese		Korean		Laotian
	Samoan		Vietnamese		Other Asian	X	Other Race
	Mixed Race		Alaskan Native		White		Black/African
	American Indian		Filipino		Asian Indian		Cambodian
	Chinese				Guamanian		

Client Identification and Demographic Data Tab (Page 3)

Ethnicity (select one)
☐ Not Hispanic
☒ Mexican/Mexican America
☐ Cuban
☐ Puerto Rican
☐ Other Hispanic/Latino

Veteran (Y/N) ____ or
☒ Client Declined to State
☐ Client Unable to Answer**
Cannot be 'Yes' if age is less than 17.

Disability/Disabilities (select all that apply)
☒ None
☐ Visual
☐ Hearing
☐ Speech
☐ Mobility
☐ Mental
☐ Developmentally Disabled
☐ Other (not AOD)
☐ Client Declined to State
☐ Client Unable to Answer**

Consent: Is there a signed consent form for future contact on the file within your agency? (Y/N) N

Lesbian, Gay, Bisexual, Transgender (LGBT):
☐ Heterosexual / Straight
☒ Lesbian (female)
☐ Gay (male)
☐ Bisexual
☐ Unsure / Questioning
☐ Declined to State
☐ Transgender

Transaction Data Tab

Admission Transaction Type: *(Refer to the CalOMS Data Collection Guide)*
☒ Initial Admission *(New Admission or 30+ Days Interruption in Treatment Service)*
☐ Transfer or Change in Service *(Transfer/Change with less than 30 Days Interruption in Treatment Services)*

DOMH-SAP-127 (11/2011)
CalOMS Admission (Contract Provider)
CONFIDENTIAL PATIENT INFORMATION
Page 1 of 4

There are two entries for the type of admission transaction:

1. Initial admission. An initial admission is used to report the beginning of an individual's treatment episode. A treatment episode is a continuous period of planned treatment with no unplanned breaks in services exceeding 30 days.

2. Transfer or change in service. This is used for reporting when an individual has already been admitted to another program or service modality and is transferring to a different program or modality (including those occurring within the same provider).

- Example for transfer: an individual is admitted to an outpatient program and begins receiving services. After some time, the individual informs the provider s/he is no longer able to make it to the program due to transportation problems. The individual is discharged from the program in which s/he was participating and is transferred to a different program which s/he is better able to get to.
- Example for change in service: an individual is admitted to a detoxification program. After several days s/he completes the detoxification services and, as part of his/her treatment plan, is ready to move on to outpatient services. The individual is discharged from the detoxification program and a discharge record is submitted. A new admission is opened for the individual in the outpatient program, and two is entered in this field to indicate the individual is continuing his/her treatment episode, but has had a change in services.

Client Name: DOE (Current Last) JANE (Current First) Client Number: 980123456 Prog ID: 333333

Admission Data Tab

Source of Referral (select one)

- ☐ Individual includes self referral
- ☒ Alcohol/Drug abuse program
- ☐ Other health care provider
- ☐ School/Education
- ☐ Employer/EAP
- ☐ 12 Step Mutual Aid
- 7 ☐ SACPA/Prop 36/OTP/Probation or Parole
- 8 ☐ Post-Release Community Supervision (AB109)
- ☐ DUI/DWI
- 10 ☐ Adult Felon Drug Court
- ☐ Dependency Drug Court
- 12 ☐ Non-SACPA Court/Criminal Justice
- ☐ Other Community Referral
- ☐ Child Protective Services

If 'Source of Referral' is 7, 10, or 12 then "Criminal Justice Status" cannot be 'Not Applicable' (1). If 8, then status must be 'On Probation from any Jurisdiction' (4).

Days Waited to Enter Treatment: *(0-999)* 0 or
(How many days were you on a waiting list before you were admitted to this treatment program?)

- ☐ *99901 = Not Sure/Don't Know*
- ☐ *99904 = Client Unable to Answer***

Number of Prior Episodes *(0-99)* 0 or
(Number of prior episodes in any alcohol or drug treatment / recovery program in which client has participated)

- ☐ *99900 = Client Declined to State*
- ☐ *99901 = Not Sure/Don't Know*
- ☐ *99904 = Client Unable to Answer***

Value can only be yes if CalWORKs Recipient is also Yes

CalWORKs Recipient
(Y/N) Y or ___ Not Sure/Don't Know

Substance Abuse Treatment Under CalWORKs
(Y/N) Y or ___ Not Sure/Don't Know

County Paying for Services: NONE
(Gibson House = Riverside, Cedar House = Riverside, All others select "None or Not Applicable")

Special Services Contract ID: 99902
(Gibson House = 4-digit code, Cedar House = 4-digit code, All others enter 99902)

Alcohol and Drug Use Tab (Page 1)

(Primary Drug must be selected and cannot be NONE)

Drug Problem: Enter 1 **AND** 2 to Select for **Primary Drug (1)** and **Secondary Drug (2)** of Choice (Code).

2	Alcohol	1	Marijuana/Hashish		Other Hallucinogens*		Over-the-Counter*
	Barbiturates*		Methamphetamine		Other Opiates or Synthetic*		OxyCodone/Oxy Contin
	Cocaine/Crack		None		Other Sedatives or Hypnotics*		PCP
	Ecstasy		Non-Prescription Methadone		Other Stimulants*		Tranquilizers (e.g. Benzodiazepine)*
	Heroin		Other Amphetamines*		Other Tranquilizers*		
	Inhalants*		Other Club Drugs*		Other **(specify)***		

If Drug Problem is alcohol, the value selected must be Oral.

A value must be provided if Drug Problem has an (*) asterik (i.e., 'Inhalants')

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Secondary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Primary Drug

Frequency: (0-30) 0 or _____ (99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Primary Drug?)

Route of Administration

- ☐ Oral
- ☒ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

NOT allowed at admission for Primary Drug Code.

Age of First Use
(5-105) 19 or _____ (99904 = Client Unable to Answer**)

Secondary Drug

Frequency: (0-30) 10 or _____ (99902 = Not Applicable) (How many days in the **past 30 days** has the client used the Secondary Drug?)

If Drug Problem is inhalant, the value selected must be Inhalation.

Route of Administration

- ☒ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Age of First Use
(5-105) 18 or _____ (99904 = Client Unable to Answer**)

Indicate **Alcohol Frequency *ONLY*** if the Primary & Secondary drugs are **NOT** alcohol.
Number of days in the **past 30 days** that the client has used alcohol?: (0-30) _____

Needle Use (Past 30 Days): (0-30) 0 or ☐ 99900 Client Declined to State ☐ 99904 Client Unable to Answer**

Intravenous or Intramuscular

Needle Use in the Last 12 Months: (Y/N) NO or _____ *99904 = Client Unable to Answer***

If Route of Administration is Injection and Frequency is greater than or equal to one, Needle Use in the Last 12 Months must be Yes.

Client Name: DOE (Current Last) JANE (Current First) Client Number: 980123456 ProgID: 333333

Employment Data Tab

Enrolled in School (Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Highest School Grade Completed: (0-29) _12_ or
- ☐ 30+ Years
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Employment Status
- ☐ Employed Full Time (35 hrs or more)
- ☐ Employed Part Time (less than 35 hrs)
- ☒ Unemployed, looking for work
- ☐ Unemployed – (Not Seeking)
- ☐ Not in the Labor Force (Not Seeking)

'Employed Full Time' cannot be checked if client is 14 or less.

Enrolled in Job Training (Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Work Past 30 Days: *(0-30)* _0_ or
- ☐ *99900 = Client Declined to State*
- ☐ *99904 = Client Unable to Answer**

Criminal Justice Data Tab

Criminal Justice Status Follow "Source of Referral" rule.
- ☒ Not Applicable
- ☐ Under parole supervision by CDC
- ☐ On parole from any other jurisdiction
- ☐ On probation from any other jurisdiction
- ☐ Admitted under diversion from any court under CA Penal Code, Section 1000
- ☐ Incarcerated
- ☐ Awaiting trial, charges, or sentencing
- ☐ Client Unable to Answer**

CDCR Number: _____ or
*Leave blank if Youth.
- ☐ 99900 = Client Declined to State
- ☐ 99901 = Not Sure/Don't Know
- ☒ 99902 = None or Not Applicable
- ☐ 99904 = Client Unable to Answer**

If PSN or FOTP Parolee is 'Yes', then CDCR Number must be provided.

If client age is under 18, leave blank

Number of Arrests Past 30 Days:
(0/30) _0_ or _____ 99904 = Client Unable to Answer**

Number of Jail Days Past 30 Days:
(0/30) _0_ or _____ 99904 = Client Unable to Answer**

Number of Prison Days Past 30 Days:
(0/30) _0_ or _____ 99904 = Client Unable to Answer**

Parolee Services Network(PSN): Must be a valid PSN provider to answer 'Yes'
(Y/N) _N_ or _____ 99904 = Client Unable to Answer**

FOTP Parolee:
(The Ranch **ONLY** can answer, all others use "N")
(Y/N) _N_ or _____ 99904 = Client Unable to Answer**

Must be a valid FOTP provider to answer 'Yes' and client must be 'female'

FOTP Priority Status
(The Ranch **ONLY** can answer, all others Leave Blank)
- ☐ Completed "Forever Free" and released and enrolled in
- ☐ Any woman paroling from CIW
- ☐ Completed "Forever Free" and goes direct to FOTP facility
- ☒ None or Not Applicable
- ☐ Client Unable to Answer**

Medical/Physical Health Data Tab (Page 1)

Medi-Cal Beneficiary
(Y/N) _Y_ or _____99904 = Client Unable to Answer**

Emergency Room Past 30 Days:
(0/99) _0_ or _____ 99904 = Client Unable to Answer**

Hospital Overnight Stay Past 30 Days:
(0/30) _1_ or _____ 99904 = Client Unable to Answer**

Medical Problems Past 30 Days:
(0/30) _1_ or _____ 99904 = Client Unable to Answer**

If Emergency Room Last 30 Days or Hospital Overnight Last 30 Days are greater than 0, then Medical Problems Last 30 Days must be greater than 0

Pregnant At Admission
(Y/N) _N_ or _____ Not Sure/Don't Know

Medication Prescribed as Part of Treatment
(NTP programs select 'Methadone', all others 'None')
- ☒ None
- ☐ Methadone
- ☐ LAAM
- ☐ Buprenorphine (Subutex)
- ☐ Buprenorphine (Suboxone)
- ☐ Other

Communicable Diseases: Tuberculosis
(Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Communicable Diseases: Hepatitis C
(Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Communicable Diseases: Sexually Transmitted Diseases
(Y/N) _Y_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Tested (Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Test Results can only be Yes when HIV Tested is Yes.

HIV Test Results (Y/N) _N_ or
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Client Name: __DOE_____JANE___ Client Number: __980123456_ Prog ID: _333333__
(Current Last) (Current First)

Mental Illness Tab

Mental Illness Diagnosis
(Y/N) __N___ or _____ Not Sure/Don't Know

Emergency Room Use / Mental Health Past 30 Days:
(0/99) __0__ or _____ 99904 = Client Unable to Answer**

Psychiatric Facility Use Past 30 Days:
(0/30) __0__ or _____ 99904 = Client Unable to Answer**

Mental Health Medication
(Y/N) __N___ or _____ Client Unable to Answer**

Family/Social Data Tab

Social Support: (0-30) __20_____
*(Number of days in the **Past 30 Days** has the client participated in any social support recovery activities, including 12-step meeting, religious/faith recovery meetings, and interactions with family members or friends supportive of recovery.)*

Current Living Arrangements
- ☐ Homeless
- ☒ Dependent Living
- ☐ Independent Living

"Current Living Arrangements" is (homeless) if "Zip Code" is (00000)

Living with Substance "User" Past 30 Days:
(0-30) __30_____ or
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Family Conflict Past 30 Days: (0-30) __30_____ or
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Number of Children Age 17 or Younger:
(0/30) __1__ or _____ 99904 = Client Unable to Answer**

Number of Children Age 5 or Younger:
(0/30) __1__ or _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else:
(0/30) __0__ or _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else and Parental Rights Terminated:
(0/30) __0__ or _____ 99904 = Client Unable to Answer**

Value must be less than or equal to "Number of Children Age 17 or Younger"

*ADMIN ONLY function
Note that **99904 (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

Program Support Billing Error Reports

Duplicate Services

Hello

The Riverside County Department of Mental Health is in receipt of your January 2013 Services invoice for processing and payment. However the below listed ELMR report shows either duplicate services, incorrect procedure code or an incorrect performing provider was selected by your organization. Please review this report in detail, and note the Riverside County Department of Mental Health will be denying the duplicate data entry.

Please note this type of error delays the processing of your organization's invoice(s). Please make every effort to prevent this error by reviewing the client's treatment history prior to generating a bill and deleting the service. Once the bill has been generated each client's services must be reviewed again and any invalid duplicates are unselected so that they are not included on the bill submission to the County. Make note of these services as you will need to go to the client's treatment history and delete the invalid duplicate service so that they are not picked up in future generated bills.

Please confirm before the end of the day today if the service is a true duplicate, incorrect provider, or incorrect procedure code so we can commence processing of services for your organization.

Please feel free to call or email if you have any questions

Provider ID & Batch Number		95 1/16/2013	-SA440-	Client ID	Auth#	Svc Date	Svc Code	Clinician	Dur	Unit	Rate
2	3116	95		SI ,	10	1/16/2013	SA440	H	90	1	27.8
2	3116	95		SI ,	10	1/16/2013	SA440	H	90	1	27.8
Provider ID & Batch Number		95 1/16/2013	-SA450-								
2	3116	95		SI ,	10	1/16/2013	SA450	H	60	1	65.41
2	3116	95		SI ,	10	1/16/2013	SA450	H	60	1	65.41
Provider ID & Batch Number		95 1/16/2013	-SA440-								
2	3116	95		SI ,	10	1/16/2013	SA440	H	90	1	27.8
2	3116	95		SI ,	10	1/16/2013	SA440	H	90	1	27.8
Provider ID & Batch Number		96 1/16/2013	-SA421-								
2	3116	96		BI ,	11	1/16/2013	SA421	H	60	1	65.41
2	3116	96		BI ,	11	1/16/2013	SA421	H	60	1	65.41
Provider ID & Batch Number		96 1/16/2013	-SA440-								
2	3116	96		B ,	11	1/16/2013	SA440	H	90	1	27.8
2	3116	96		B ,	11	1/16/2013	SA440	H	90	1	27.8

Services – Before Admission or After Discharge Date

Hello
The Riverside County Department of Mental Health is in receipt of your January 2013 Services invoice for processing and payment. However the below listed ELMR report shows the following clients have services denied because the services are after the discharge date of 1/14/2013. Will you please advise of this error in the comments section of the attached sheet before the end of the day today so we can commence processing of services for your organization.

Contracting Provider:
Batch Num: 3100
Account: 410
Service Status: Denied

97	Q	10	1/16/2013	SA210	Y		1440	0	0.00
97	Q	10	1/17/2013	SA210	Y		1440	0	0.00
97	Q	10	1/18/2013	SA210	Y		1440	0	0.00
97	Q	10	1/19/2013	SA210	Y		1440	0	0.00
97	Q	10	1/20/2013	SA210	Y		1440	0	0.00
97	Q	10	1/21/2013	SA210	Y		1440	0	0.00
97	Q	10	1/22/2013	SA210	Y		1440	0	0.00
97	Q	10	1/23/2013	SA210	Y		1440	0	0.00
97	Q	10	1/24/2013	SA210	Y		1440	0	0.00
97	Q	10	1/25/2013	SA210	Y		1440	0	0.00
97	Q	10	1/26/2013	SA210	Y		1440	0	0.00
97	Q	10	1/27/2013	SA210	Y		1440	0	0.00
97	Q	10	1/28/2013	SA210	Y		1440	0	0.00
97	Q	10	1/29/2013	SA210	Y		1440	0	0.00
97	Q	10	1/30/2013	SA210	Y		1440	0	0.00
97	Q	10	1/31/2013	SA210	Y		1440	0	0.00
97	Q	10	1/15/2013	SA210	Y		1440	0	0.00

Service Program to Authorization Program Mismatch

Hello
The Riverside County Department of Mental Health is in receipt of your January 2013 services invoice for processing and payment. However, the below listed ELMR report shows either the authorized RU selected or the billed RU selected by your organization is incorrect. Please review the report in detail and identify which RU is the correct "bill to" and correct "service site" by the end of the day today in order for your invoice to be processed and paid with the 30 day contract limitation.

Please note that these types of errors delay the processing of your organization's invoice(s). Please make every effort to identify these errors prior to submitting the bill so that your organization will have a valid P.I.F for the requested services. These errors can be prevented by verifying the authorization service site is correct and that it matches the service entry site for the "authorized program". Please feel free to call or email if you have any questions.

BATCHID	PATID	PROVID	auth_nbr	DOS	procedure_code_code	Service Program Name		Auth Program Name	
31	95	1	11	1/30/2013	SA110	C	77	C	01
31	95	1	11	1/31/2013	SA110	C	77	C	01
31	95	1	11	1/30/2013	SA110		77		01
31	95	1	11	1/31/2013	SA110		77		01

Incorrect Duration

Hello
Please note the Riverside County Department of Mental Health is in receipt of your January 2013 invoice for processing and payment. However, the below listed ELMR report shows the incorrect duration was entered by your organization. Please review this report in detail and please also note that the RCDMH will manually adjust the duration. Please note this type of error may delay the processing of your organization's invoice.

Please make every effort to identify these errors prior to submitting the bill so that your organization will have a valid P.I.F for the requested services. Please ensure that services for the SA210 are entered with 1440 minutes.

Please feel free to call or email if you have any questions.
Thank you.

Contracting Provider:

96	LI	10	1/7/2013	SA210	E	No Entry	140	1	61.00
96	LI	10	1/8/2013	SA210	E	No Entry	140	1	61.00

Group Size

Hello
The Riverside County Department of Mental Health is in receipt of your invoice for January 2013 services for processing and payment. However the below listed ELMR report shows that Drug Medi-Cal group services were submitted by your organization with a group size of less than 4.

Please review this report in detail, and note the Riverside County Department of Mental Health will be denying the services not in compliance with Drug Medi-Cal standards. If, after review you find there has been a typo, indicate the correct number in the group field and submit original sign in sheets for that group to Substance Abuse Administration for review and processing. Please note this type of error will delay the processing of your organization's invoice(s). Also as discussed please enter in the comments section of this sheet if some of the clients are medi-cal or County financial assistance.

Please feel free to call or email if you have any questions

Contracting Provider:

95	G	10	1/3/2013	SA440	2	M	90	1	27.80
95	C	10	1/28/2013	SA440	3	P	90	1	27.15
95	C	10	1/22/2013	SA440	3	P	90	1	27.15
95	S	94	1/10/2013	SA440	3	P	90	1	27.80

Substance Abuse Administration Notification Reports

Service Authorization Confirmation Email

Hello,

The following authorizations have been processed and can now be viewed in Provider Connect:

CLIENT ID	CLIENT NAME	AUTH #	RU	Modality as selected or corrected on Pre-Admit Form
1	S	11	33	ODF
9	G	11	33	ODF
9	G	11	33	ODF
9	J(	11	33	ODF

Void & Replace

Hello,

An e-mail will follow with an attachment of the Void & Replace report. This is a report of service denials that have come back from the State.

The password to access this report is:

Please disregard the following error codes until further instruction as they are under review by SA administration for possible re-bill. SA Administration will be in contact with you for correction approval or confirmation that the services will remain in a denied status.

CO_18
A1_M80

The following codes are on the attached report:

CO_11: Perinatal service billed, but beneficiary is not identified as perinatal eligible, OR DCR service billed, but beneficiary is not EPSDT eligible per MEDS, and is not identified as perinatal-eligible.

Is the client pregnant? If so, please provide the pregnancy start date and termination date if applicable. Please verify that client information is correct, as they will require a transfer out of the program if not eligible

CO_22 – MEDS indicates this client has non-Medicare other health coverage (OHC), and the claim does not indicate that coverage has been billed first.

Please submit an E.O.B to confirm if payments have been received or denied, or proof of a 90 day no response from the other coverage.

CO_31 and/or Co_177 – Claim denied because client is ineligible per MEDS/Beneficiary aid code(s) do not indicate eligibility for DMC services

Please provide a print-out of client's eligibility from their chart, ONLY for the months of which services are being denied.

CO_119_N362 – Service denied because it would exceed limit of 20 units of NTP counseling service per month for beneficiary.

Please verify and let us know if some were done in error

Please respond to these issues by

If you have any questions, please call or e-mail.

Thank you,

Information Missing

Hello,

The following client(s) require corrections in order to be processed:

To prevent any delays in your billing, please respond within 12 hours of this e-mail. If you are faxing corrections be sure to use a cover sheet.

Thank you!

Active Caseload – No Services last 30 days

> Hello,
>
> Attached are caseload reports which show clients currently open in your programs. Please review and submit discharges for clients that have not received services for more than thirty days.
>
> Password will follow in a separate e-mail.
>
> Thank you,

Riverside County Department of Mental Health

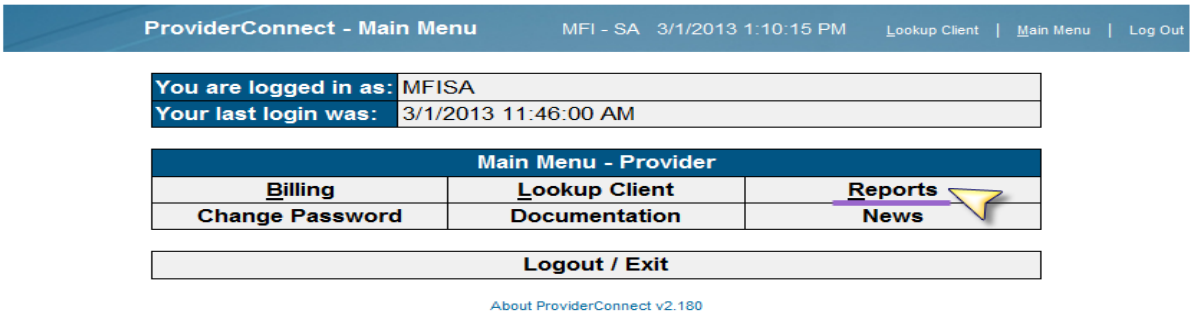
DAS 1000: Open Caseload Report

Reporting Unit: **Number of Clients with Open Cases: 29**

Client ID	Client Name	Age	Days Since Last Svc	Admit Date	City	Zip Code	Attending Practioner
97	A	1		1/24/2013	T	9:	
97	B	4	110.00	11/6/2012	T	9:	
97	B	4	67.00	11/19/2012	P	9:	
10	B	3	168.00	8/28/2012	L		
97	B	1		1/16/2013	L	9:	

PROVIDER CONNECT – PROVIDER BILLING REPORTS

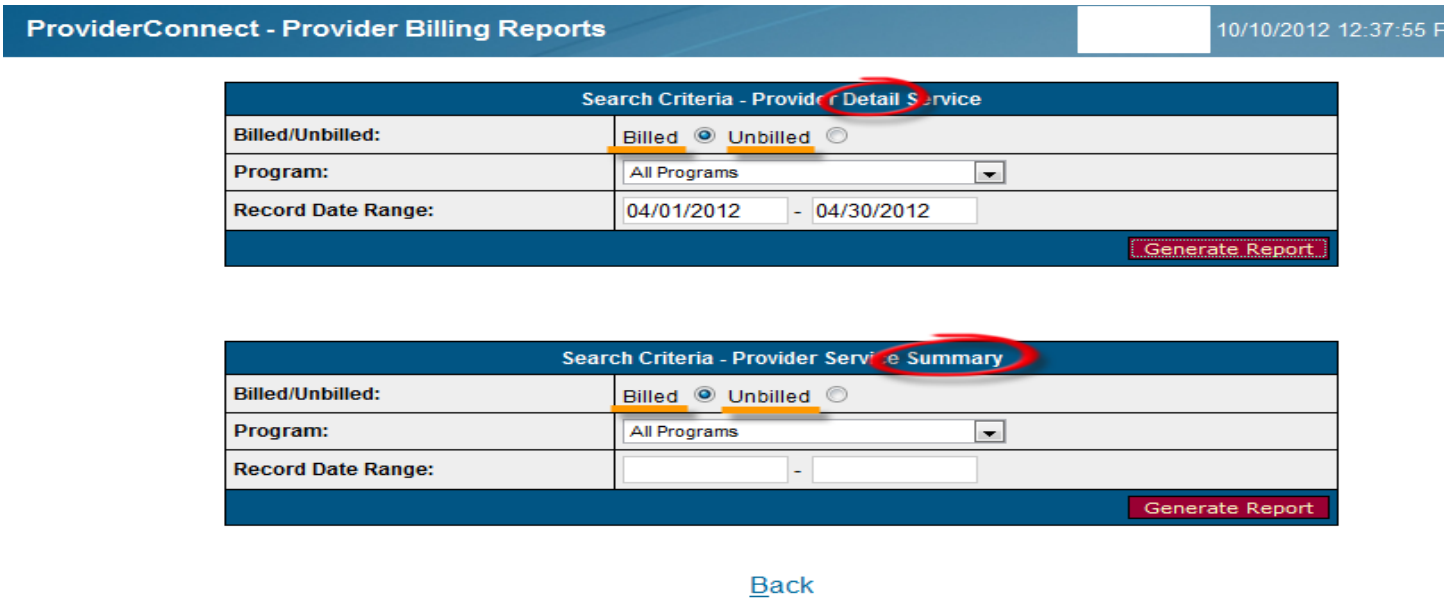
Main Menu



Reminder that Provider Connect has reports that identify services that have been billed and what has not been billed in the Reports Menu under "Provider Billing Reports"

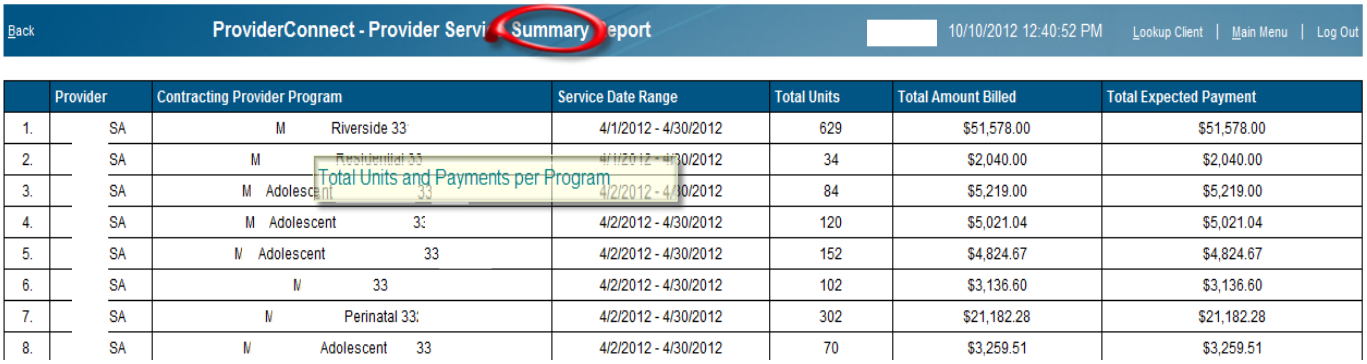
Billed services will show everything that has been billed to the County for payment.

Unbilled services will show what services have been entered and to which Program ID/Reporting Unit (RU). This report can be used to confirm the right services have been entered to the right (RU) **BEFORE** a bill is generated. If there are any errors, they can be fixed before generating the bill for submission to the County.



Select either Detail or Summary listing.

SUMMARY VIEW



	Provider	Contracting Provider Program	Service Date Range	Total Units	Total Amount Billed	Total Expected Payment
1.	SA	M Riverside 33	4/1/2012 - 4/30/2012	629	$51,578.00	$51,578.00
2.	SA	M	30/2012	34	$2,040.00	$2,040.00
3.	SA	M Adolesc nt 33	4/2/2012 - 4/30/2012	84	$5,219.00	$5,219.00
4.	SA	M Adolescent 33	4/2/2012 - 4/30/2012	120	$5,021.04	$5,021.04
5.	SA	M Adolescent 33	4/2/2012 - 4/30/2012	152	$4,824.67	$4,824.67
6.	SA	M 33	4/2/2012 - 4/30/2012	102	$3,136.60	$3,136.60
7.	SA	M Perinatal 33	4/2/2012 - 4/30/2012	302	$21,182.28	$21,182.28
8.	SA	M Adolescent 33	4/2/2012 - 4/30/2012	70	$3,259.51	$3,259.51

Breakdown of total number of units processed and total expected payment (paid amounts) per program id.

DETAIL VIEW

BILLED

	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1.	SA	M Riverside 33	10000	MC , K	53	4/6/2012	PerinatalResidentialTreatmentDay	1	1440	Office	M ,L	$82.00	$82.00	Billed
2.	SA	M Riverside 33	1000(	MC , K	53	4/7/2012	PerinatalResidentialTreatmentDay	1	1440	Office	M ,L	$82.00	$82.00	Billed
3.	SA	M Riverside 33	1000(	MC , K	53	4/8/2012	PerinatalResidentialTreatmentDay	1	1440	Office	M ,L	$82.00	$82.00	Billed

UNBILLED

	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1.	SA	M Riverside 33	970(	E , K	56	4/30/2012	PerinatalResidentialTreatmentDay	1	1440	Office	M	$82.00	N/A	Unbilled

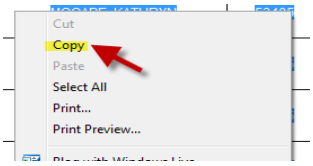
Review all data to ensure that claim line is accurate. This will minimize in billing errors and delay in invoice processing. Make sure that the correct Contracting Provider Program is selected, the correct service code to units and duration, date of service, as well as clinician who rendered the service. Review for any invalid duplicates on the bill. Once review of this report is complete and service edits/deletions made, generate your monthly bill for submission to the County.

Convert to Excel for sorting if needed -

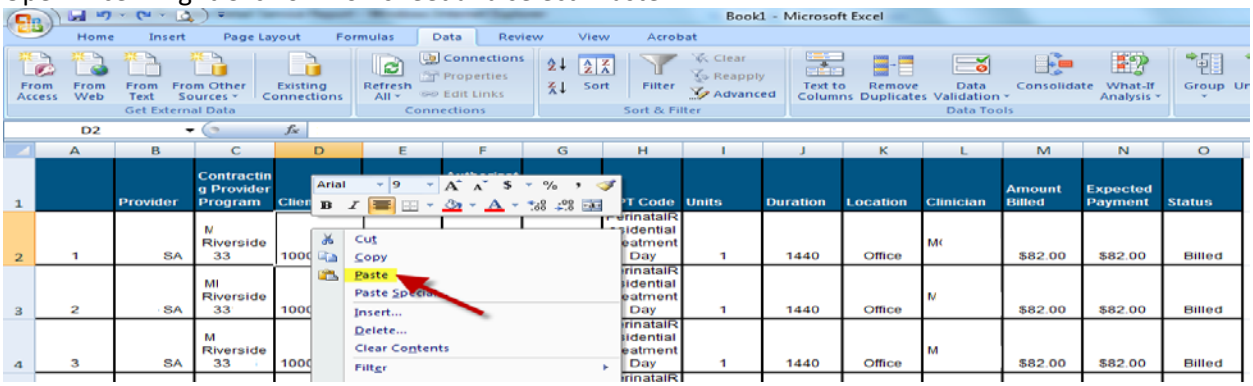
Back **ProviderConnect - Provider Detail Service Report** [redacted] 10/10/2012 12:44:14 PM Lookup Client | Main Menu | Log Out

	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1	SA	Riverside 3	1000	M	53	4/1/2012	PerinatalResidentialTreatmentDay	1	1440	Office		$82.00	$82.00	Billed
2	SA	Riverside	100	M	53	4/2/2012	PerinatalResidentialTreatmentDay	1	1440	Office		$82.00	$82.00	Billed
3	SA	Riverside 3	100	M	53	4/3/2012	PerinatalResidentialTreatmentDay	1	1440	Office		$82.00	$82.00	Billed
4	SA	Riverside 3	10000	MO	53	4/4/2012	PerinatalResidentialTreatmentDay	1	1440	Office		$82.00	$82.00	Billed
5	SA	Riverside 3	1000	M	53	4/5/2012	PerinatalResidentialTreatmentDay	1	1440	Office		$82.00	$82.00	Billed

Highlight the data in the Provider Connect report table. Right Click and select “Copy”.



Open Excel. Right Click on worksheet and select “Paste”



RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH SUBSTANCE ABUSE
PROCESSING SCHEDULE
FY 2013/2014

CLAIM MONTH	Final Data Entry Date for Claim Month & Provider Connect Submit Bill Deadline Date
	5th working day of the month
July 2013	08/07/13
August 2013	09/09/13
September 2013	10/07/13
Ocotber 2013	11/07/13
November 2013	12/06/13
December 2013	01/08/14
January 2014	02/07/14
February 2014	03/07/14
March 2014	04/07/14
April 2014	05/07/14
May 2014	06/06/14
June 2014	07/08/14

*06/30/14 is year end

Exhibit C
"Attachment A"

DATE SUBMITTED TO COUNTY: _____

BILLING/SERVICE PERIOD: _____

BILL ENUMERATOR: _____

PROVIDER AGENCY NAME: _____

CONTRACT NAME AND REGION: _____

SERVICE LOCATION (ADDRESS): _____

RU's (FOR THIS LOCATION AND BILLING ONLY): _____

CERTIFICATION OF CLAIMS AND PROGRAM INTEGRITY FORM

Drug Medi-Cal Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of _____ , **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by _____ in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for Drug Medi-Cal beneficiaries. The beneficiaries were eligible to receive Drug Medi-Cal services at the time the services were provided to the beneficiaries. The services included in the claim were actually provided to the beneficiaries in association with and as stipulated by the claim. Medical necessity was established by my organization for the beneficiaries as defined under Title 22, California Code of Regulations, Exhibit1, Section 51341.1, 51490.1 and 51516.1 for the service or services provided, for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client plan was developed and maintained for the beneficiaries that met all client plan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

_____ _____

Signature of Authorized Provider Printed Name of Authorized Provider

Date: _____

Non-Drug Medi-Cal Eligible Certification of Claims and Program Integrity (ONLY)

I, as an authorized representative of _____, **HEREBY CERTIFY** under penalty of perjury to the following: An assessment of the beneficiaries was conducted by _____in compliance with the requirements as set forth and established in the contract with the Riverside County Department of Mental Health (RCDMH) and as stipulated by all applicable Federal, State and/or County laws for consumers who are referred by the County to the Provider for substance abuse services. The beneficiaries were referred to receive services at the time the services were provided to the beneficiaries in association with and as stipulated by the claim. The services included in the claim were actually provided to the beneficiaries and for the time frame in which the services were provided, and by a certified and/or licensed professional as stipulated by all applicable Federal, State and County laws and regulations. A client plan was developed and maintained for the beneficiaries that met all client plan requirements established in the contract with the RCDMH and as stipulated by all applicable Federal, State and/or County law.

_____ _____

Signature of Authorized Provider Printed Name of Authorized Provider

Date: _____

RCDMH Admin. Use Only

BATCH #'s: _____

SAMPLE SCHEDULE I

SCHEDULE I
MENTAL HEALTH

Provider Agency Name:

Service Contract Name and Region: xxxxxxxxxxxxxxxx-NNA/DAS-Substance Abuse Region FISCAL YEAR: 2012/2013

Service RU's: 33#### **RENEWAL**

SETTLEMENT TYPE:NEGOTIATED RATE ( ) ACTUAL COST (XX)

Use one PIF Form per service location **4100514###/55600**

CALOMS#	33####				**TOTAL:**	**$88,764**
SYSTEM #	33####		33####			
TYPE OF MODALITY	ODF GROUP ADOL.	ODF IND. ADOL	ODF GROUP ADOL. Minor Consent	ODF IND. ADOL Minor Consent		
MODE OF SERVICE:	40	40	40	40		
SERVICE FUNCTION:	33	34	33	34		
SERVICE TYPE: M/C, NON M/C	M/C	M/C	Minor Consent	Minor Consent		
PROCEDURE CODE	SA440	SA421, SA443, SA444, SA450	SA440	SA421, SA443, SA444, SA450		
NUMBER OF UNITS:	604	314	67	35	1,020	
COST PER UNIT:	$27.80	$65.41	$27.80	$65.41		
GROSS COST:	$16,779	$20,569	$1,863	$2,292	$41,503	
FUNDING CODE						
PROGRAM CODE	97	97	97	97		
SERVICE CODE	33	34	33	34		
UNIT REIMBURSEMENT	Contact	Contact	Contact	Contact		
LESS REVENUES COLLECTED BY CONTRACTORS:						
A. PATIENT FEES					0	
B. PATIENT INSURANCE						
C. OTHER	0	0	0	0	#REF!	
TOTAL CONTRACTOR REVENUES	0	0	0	0	0	
MAXIMUM OBLIGATION	$16,779	$20,569	$1,863	$2,292	$41,503	
SOURCES OF FUNDING FOR MAXIMUM OBLIGATION:						%
A. MEDI-CAL/FFP	$8,389	$10,284	$0	$0	$44,381	50.00%
B. FEDERAL FUNDS	$0	$0	$0	$0	$0	0.00%
C. REALIGNMENT FUNDS	$0	$0	$0	$0	$0	0.00%
D. STATE GENERAL FUNDS	$8,390	$10,284	$1,863	$2,292	$44,383	50.00%
E. COUNTY FUNDS	$0	$0	$0	$0	$0	0.00%
F. OTHER	$0	$0	$0	$0	$0	0.00%
TOTAL (SOURCES OF FUNDING)	$16,779	$20,568	$1,863	$2,292	**$88,764**	100.00%

FUNDING SOURCES DOCUMENT: _____

STAFF ANALYST SIGNATURE: _____

FISCAL SERVICES SIGNATURE: _____

ODF INDIVIDUAL SERVICES PROCEDURE CODE KEY: 421= INTAKE, 442= TX PLANING, 443= CRISIS,

Exhibit A

Proposed Drug Medi-Cal Rates-For Fiscal Year 2012-2013 with 8.2% Admin Charge

Regular DMC

Description	Unit of Service (UOS)	FY 2012-2013 UOS Rate****	UOS Rate Less 8.2% Admin
Narcotic Treatment Program (NTP) - Methadone	Daily	$11.97 $1.09 (*)	$10.88
NTP - Individual Counseling (**)	One 10-minute Increment	$14.24 $1.31 (*)	$12.93
NTP - Group Counseling (**)	One 10-minute Increment	$3.36 $0.31 (*)	$3.05
Day Care Rehabi.litative (DCR)	Face-to-Face Visit	$65.38 $5.36	$60.02
Naltrexone (NAL) (***)	Face-to-Face Visit	$19.07 $1.56	$17.51
Outpatient Drug Free (ODF) Individual Counseling	Face-to-Face Visit (Per Person)	$71.25 $5.84	$65.41
ODF Group Counseling	Face-to-Face Visit (Per Person)	$30.28 $2.48	$27.80

Perinatal DMC

Description	Unit of Service (UOS)	FY 2012-2013 UOS Rate****	UOS Rate Less 8.2% Admin
Narcotic Treatment Program (NTP) - Methadone	Daily	$13.05 $1.19 (*)	$11.86
NTP - Individual Counseling (**)	One 10-minute Increment	$20.39 $1.86 (*)	$18.53
NTP - Group Counseling (**)	One 10-minute Increment	$6.81 $0.62 (*)	$6.19
Day Care Rehabi.litative (DCR)	Face-to-Face Visit	$78.23 $6.41	$71.82
Perinatal Residential (RES)	Daily	$96.28 $7.89	$88.39
Outpatient Drug Free (ODF) Individual Counseling	Face-to-Face Visit (Per Person)	$101.99 $8.36	$93.63
ODF Group Counseling	Face-to-Face Visit (Per Person)	$61.33 $5.03	$56.30

* Denotes the administrative costs which are included within the rate.

** ADP reimburses NTP providers for up to 200 minutes of counseling per calendar month, per beneficiary, under methadone service only. Counseling is individual and/or group.

*** From FY 2002-03 through FY 2008-09, Naltrexone was frozen at $21.19 (the FY 1999 2000 approved rate). Counties and seivice providers have not provided, submitted claims, nor reported cost for this service since FY 1997-98. For FY 2009-10, the $21.19 frozen rate was reduced by 10 percent to $19.07. ADP used $19.07 as the developed rate.

**** FY 2009-2010 rates were adjusted by the cumulative growth in the Implicit Price Deflator, in accordance with Welfare & Institutions Code Section 14021.9. The 7.1 percent combined deflator is 2.4 percent for the change from FY 2009-10 to FY 2010-11, plus 2.8 percent for the change from FY 2010-11 to FY 2011-12, plus 1.9 percent for the change from FY 2011-12 to FY 2012-13.

DESK PROCEDURE: ELIGIBILITY VERIFICATION VIA MEDI-CAL WEBSITE

Created:		Last reviewed:	10/30/08	Revised:	06/04/09

Purpose: This document describes the procedure used to verify Medi-cal eligibility on-line in real-time via the Medi-cal website.

Scope: This procedure applies to the end user responsible for verifying clients' Medi-cal status and establishing their eligibility accordingly.

Procedure:

1. Access Medi-Cal website via www.medi-cal.ca.gov
2. Once in website, click on "Transactions" tab.
3. Enter the user ID.
4. Enter the password, and click on "Submit."
5. To determine monthly patient (subscriber) eligibility, obtain an EVC number and Aid Code, click "Single Subscriber".
6. Enter the client's 9-digit SSN or CIN number in the "Subscriber ID" box with no hyphens (i.e. 123456789). The CIN# is the first 9-characters of the BIC#. For example, BIC # is 94535721A57260. The CIN# is 94535721A (the first 9-digits of the BIC#). The SSN # may be used until further notice.
7. Enter clients DOB in "Date of Birth" box as 2-digit month, 2-digit day, and 4-digit year, separated by slashes (i.e. 06/30/2000).
8. Enter today's date in "Card Issue Date" box as 2-digit month, 2-digit day, 4-digit year, separated by slashes (i.e. (01/15/2008).
9. Enter any date of service to determine eligibility for that month/year as 2-digit month, 2-digit day, and 4-digit year, separated by slashes (i.e. 01/01/2004
10. Click on "Submit".
11. The screen will provide the client's name, primary aid code, subscriber county code, spend down amount obligation (monthly Share of Cost), remaining spend down amount (outstanding SOC for that month/year), eligibility verification confirmation (EVC) #, and the eligibility message including the 14-digit BIC# **(use the first 9 digits or CIN#** to include on Pre-Admission Request Form).

Skip to: Content | Footer | Accessibility

Search Medi-Cal GO

Department of Health Care Services Medi-Cal

http://www.medi-cal.ca.gov

Home | Transactions | Publications | Education | Programs | References | Contact Medi-Cal

System Status | Login | Services Available | Enrollment Requirements

Home » Login to Medi-Cal

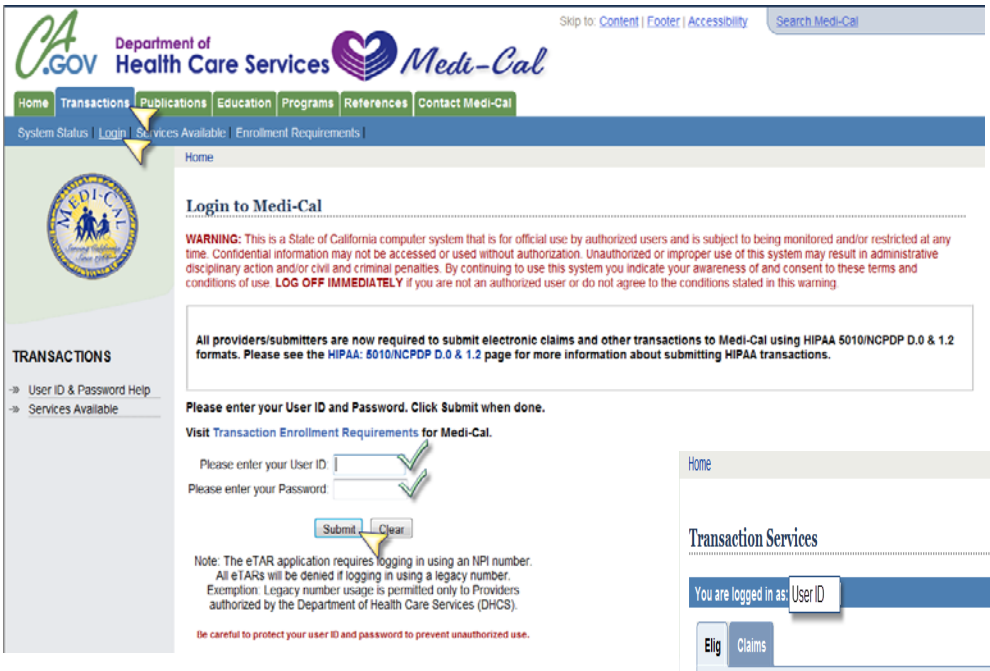
Transaction Enrollment Requirements

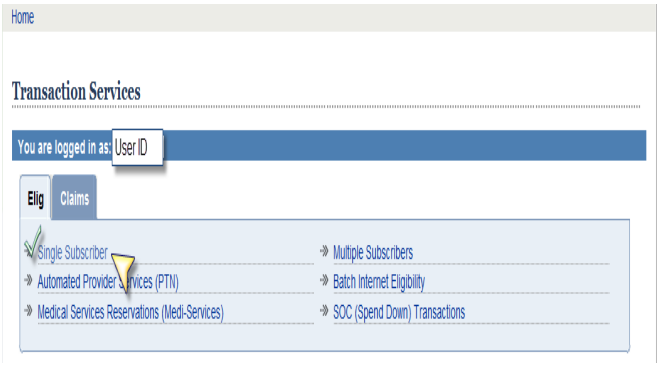
ENROLLMENT REQUIREMENTS FOR MEDI-CAL INTERNET TRANSACTIONS

Eligibility, Share of Cost, Medi-Services, Medicare Drug Pricing, Automated Provider Services, Batch Eligibility	Must have a Medi-Cal Provider number and PIN and have a Medi-Cal POS Network/Internet Agreement form on file. For information on Provider Enrollment Click Here. Please call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.
Family PACT	Must have a Medi-Cal Provider number and PIN and have a Medi-Cal POS Network/Internet Agreement form form on file. The provider must be enrolled in the Family PACT program.

TRANSACTIONS

- User ID & Password Help
- Services Available
- Enrollment Requirements





Home » Transaction Services

Eligibility Verification

You are logged in as: User ID

Swipe Card:

Subscriber ID: — SSN or CIN

Subscriber Birth Date: MM/DD/YYYY

Issue Date: — Today's Date

Service Date: MM/DD/YYYY

Indicates Required Field

SUBMIT CLEAR — Month verifying for Eligibility

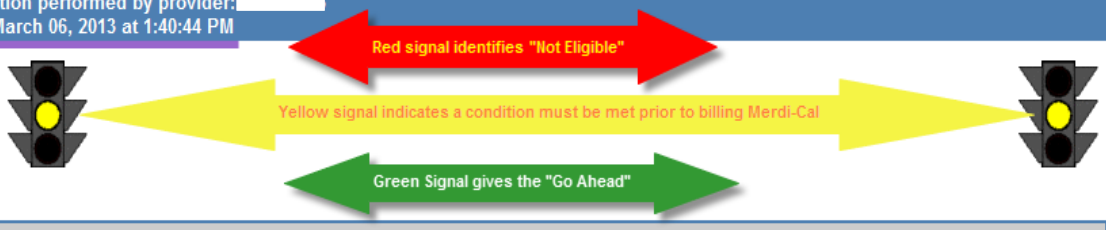
Recall data from last transaction

Click here ? for help on button usage.

For help on fields, place the cursor in the desired field and click on the Help link on the left.

Eligibility Response

Eligibility transaction performed by provider:
on Wednesday, March 06, 2013 at 1:40:44 PM



Name: SIM , R		
Subscriber ID: 9 A		
Service Date: 03/01/2012	Subscriber Birth Date: /19	Issue Date: 03/06/2013
Primary Aid Code: 60	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 33 - Riverside	HIC Number: 5 A	
Primary Care Physician Phone #:	Service Type: OIM R	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 706D8T2CC1		
Eligibility Message: SUBSCRIBER LAST NAME: SIM . EVC #: 706D8T2CC1. CNTY CODE: 33. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. PART A, B AND D MEDICARE COV W/HIC #555863107A . MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL.MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. OTHER HEALTH INSURANCE COV UNDER MEDICARE RISK HMO. CARRIER NAME: IEHP HEALTH ACCESS. COV: OIM R.		

Eligibility Response

Eligibility transaction performed by provider:
on Wednesday, March 06, 2013 at 1:52:22 PM

Name: R , R		
Subscriber ID: 9 P		
Service Date: 12/01/2012	Subscriber Birth Date:	Issue Date: 03/06/2013
Primary Aid Code: 7M	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 33 - Riverside	HIC Number:	
Primary Care Physician Phone #:	Service Type:	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 956MP9RV0Q		
Eligibility Message: SUBSCRIBER LAST NAME: R . EVC #: 956MP9RV0Q. CNTY CODE: 33. PRMY AID CODE: 7M. SUBSCRIBER LIMITED TO SVCS RELATED TO SEXUALLY TRANSMITTED DISEASES, SEXUAL ASSAULT, DRUG AND ALCOHOL ABUSE, AND FAMILY PLANNING W/ NO SOC/SPEND DOWN.		

Eligibility Response

Eligibility transaction performed by provider:
on Wednesday, March 06, 2013 at 1:56:35 PM

Name: A , A		
Subscriber ID: 9 D		
Service Date: 07/01/2012	Subscriber Birth Date:	Issue Date: 03/06/2013
Primary Aid Code: 38	First Special Aid Code: 42	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 33 - Riverside	HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number): 716HCR7JDQ		
Eligibility Message: SUBSCRIBER LAST NAME: A . EVC #: 716HCR7JDQ. CNTY CODE: 33. PRMY AID CODE: 38. 1ST SPECIAL AID CODE: 42. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN.		

Eligibility Response

Eligibility transaction performed by provider:
on Wednesday, March 06, 2013 at 1:58:41 PM

Subscriber ID: 120		
Service Date: 03/01/2013	Subscriber Birth Date:	Issue Date: 03/06/2013
Primary Aid Code:	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: - unknown	HIC Number:	
Primary Care Physician Phone #:	Service Type:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: NO RECORDED ELIGIBILITY FOR 03/13.		

AUGUST 2011

FACT SHEET
MINOR CONSENT SERVICES

What is Minor Consent?
Under the California Family Code, certain limited medical services can be provided to minors (youth) without their parent's or guardian's consent, including substance use disorder (SUD) treatment. Minors may consent to SUD treatment services without parental or guardian permission. These services, referred to as "minor consent," are paid for with state-only funds. The youth can independently establish Medi-Cal eligibility for specific, limited services and may exclude their parent's or guardian's income and resources on his/her Medi-Cal application. State and federal laws and regulations protect the privacy and identity of youth applying for Minor Consent services. As such, providers are prohibited from contacting the parents or guardians of these youth.

Source: Title 22, California Code of Regulations (CCR), Sections 50147.1, 50167(a)(6)(D)4., 50063.5, 50157(f)(3), 50703(d); Family Code, Section 6929; Welfare and Institutions Code, Section 14010.

Minor Consent Services
Title 22, CCR, Section 50063.5 defines Minor Consent services as services related to:

- Sexual assault
- Drug or alcohol abuse for children 12 years of age or older
- Pregnancy
- Family Planning
- Venereal disease for children 12 years of age or older
- Sexually transmitted diseases as defined by the director of California Department of Health Care Services for children 12 years of age or older
- Mental health care for children 12 years of age or older who are one of the following:
  - In danger of causing serious physical or mental harm to self or others; or
  - An alleged victim of incest or child abuse.

Drug Medi-Cal (DMC) Minor Consent Services
DMC services are Medi-Cal's substance use disorder (SUD) services. Minor Consent SUD services are primarily outpatient drug-free counseling services. Each county welfare office chooses from a limited menu of services it can offer minors:

- Between 12 and 21 years of age, he/she can receive SUD services
- Narcotic Treatment Program services are limited to youth age 18 to 21 years
- Pregnant or postpartum females may receive SUD services that are related to her health during pregnancy or the postpartum period

Source: Title 22, CCR, Sections 50147.1, 50063.5, 50157(f)(3), 50167(a)(6)(D), 50703(d)

Minor Consent Eligibility

Minor consent eligibility is for a 30-day period. The minor must reapply in person at the county welfare office to receive subsequent Minor Consent services. Children receiving Minor Consent DMC services are not eligible for full scope medical services such as Early and Periodic Screening, Diagnosis and Treatment supplemental services.

How are Minor Consent Services Paid?

Minor Consent services are only supported with State General Funds. Except for services provided to pregnant and postpartum minors, no federal funds are used.

Confidentiality

Under title 42, Code of Federal Regulations (CFR), Section 2.14, the SUD program and/or county cannot disclose that the minor is receiving Minor Consent services. Title 42 CFR states, “If a minor patient acting alone has the legal capacity under applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under subpart C of these regulations may be given only by the minor patient.”

Other Health Coverage (OHC)

This section describes the required steps for billing Medi-Cal when a recipient also has OHC, Medicare and Medicare HMO. Refer to the *Other Health Coverage (OHC) Codes Chart* and *Other Health Coverage Guidelines for Billing* sections in the Part 1 manual for information about how to determine OHC beneficiary eligibility.

Medicare and OHC

When a recipient has both Medicare fee-for-service and cost-avoided OHC, the provider must bill:

1. Medicare for the Medicare-covered services, (do not bill as an automatic crossover claim) and
2. The OHC carrier
3. Medi-Cal last. Attach the Medicare *Explanation of Medicare Benefits* (EOMB)*/Medicare Remittance Notice* (MRN) and the OHC Explanation of Benefits (EOB) to the Medi-Cal claim, except Pharmacy providers.

Pharmacy Providers

Pharmacy providers do not submit OHC attachments for electronic or hard copy claim submissions. For more information, see "Pharmacy: Self-Certification for OHC" in this section.

Note: If the OHC is a Medicare supplemental policy through an HMO, refer the recipient to the HMO.

Medical Supply Claims: OHC Documentation

OHC documentation requirements for providers billing for medical supplies are simplified. Refer to "Other Health Coverage Documentation" information in the *Medical Supplies* section of the appropriate Part 2 manual for information.

Billing Medi-Cal After OHC

These principles must be followed when billing Medi-Cal after billing OHC:

- The OHC must be used completely.
- Medi-Cal may be billed for the balance, including OHC copayments, OHC coinsurance and OHC deductibles. Medi-Cal will pay up to the limitations of the Medi-Cal program, less the OHC payment amount, if any.
- Medi-Cal will not pay the balance of a provider's bill when the provider has an agreement with the OHC carrier/plan to accept the carrier's contracted rate as a "payment in full."

- An Explanation of Benefits (EOB) or denial letter from the OHC must accompany the Medi-Cal claim, except for Pharmacy providers. Refer to "Pharmacy: Self-Certification for OHC" in this section.

- The amount, if any, paid by the OHC carrier for all items listed on the Medi-Cal claim form must be indicated in the appropriate field on the claim. Providers should not reduce the *Charge* amount or *Total Amount* billed because of any OHC payment. Refer to claim form completion instructions in this manual for more information.

OHC EOB or Denial Letter: Documentation Required by Medi-Cal

When billing Medi-Cal for any service partially paid or denied by the recipient's OHC, the OHC EOB or denial letter must accompany the claim and state the following:

- Carrier or carrier representative name and address
- Recipient's name or Social Security Number
- Date
- Statement of denial, termination or amount paid
- Procedure or service rendered
- Termination date or date of service

When a service or procedure is not a covered benefit of the recipient's OHC, a copy of the original denial letter or EOB is acceptable for the same recipient and service for a period of a year from the date of the original EOB or denial letter.

A dated statement of non-covered benefits from the carrier is also acceptable if it matches the insurance name and address and the recipient's name and address.

It is the provider's responsibility to obtain a new EOB or denial letter at the end of the one-year period. Claims not accompanied by proper documentation will be denied.

Pharmacy and Medical Supply Providers

Pharmacy providers do not include OHC attachments with pharmacy claims because the entry of the OHC code on the claim self-certifies for the OHC requirement. Pharmacy providers must, however, be able to retrieve information received from a recipient's OHC carrier. Refer to "Pharmacy: Self-Certification for OHC" in this section.

Providers billing for medical supplies may refer to "Other Health Coverage Documentation" information in the *Medical Supplies* section of the appropriate Part 2 manual for important OHC billing information.

OHC Cost-Sharing

Providers are prohibited from billing Medi-Cal recipients, or individuals acting on their behalf, for any amounts other than the Medi-Cal copayment or Share of Cost (SOC).

Therefore, if the recipient's OHC requires a copayment, coinsurance, deductible or other cost-sharing, the provider is not permitted to bill the recipient. If the provider bills the OHC and the OHC denies or reduces payment because of its cost-sharing requirements, the provider may then bill Medi-Cal. Medi-Cal will adjudicate the claim, deducting any OHC payment amounts.

When to Bill OHC

Refer to the chart in the *Other Health Coverage (OHC) Codes Chart* section of the Part 1 manual to determine when to bill OHC.

Delayed Insurance Response

If a response from the OHC carrier is not received within 90 days of the provider's billing date, providers may bill Medi-Cal. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. State "90-day response delay" on the attachment.

Medi-Cal Remittance Advice Details (RAD)

OHC billing information is included on the Medi-Cal *Remittance Advice Details* (RAD) when a claim is denied because the provider did not include proof of insurance billing with the Medi-Cal claim.

If available, the OHC information provided will include the insurer's name and billing address and the policyholder's Social Security Number. This information helps providers billing OHC. For more information, refer to the Remittance Advice Details (RAD) examples and *Remittance Advice Details (RAD): Payments and Claim Status* sections in this manual. For general RAD information, refer to the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* section in the Part 1 manual.

HMO Denial Letters

EDS often receives HMO denial letters containing the statement: "HMO eligible, but services were not rendered by an HMO facility/provider; therefore, patient is not eligible for HMO benefits." This is not an acceptable denial letter because the recipient did not exhaust the HMO coverage.

In order to establish Medi-Cal liability to pay claims for a recipient with HMO coverage, the provider must obtain a denial letter or EOB that clearly states one of the following:

- The recipient's HMO coverage has been exhausted, or
- The specific service is not a benefit of the HMO.

Kaiser Denial Letters

Providers billing Medi-Cal for Kaiser non-covered services must attach a specific denial letter from Kaiser (see sample on a following page). Denial reasons 2, 5 and 8 are not acceptable.

Although the directive in item 8 of the Kaiser denial letter states that providers should bill the patient directly, providers are reminded that State law prohibits them from billing Medi-Cal recipients.

Note: Kaiser facilities billing Medi-Cal for services that are not benefits of Kaiser must also include a statement with the claim containing the required denial information. A rubber stamp is acceptable only if it provides spaces to fill in the required information, directly relating it to the claim form submitted.

On Kaiser Letterhead

Provider Name and Address:

Date:
Kaiser Plan No.:

RE:
DATE(S) OF SERVICE:
TYPE OF SERVICE:

We are unable to consider payment for the above service you rendered for the following reason(s):

___ 1. **The person named above was not covered by our Plan at the time of service.**

___ 2. **Our members are not covered for non-emergency services obtained from non-Plan providers. All services except certain emergency care must be obtained from Plan facilities and physicians.**

___ 3. **Our members are not covered for the type of service specified above. This service is a contractual exclusion of our plan.**

___ 4. **The person named above is not covered by our prescription drug benefit.**

___ 5. **Prescriptions purchased at non-Plan pharmacies are not covered by our prescription benefit.**

___ 6. **The item purchased is not covered by our prescription drug benefit.**

___ 7. **The person named above does not have coverage for eyeglasses or contact lenses.**

___ 8. **Please bill the patient directly. Kaiser Foundation Health Plan will consider reimbursement only for emergency care and only when our member requests reimbursement through our Out-of-Plan Claims procedure.**

___ 9. **We are unable to identify the above person as a member of our program.**

___ 10. **Other:** _____

_____

_____

_____

KAISER FOUNDATION HEALTH PLAN, INC.

SERVICE REPRESENTATIVE

Sample Kaiser Denial Letter.

Prescription Drugs for Long Term Care Recipients: COV Code "P"

Pharmacy providers are required to bill OHC prior to billing Medi-Cal for prescription drugs dispensed to recipients in Long Term Care (LTC) facilities. The provider may request that Scope of Coverage (COV) code "P" be removed from the recipient's eligibility record if:

- The recipient has no insurance.
- The recipient's OHC has lapsed.
- The OHC does not cover pharmacy services dispensed in an LTC facility.
- The OHC is limited to specific pharmacy providers who cannot meet facility licensing standards.

Follow existing Medi-Cal billing requirements regarding OHC (submit claims to EDS with OHC denial letters attached) until the eligibility verification message does not reflect COV code "P."

Pharmacy Providers

A sample *Pharmacy Long Term Care Insurance Referral* form with the address for the Health Insurance Section/LTC Unit is found at the end of this section. Copy this form as needed. Additional supplies are not available.

Medicare Drug Coverage for NF-B Patients – Part A Benefits for Long Term Care

Under the provisions of the Medicare Catastrophic Coverage Act, Medicare Part A covers up to 150 days of Nursing Facility Level B (NF-B) services per calendar year. Some residents who are eligible for both Medicare and Medi-Cal have been relocated in order to use this Medicare benefit.

Payment for NF-B Resident Prescription Drug Services

Pharmacy providers should first inquire about the actual location of the NF-B resident within the facility before rendering Medi-Cal prescription drug services.

- If residents have Medicare coverage, Pharmacy providers must bill the facility for the drug services since Medicare reimburses the Nursing Facility with payments for all services including drug services. Do not bill Medi-Cal.
- If residents do not have Medicare coverage, Pharmacy providers may bill Medi-Cal separately for prescription drugs.

Pharmacy: Self-Certification for OHC

Pharmacy providers may complete self-certification for OHC electronically or by using the *Pharmacy Claim Form (30-1).* Pharmacy providers do not need to submit an OHC attachment. However, providers must be able to readily retrieve proof of claim submission and payment if collected from the other payer(s).

Note: The ability to self-certify for Other Health Coverage on pharmacy claims does not apply to medical supplies, with the exception of diabetic supplies.

Electronic Self-Certification

OHC will be self-certified for providers submitting electronic claims if a valid OHC code is entered. If an invalid code is entered for a recipient with OHC, the claim will be denied. Valid OHC codes can be found in the *Medi-Cal POS NCPDP Pharmacy Transaction Specifications* guide available on the Medi-Cal Web site (*www.medi-cal.ca.gov*). To access the guide, click "Technical Specs" under "Provider Resources," then click the "Medi-Cal POS NCPDP Pharmacy Transaction Specifications, Third Party Vendors" link. Field number 308 contains the most current approved values. Search for "308" to find all instances of this field. Questions regarding the placement of these codes in claims produced by pharmacy software programs should be directed to the software vendor.

Claim Form Self-Certification

OHC will be self-certified for providers submitting paper claims if the *Other Coverage Paid* field (Box 24) and the *Other Coverage Code* field (Box 25) are completed as instructed in the *Pharmacy Claim Form (30-1) Completion* section of the Part 2 *Pharmacy* manual.

Long Term Care Recipients: COV Code "L"

If the recipient's insurance does not cover LTC services, the policy has lapsed or the benefits have been exhausted, COV code "L" can be removed from the recipient's eligibility file.

To request removal of an incorrect COV code, send a copy of the OHC denial letter or EOB, along with a completed *Long Term Care Insurance Referral* form, to the Department of Health Care Services (DHCS) Health Insurance Section/LTC Unit. Follow existing Medi-Cal billing requirements regarding OHC (that is, submit claims with the OHC denial letters attached) until the eligibility verification message does not reflect COV code "L."

Long Term Care Providers

A sample *Long Term Care Insurance Referral* form with the address for the Health Insurance Section/LTC Unit is found at the end of this section. Copy this form as needed. Additional supplies are not available.

California Department of Alcohol and Drug Programs
Questions & Answers Regarding Billing Drug Medi-Cal
for Patients Who Have Other Health Coverage
(Updated April 8, 2011)

Federal Medicaid and California Medi-Cal laws and regulations

The basic federal law on billing Other Health Coverage (OHC) is the Social Security Act, Title 19, Section 1902(a)(25). The basic regulations on billing OHC are in Title 42 of the Code of Federal Regulations, Sections 433.138 and 433.139.

In addition to these, there are other federal laws and regulations related to billing OHC. Documents containing these federal laws and regulations can be found on the website for the Centers for Medicare & Medicaid Services (CMS), www.cms.gov. From the home page, follow these steps:

- Select "Medicaid" on the left side of the page
- Select "Third Party Liability"
- Select "Summary of Federal Statutory Requirements"
- Select "Summary of Federal Regulatory Requirements"
- Select "Summary of State Plan Requirements"

The last bullet above means the Medicaid State Plan. California administers its Medi-Cal Program through a Medicaid State Plan submitted to CMS.

The State regulation on billing OHC is the California Code of Regulations, Title 22, Section 51005. The basic State laws on billing OHC are found in the Welfare and Institutions Code, Sections 14005, 14023.7, 14024, and 14124.90. Other State laws on billing OHC are listed in the California Code of Regulations, Title 22, Section 51005 after item (e).

Questions from Counties/Service Providers and ADP Answers

1. **Q:** A letter from the OHC (Kaiser Foundation Health Plan) states that the patient did not have health coverage through the OHC on the date services were provided. Is this an acceptable denial reason? The patient has no other health care coverage.

> **A:** *The letter provides the appropriate support for billing Drug Medi-Cal (DMC). The letter states that the client does not have other health coverage from Kaiser. If you have confirmed with the client that he/she does not have coverage through another OHC, then you can submit your claim to DMC. Please keep the OHC (Kaiser) letter on file to support the DMC billing.*

2. **Q:** In the past, we were required to bill ADP for DMC within 30 days from the date of service. Regarding clients who have OHC, do we still need to enter services within the 30-day window and somehow suppress them so we do not bill for DMC before we get OHC denial/payment? The alternative would be not to enter the client services until we get OHC denial/payment. Is this acceptable?

> **A:** *A county or service provider (county/provider) must submit DMC claims to ADP within 30 days of the date of service. This is in accordance with the California Code of Regulations (CCR), Title 22, Section 51490.1. However, a county/provider may submit a DMC claim after 30 days if there is good cause for late submission, as defined in CCR, Title 22, Sections 51008 and 51008.5. Delays resulting from billings to OHC are circumstances that constitute good cause for late submission; but such billings must be submitted not later than one year after the month of service (see CCR, Title 22, Section 51008.5(a)(2)). Late billings with applicable good cause must use the appropriate delay reason code found on ADP's website (www.adp.ca.gov). Click on "Drug Medi-Cal Billing" and then select "Good Cause Certification - ADP 6065A (instructions) rev 3-4-10."*

3. **Q:** There are two reasons for denial acceptable to the Department of Health Care Services (DHCS) for DMC reimbursement for clients who have OHC. If the provider goes online to the private insurance carrier for a specific client, prints out documentation showing the client name, subscriber ID, effective and end dates, insurance carrier information AND policy information that indicates substance abuse in-network and out-of-network services are "not covered," is this acceptable to submit as proof of denial under "The specific service is not a benefit of the OHC" reason?

> **A:** *We consulted with DHCS, the lead agency for administering California's Medicaid (Medi-Cal) Program, to answer this question. According to DHCS, this is not an acceptable proof of denial of coverage. If a beneficiary is coded as having OHC, then a notice or denial letter from the Medi-Cal beneficiary's OHC carrier must be obtained prior to billing DMC.*

4. **Q:** We are working on some denials where the claim was rejected because "Non-Medicare coverage not billed first." It is our understanding that Medicare is not required for ADP clients. However, one of our billers asked about Medicare HMO. For instance, clients receive services at Kaiser through a Medicare Risk HMO. Specifically, these clients have an "F" in the QM screen on State MEDS system. Why are these coming back as "Non-Medicare coverage" when they are a Medicare Risk HMO? Most of these are from a few months ago. Is this something that may have been changed? Should we resubmit as a replacement? ADP Bulletin #11-01 addresses HMO eligible and benefits, but not Medicare HMO Risk. Is there another letter that addresses Medicare HMO Risk?

> ***A:*** *The problem appears to be that a Drug Medi-Cal (DMC) claim is being submitted without billing the OHC first. Therefore, the DMC claim is being denied. The solution is to bill the OHC before billing DMC.*

Medicare beneficiaries have the option to receive Medicare medical benefits through private health insurance plans, instead of directly from Medicare. These private plans are known as Medicare Advantage plans. Examples of such plans are Medicare HMO, Medicare Risk HMO, or Medicare Preferred Provider Organization (PPO) plans. The services for such a plan could be provided by an HMO such as Kaiser.

Medicare subsidizes these Medicare Advantage plans to reduce a beneficiary's out-of-pocket medical expenses. Medicare pays the private health plan a set amount every month for each member. The beneficiary usually pays a monthly premium for the plan, and pays a co-payment and/or coinsurance for covered services. These private plans are required to offer a benefit package that is at least as good as Medicare's. They are required to cover everything that Medicare covers, and may cover services that Medicare does not cover. The federal Centers for Medicare and Medicaid Services (CMS) determined that the services provided within DMC are categorically not covered by Medicare. As a result, when the service provider provides DMC services to a Medicare-eligible client, that service provider may bill DMC directly and is not required to bill Medicare before billing DMC. However, the CMS determination does not apply to the various private Medicare Advantage plans that are available. As Medicare Advantage plans may cover services that Medicare does not cover, the State is not free to allow service providers to bill DMC directly without billing the Medicare Advantage plans first.

When the beneficiary notifies the county that he/she has a Medicare Advantage plan, the beneficiary is coded in the Medi-Cal Eligibility Determination System (MEDS) with an Other Health Coverage (OHC) code of "F". MEDS recognizes the beneficiary as having OHC as a substitute for traditional Medicare coverage. If a service provider submitted a DMC claim for such a beneficiary, the Short-Doyle/Medi-Cal claim processing system would assess whether the OHC (i.e., Medicare Advantage plan) was billed first before paying the DMC claim. If the system does not detect the OHC billing, the DMC claim would be denied. The solution is for the service provider to consider the Medicare Advantage plan an OHC (e.g., Medicare HMO, Medicare Risk HMO, Medicare PPO) and bill DMC similar to how it bills DMC for any other beneficiary having OHC. ADP Bulletin #11-01 provides instructions for billing DMC for beneficiaries having OHC.

Normally, when a service provider provides a substance use disorder service to a Medicare beneficiary, that service provider does not need to bill Medicare first before billing DMC. However, the "F" code in the beneficiary's MEDS record recognizes the Medicare beneficiary as having OHC, and requires the service provider to bill the OHC before billing DMC.

ADP Bulletin #11-01 does not address these Medicare Advantage Plans; however, we will provide updates on the subject in our next bulletin.

5. ADP Bulletin #11-01 states that there are only two denial reason codes:
   - The recipient's OHC has been exhausted
   - The specific service is not a benefit of the OHC

   Service providers have received a number of different denial reasons from various OHC insurance companies. Following are questions and answers about whether each of these can be interpreted as a legitimate denial and how to submit the claim to DMC.

   Note: If the OHC carrier's denial notice is unclear, the county/provider should seek clarification of the denial notice by contacting the OHC carrier. After contacting the OHC carrier, if the county/provider confirms that the denial notice means the beneficiary did not have OHC on the date of service; the beneficiary's OHC has been exhausted, or the specific service is not a benefit of the OHC, then the county/provider may bill DMC and include the information regarding the OHC denial.

Q: "Client unidentified," "Client cannot be found in database," "Client not known to provider" – after exhausting every effort to identify the client, can the county assume the client is not eligible for OHC and bill Medi-Cal?

> ***A:*** *The county/provider must clarify the identification problem with the OHC carrier and, if necessary, seek the client's help. After contacting the OHC carrier, if the county/provider determines that the beneficiary does not have OHC, then the county/provider may submit the DMC claim and include the information regarding the OHC denial.*

Q: "Member Termed" before service date – can this be interpreted as coverage has been exhausted?

> ***A:*** *After contacting the OHC carrier, if the county/provider confirms that "Member Termed" means that the client no longer has OHC, then the service provider may submit the DMC claim and include the information regarding the OHC denial.*

Q: Timeliness -- if the OHC company refuses to pay because the bill was received too late, can the county still bill Medi-Cal?

> ***A:*** *Under this circumstance, the county should not bill Drug Medi-Cal. An untimely claim to the OHC carrier does not allow the OHC carrier the opportunity to deny the claim under its normal claim processing timeline. The county/provider should adjust its claim processing procedures to conform to the OHC carrier's timeline.*

Q: Billed code is mutually exclusive or incidental to primary procedure billed – the insurance company will only pay for one service per day. If the client received two services (i.e., an individual treatment and methadone dosage on the same day), can the county bill Medi-Cal for the service that was not paid?

> ***A****: After contacting the OHC carrier, if the county/provider confirms that the OHC carrier will only pay for one service per day, then the service provider may bill the other service to DMC. It is only by contacting the OHC carrier that the question can be answered and a solution determined. The problem could relate to a billing code rather than an interpretation that the OHC carrier will only pay for one service per day.*

Q: Patient did not have health coverage through health plan on dates provided – can this be interpreted as a denial and bill Medi-Cal?

> ***A:*** *After contacting the OHC carrier, if the county/provider confirms that the client does not have OHC, then the service provider may submit the DMC claim and include the information regarding the OHC denial. It is the county's responsibility to assure that correct, current information about the OHC is on file with the State for Medi-Cal beneficiaries in accordance with the California Code of Regulations, Title 22, Section 50765.*

DMC PROVIDERS ONLY – follow-up to email sent on 1/3/2013

Attention: Mental Health & Substance Abuse Programs serving minors currently enrolled in the Healthy Families Program (HFP)

On January 1, 2013, the Department of Health Care Services began transitioning HFP participants to Medi-cal due to a new State law and in preparation for Integrated Healthcare coverage. The transition will occur in four (4) phases over the course of the year.

Riverside, San Bernardino, Orange, San Diego, Alameda and San Francisco county enrollees began their transition on January 1, 2013 as part of Phase 1-Part A. It is unknown how long the transition will take and when specific Riverside County clients will be completely transitioned. Parents or guardians of participants are being notified in writing by the State that their child(ren) have been transitioned to Medi-cal. At this time, there is no notification to Counties when enrollees have been transitioned.

In anticipation of the change, the State has added seven (7) new Medi-cal aid codes effective December 19, 2012 for HFP participants who are being transitioned to Medi-cal. The new Medi-cal aid codes will replace the previous HFP aid codes (9H, 9R, 7X, 8X & E1) and are listed below;

1. H1
2. H2
3. H3
4. H4
5. H5
6. 5C
7. 5D

How should Programs respond to these changes?

To ensure the Department's ability to **identify** and **track** former HFP participants who have been transitioned to Medi-cal, it is ***critical*** that programs create the link between the State's eligibility file and the eligibility information in ELMR by accurately submitting on the Admission Request Form the clients' SSN (on page one). When the SSN is used to verify eligibility in the State website as well as the County ELMR system, the CIN# is automatically populated in the County internal system for Billing AND Reporting purposes.

With the eligibility link intact, Medi-cal eligibles' aid codes are **"automatically"** updated in the "Aid Code" field when the monthly MEDS Eligibility file (MMEF) is uploaded in ELMR and/or when the clients' services are claimed. This includes updates of aid codes for former HFP participants.

Additional Program instructions;

- When performing your monthly Medi-cal eligibility verifications, check for one of the new Medi-cal aid codes listed above for your HF clients.
- Once your HF client is transitioned to Medi-cal;
    - ❖ Notify Substance Abuse Administration by faxing the State eligibility printout when changes occur so that the ELMR billing system can be updated with the appropriate effective dates. This holds true to any changes in eligibility for any client. It will ensure accurate claiming to the State. ELMR is populated with initial admission data provided, but during the course of treatment client may have a change in eligibility status or data.

Please contact the Substance Abuse Administration at (951) 782-2400 if you have further questions.

http://www.dhcs.ca.gov/services/hf/Pages/HFPFAQ.aspx

From: Shaverdi, Nicole
Sent: Thursday, January 03, 2013 4:14 PM
Subject: Healthy Families Emailt to send to DMC Providers and Clinics

County Clinics and DMC Contract Providers:

As a Phase 1A County, DHCS informed us a change occurred January 1 for Riverside County. Healthy Family (HFP) recipients are now qualified to receive substance abuse treatment under DMC. You may experience an influx of adolescents entering your program that were once qualified under HFP. We need to track these individuals and report back to the state weekly during the transition period. For now, I ask that you keep a manual log of these adolescents. Our staff will contact you for the information until we determine a more automated and reliable process.

How will you know who these individuals are? As you are aware, DMC eligibility must be established when the client enters your program and every month thereafter. You will continue to check eligibility and if the client has one of the below aid codes, you will document them as a former HFP recipient.

- Aid codes 5C and 5D are transitional aid codes for those children who were in the Healthy Families Program and transferred to Medi-Cal under the Targeted Low Income Children Program. (For example, the children who were in Healthy Families and resided in Phase 1A counties as of December 31, 2012, will be in Medi-Cal under these new aid codes as of January 1, 2013.) The children will stay in these aid codes until the time of their eligibility redetermination (see next bullet). This information is referenced in ACWDL 12-30.
- Aid codes H1 through H5 are the Targeted Low Income Children Program aid codes for children that are newly enrolled in Medi-Cal and would have gone into Healthy Families instead of Medi-Cal if we had not implemented the transition. These codes are also for those children that were transitioned from Healthy Families, initially placed into aid codes 5C and 5D, and have been redetermined eligible at their renewal dates in 2013. The detailed description of these aid codes and their purpose is in ACWDL 12-33.

Check the State website for eligibility, print out the screen and submit with your admission paperwork. You may already have some of these individuals in your program so I suggest you re-check eligibility on all adolescents and include them.

I will keep you abreast of other requirements and issues arising from this transition as they become available. We appreciate your cooperation and feedback about this very recent change. If you have any questions, please feel free to give me a call.

From: Reino-Webb, Andrea
Sent: Wednesday, January 30, 2013 8:43 AM
Subject: DMC Aid Code Master Chart 1-29-13

Attached is the updated Aid Code Master Chart.
Please discard of any previous versions and begin using the updated chart. Addition of Healthy Family replacement aid codes and descriptions.

If you have any questions please contact Substance Abuse Administration at (951) 782-2400

From: Reino-Webb, Andrea
Sent: Thursday, February 14, 2013 9:20 AM
Subject: RE: DMC Aid Code Master Chart 1-29-13

How to read the new Aid Code Master Chart:

1. Identify that the "Benefits" are 'Full' or services rendered meet any identified 'Restrictions'.
2. Identify under the "DMC" column if 'No' or 'Yes'. (No = Aid Code not valid for DMC services) (Yes = Aid Code Valid for Reimbursement as long as the "Benefits" column is valid)

Department of Health Care Services – Short Doyle / Medi-Cal Aid Code Master Chart for MHS and DMC

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	Benefits	SOC	Program/Description	MHS	MEG	DMC	SD/MC	Inactive in MEDS	EPSDT
8N	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented / Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 % of the federal poverty level.	Yes	MCHIP	No			No
8P	Full	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 % of the federal poverty level.	Yes	MCHIP	Yes			Yes

EPSDT:

Benefit	Definition
Full	No restrictions
Restricted	Special Condition: e.g. Undocumented or non-satisfactory immigration status; Pregnancy; Emergency, etc.
Limited	A restriction based upon time (e.g. IP off the grounds of the prison for <24H)

The chart columns identify Mental Health Services (MHS), Medicaid Eligibility Group (MEG)[1], Drug Medi-Cal Program (DMC), Effective Dates and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MHS and DMC column indicate a "yes" if the aid code is appropriate for use by MHS and/or DMC; and "no" if it is not. The Short Doyle / Medi-Cal (SD/MC) column indicates the effective date of the aid code for Medi-Cal eligibility. The Inactive in MEDS column indicates the date for which FFP is no longer available for an aid code. The EPSDT column identifies aid codes that may include beneficiaries under age 21 who are eligible for expanded Medi-Cal benefits under the EPSDT program.

Short-Doyle Medi-Cal (SDMC)

Aid Code Master Chart

October 28, 2013

The following chart organizes Medi-Cal aid codes into six groups based on the percent of federal financial participation (FFP) that will be paid for Medi-Cal eligibles within that group, provided FFP is available:

- Refugee (100% FFP)
- Managed Risk Medical Insurance Board (MRMIB) at Title XXI 65%
- Aid codes (Regular FFP) at Title XIX 50%
- Title XXI of the Social Security Act (Enhanced FFP) at 65%
- Breast and Cervical Cancer Treatment Program (BCCTP) Aid Codes (Enhanced FFP) at 65%
- Mixed Funding based on diagnostic and/or procedure codes. Emergency (Regular FFP) at Title XIX 50%, and/or Pregnancy (Enhanced FFP) at Title XXI 65%

Please note all Affordable Care Act (ACA) Aid Codes will not be effective until January 1, 2014 (see listing of Aid Codes on Change Log page 4).

ACA Aid Codes:

The new aid codes identify those individuals eligible for benefits in the ACA new adult group, expansion children, pregnant women and parents/caretaker relatives.

Aid Codes L1, N0 and N9 will be at 100% FFP until 2016.

For Aid Codes M1, M2, N5, N6, N7 and N8 please refer to the following table:

FFP	Dates
100%	2014-2016
95%	2017
94%	2018
93%	2019
90%	2020 and thereafter

Benefit	Definition
Full	No restrictions
Restricted	Special Condition: e.g. Undocumented or non-satisfactory immigration status; Pregnancy; Emergency, etc
Restricted Limited	A restriction based upon time (e.g. IP off the grounds of the prison for <24H)

The chart columns identify Mental Health Services (MHS), Medicaid Eligibility Group (MEG)[1], Drug Medi-Cal Program (DMC), Effective Dates and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MHS and DMC column indicate a "yes" if the aid code is appropriate for use by MHS and/or DMC; and "no" if it is not. The SD/MC column indicates the effective date of the aid code for Medi-Cal eligibility. The Inactive in MEDS column indicates the date for which FFP is no longer available for an aid code. The EPSDT column identifies aid

[1] The Centers for Medicare and Medicaid Services (CMS) requires that the State (DHCS) submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms for the Specialty Mental Health Waiver. The method used to develop the trends historical data is compiled by quarter by MEG which are: Disabled, Foster Care, MCHIP and Other. PLEASE NOTE: MEGs DO NOT APPLY TO DMC.

codes that may include beneficiaries under age 21 who are eligible for expanded Medi-Cal benefits under the EPSDT program.

Historical FFP Rates (As of Date Payment)

Federal Fiscal Year (October 1 through September 30)	Regular FFP	Enhanced FFP[2]
2005 - 2012	50.00%	65.00%
July 1, 2004 - September 30, 2005	50.00%	65.00%
October 1, 2003 - June 30, 2004	52.95%	65.00%
April 1, 2003 - September 30, 2003	54.35%	65.00%
October 1, 2002 - March 31, 2003	50.00%	65.00%
2001 – 2002	51.40%	65.98%
2000 – 2001	51.25%	65.88%
1999 – 2000	51.67%	66.17%

Effective October 1, 2008, Beneficiary Services received a stimulus of 11.59% FMAP rate for FY 08/09 with a date of service from October 1, 2008 through December 31, 2010. On August 10, 2010 the American Recovery and Reinvestment Act (ARRA) of 2009 was extended to continue the additional Federal assistance for six months, ending June 30, 2011, but would phase down the level of assistance. Therefore, the ARRA FMAPs for QTR 2 of FY 2011 are 3 percent less than the QTR 1 levels (6.2 percent minus 3.2 percent) and the ARRA FMAPs for QTR 3 of FY 2011 are 2 percent less than those for QTR 2 (3.2 percent minus 1.2 percent). Please see chart below:

Historical Stimulus Rates for Beneficiary Services Only

Federal Fiscal Year	Regular FFP
April 1, 2011 - June 30, 2011	56.88%
January 1, 2011 - March 31, 2011	58.77%
October 1, 2010 - December 31, 2010	61.59%
October 1, 2009 - September 30, 2010	61.59%
October 1, 2008 - September 30, 2009	61.59%

SD/MC Aid Codes Change Log

New Revision	Previous Revision	Added Codes	Removed Codes	Comments
9/10/2008	10/17/2003	3D, 3W, 65, 06, 46, 0W	5X, 5Y (discontinued in MEDS 10/1/03)	
2/11/2010	9/10/2008	C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, 2H, 5E, 8U, 8V, E1		8X, 0M, 0N, 0P,1X,1Y,47,8W, Changed from restricted to Full Benefits
8/9/2010	2/11/2010	None		All BCCTP aid codes updated Enhanced FFP – page 6
8/25/2010	8/9/2010	None		Updated '0U' benefits to be 'FFP Funds for Emergency *&* Pregnancy only'

[2] FFP of more than 50% is not applicable for DMC.

New Revision	Previous Revision	Added Codes	Removed Codes	Comments
9/13/2010	8/25/2010			Aid Codes E1, C3, C4, C5, C6, C7, C8, C9, D1, D4, D5, D6 and D7 changed to indicate “N” in the EPSDT column
10/7/2010	9/13/2010	4H, 4L – active in MEDS on 12/13/2010		Changed table deleted EDS and SD/MC- added effective dates and inactive dates
1/13/11	1/7/11	4T	4G, 53, 0R, 0T, 8Y, 81 = not eligible for FFP effective 1/10/11	Removed from Chart
1/21/11	1/13/11			7M, 7N, 7P, changed to “No” for MHS. These aid codes are not eligible for FFP.
1/27/11	1/21/11	4G on 1/25/11 (previously removed in error)		
2/11/11	1/27/11	74 for ADP (pending ITSD deployment)		Listed 8U and 8V under Title 19.
2/28/11	2/11/11	74 activated for ADP on 2/25/11		Added footnotes for aid codes 5E, 8E & 8W.
5/6/11	2/28/11			Changed ARRA language and added 7/1/11 -9/30/11 at 50% to chart. Organized aid codes according to funding. 7X, 8X now listed under Title 21 and “Yes” EPSDT.
9/13/11	2/28/11		7R = not eligible for FFP	Removed from Chart
12/02/11	9/13/11	07, 4N, 4S, 4W, 43, 49		Updated description for aid codes 3G, 3H, 3N, 3P, 3R, 30, 32, 33, 35, 39 and 59
6/5/12	12/2/11			0U, 0V are now listed under BCCTP. 0W is transitional aid code only. 48 is pregnancy only
8/29/12	6/5/12			Generally, enhanced aid codes are categorized as either SCHIP and MCHIP

New Revision	Previous Revision	Added Codes	Removed Codes	Comments
1/28/13	8/29/12	53, 65, 0R, 0T, 8Y, 81, R1 5C, 5D, H1, H2, H3, H4, H5 G0, G1, G2, G5, G6, G7, G8		State Only Aid Codes Effective Date 1/1/13 Effective Date 1/1/12
	1/28/13	3F, K1		Effective Date 4/1/13
10/24/13	1/28/13	E2, E4, E5, E7 H6, H7, H8, H9, H0, 4E, P1, P2, P3, P4, J1, J2, J3, J4, J5, J6, J7, J8, G9 L1, N9, N0, M1, M2, M3, M4, M7, M5, M6 M8, M9, M0 N5, N6, N7, N8, P5, P6, P7, P8, P9, P0 T1, T2, T3, T4,T5,T6,T7 T8, T9, T0,		Effective 1/1/14

Aid Codes Master Chart Contact Information
http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx#MasterAidCodeChart
http://www.dhcs.ca.gov/services/MH/Pages/MedCCC.aspx

MHS email**:** MedCCC@dhcs.ca.gov
DMC email: Anthony.Ortiz@dhcs.ca.gov; Jim.Jacobson@dhcs.ca.gov

Refugee Aid Codes (100% FFP through-Refugee Resettlement Program) These aid codes are funded by the Refugee Resettlement Program (not Title XIX or XXI)							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
0A	Full	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.	Yes	N/A	Yes			Yes
01	Full	No	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.	Yes	N/A	Yes			Yes
02	Full	Y/N	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.	Yes	N/A	Yes			Yes
08	Full	No	Entrant Cash Assistance (ECA) (FFP). Provides ECA benefits to Cuban/Haitian entrants, including unaccompanied children who are eligible, during their first eight months in the United States. (For entrants, the month begins with their date of parole.) Unaccompanied children are not subject to the eighth-month limitation provision.	Yes	N/A	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
G0	Full	No	Title XIX, Medi-Cal no SOC for State Medical Parolees. Full Scope Medical parolees who are Medi-Cal eligible in aid code G0 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. To the extent possible, former state inmates on Medical Parole with an OHC code of "G" will be moved into aid code G0 once it is implemented. Aid code G0 will be a secondary aid code.	Yes	Other	No	1/1/12		No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
G1	Restricted; Limited	No	Title XIX, Medi-Cal no share-of-cost (SOC) for state juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital and inpatient mental health services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G5	Restricted; Limited	No	Title XIX, Medi-Cal no SOC for county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility	Yes	Other	No	1/1/12		No
G7	Restricted; Limited	No	Title XIX, Medi-Cal SOC for county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital or inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
H7	Full	No	Hospital Presumptive Eligibility for Children age 1-6 (FPL at or below 142 percent FPL)	Yes	Other	Yes	1/1/14		Yes
H8	Full	No	Hospital Presumptive Eligibility for Children age 6-19 (FPL at or below 108 percent FPL)	Yes	Other	Yes	1/1/14		Yes
J1	Full	No	Title XIX, Medi-Cal no share-of-cost (SOC) for Compassionately released/Medical Probation County Inmates. Individuals who are Medi-Cal eligible in aid code J1 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
J2	Full	Yes	Title XIX, Medi-Cal SOC for Compassionately released/Medical Probation County Inmates. Individuals who are Medi-Cal eligible in aid code J2 will be entitled to all Medi-Cal covered services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No
J5	Full	No	Title XIX, Medi-Cal no SOC/SOC for aged (>65 years old) Compassionately released/Medical Probation County Inmates who reside in long-term care (LTC) facilities. Individuals who are Medi-Cal eligible in aid code J5 will be entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
J7	Full	No	Title XIX, Medi-Cal no SOC/SOC for disabled Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Individuals who are Medi-Cal eligible in aid code J7 will be entitled to all Medi-Cal covered LTC services because they are not considered to be incarcerated. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
K1	Full	No	Two Parent Safety Net & Drug/Fleeing Felon Family	Yes	Other	Yes	4/1/13		No
M3	Full	No	Parent/Caretaker Relative at or below 125% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		No
M7	Full	No	Pregnant Women 0% through 125% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		No
M9	Limited Scope: Pregnancy Services	No	Pregnant Women 125% - 200% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		No
P0	Restricted	No	Infant up to 1 year of age with 0 percent - 208 percent Federal Poverty Level, Undocumented, restricted to emergency services and long term care services.	Yes	Other	No	1/1/14		No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
P1	Full	No	Hospital PE Children 0-1 (at or below 208 percent FPL)	Yes	Other	Yes	1/1/14		Yes
P2	Full	No	Hospital PE Parent/Caretaker Relative (at or below 125 percent FPL)	Yes	Other	Yes	1/1/14		No
P3	Full	No	Hospital PE Adults (19-64) (at or below 138 percent FPL)	Yes	Other	Yes	1/1/14		No
P4	Limited	No	Hospital PE Pregnant Women (at or below 213 percent FPL). Limited to Ambulatory prenatal services.	Yes	Other	Yes	1/1/14		No
P5	Full	No	Children 6 to 19 years of age with 0 percent – 108 percent Federal Poverty Level, Citizen/Lawfully present, full scope no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
P7	Full	No	Children 1 to 6 years of age with 0 percent – 142 percent Federal Poverty Level, Citizen/Lawfully present, full scope, no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
P8	Restricted	No	Children 1 to 6 years of age with 0 percent - 142 percent Federal Poverty Level, Undocumented, restricted to emergency services and long term care services.	Yes	Other	No	1/1/14		No
P9	Full	No	Infant up to 1 year of age with 0 percent - 208 percent Federal Poverty Level, Citizen/Lawfully present, full scope, no cost Medi-Cal.	Yes	Other	Yes	1/1/14		Yes
03	Full	No	Adoption Assistance Program (AAP) (FFP). A cash grant program to facilitate the adoption of hard-to-place children who would require permanent foster care placement without such assistance.	Yes	Foster Care	Yes			Yes
04	Full	No	Adoption Assistance Program/Aid for Adoption of Children (AAP/AAC). Covers cash grant children receiving Medi-Cal by virtue of eligibility to AAP/AAC benefits.	Yes	Foster Care	Yes			Yes
06	Full	No	Adoption Assistance Program (AAP) Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continued Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.	Yes	Foster Care	No			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
07	Full	No	AAP Title IV-E Federal Cash and Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
0W	Full	No	BCCTP transitional Medi-Cal coverage: Provides transitional no cost-full scope Medi-Cal coverage while county makes determination of eligibility under any other Medi-Cal program to beneficiaries formerly in aid code OP who no longer meet federal BCCTP requirements due to turning 65, obtaining creditable health insurance or who no longer need treatment for breast and/or cervical cancer.	Yes	Other	Yes			Yes
1E	Full	No	Continued eligibility for the Aged (FFP), Covers former SSI beneficiaries who are Aged (with exception of persons who are deceased or incarcerated in a correctional facility) until the county predetermines their eligibility.	Yes	Other	Yes			No
1H	Full	No	Federal poverty level – Aged (FPL-Aged) Provides full scope (no share of cost) Medi-Cal to qualified aged individuals/couples.	Yes	Other	Yes			No
1X	Full	No	Multipurpose Senior Services Program Medi-Cal Qualified**,** Eligible due to application of spousal impoverishment rules. Covers persons 65 years and older who meet the Medi-Cal criteria for inpatient care in a nursing facility.	Yes	Other	Yes			No
1Y	Full	Yes	Multipurpose Senior Services Program Medi-Cal Qualified, Eligible due to application of spousal impoverishment rules. Covers persons 65 yrs and older who meet the Medi-Cal criteria for inpatient care in a nursing facility.	Yes	Other	Yes			No
10	Full	No	SSI/SSP Aid to the Aged (FFP). A cash assistance program administered by the SSA which pays a cash grant to needy persons 65 years of age or older.	Yes	Other	Yes			No
13	Full	Y/N	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status	Yes	Other	No			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
14	Full	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			No
16	Full	No	Aid to the Aged – Pickle Eligibles (FFP). Covers persons 65 years of age or older who were eligible for and receiving SSI/SSP and Title II benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions in the Lynch v. Rank lawsuit.	Yes	Other	Yes			No
17	Full	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required.	Yes	Other	Yes			No
18	Full	No	Aid to the Aged – IHSS (FFP). Covers aged IHSS cash recipients, 65 years of age or older, who are not eligible for SSI/SSP cash benefits.	No	Other	Yes		Phased out from 9/05 to 1/06	No
2A	Full	No	Abandoned baby program. Provides full scope benefits to children up to 3 months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act	Yes	Other	No			Yes
2E	Full	No	Continued eligibility for the Blind (FFP), Covers former SSI beneficiaries who are Blind (with exception of persons who are deceased or incarcerated in a correctional facility) until the county determines their eligibility.	Yes	Other	Yes			Yes
2H	Full	No	Blind – Federal Poverty Level – covers blind individuals in the FPL for the Blind Program.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
20	Full	No	SSI/SSP Aid to the Blind (FFP). A cash assistance program administered by the SSA, which pays a cash grant to needy blind persons of any age.	Yes	Other	Yes			Yes
23	Full	Y/N	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	Yes	Other	No			Yes
24	Full	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			Yes
26	Full	No	Aid to the Blind – Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of the Lynch v. Rank lawsuit. (See aid code 16 for definition of Pickle eligibles.)	Yes	Other	Yes			Yes
27	Full	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.	Yes	Other	Yes			Yes
28	Full	No	Aid to Blind – IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See aid code 18 for definition of eligibility for IHSS.)	No	Other	Yes		Phased out from 9/05 to 1/06	Yes
3A	Full	No	Safety Net – All other Families, CalWORKs Timed-Out, Child-Only Case. (FFP) Provides for continued cash and Medi-Cal coverage of children whose parents have been discontinued from cash aid and removed from assistance unit (AU) due to reaching the CalWORKs 60 month time limit without meeting a time extender exception.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
3C	Full	No	Safety Net – Two Parent, CalWORKs Timed-Out, Child-Only Case. (FFP) Provides for continued cash and Medi-Cal coverage of children whose parents have been discontinued from cash aid and removed from AU due to reaching the CalWORKs 60 month time limit without meeting a time extender exception.	Yes	Other	Yes			Yes
3D	Full	No	Not on cash aid, but cash-linked Medi-Cal eligible because the individual has been determined to be eligible for CalWORKs.	Yes	Other	Yes			Yes
3E	Full	No	CalWORKs Legal Immigrant-Family Group (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.	Yes	Other	Yes			Yes
3G	Full	No	CalWORKs – Zero Parent Exempt.	Yes	Other	Yes			Yes
3F	Full	No	Two Parent Safety Net & Drug/Fleeing Felon Family	Yes	Other	Yes	4/1/13		No
3H	Full	No	CalWORKs – Zero Parent Mixed.	Yes	Other	Yes			Yes
3L	Full	No	CalWORKs Legal Immigrant-Family Group – FAMILY GROUP (FFP). Provides aid to families in which a child is deprived because of the absence, incapacity or death of either parent.	Yes	Other	Yes			Yes
3M	Full	No	CalWORKs Legal Immigrant-Family Group – Unemployed (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.	Yes	Other	Yes			Yes
3N	Full	No	Aid to Families with Dependent Children (AFDC) – 1931(b) Non-CalWORKs	Yes	Other	Yes			Yes
3P	Full	No	CalWORKs – All Families – Exempt.	Yes	Other	Yes			Yes
3R	Full	No	CalWORKs – Zero Parent – Exempt.	Yes	Other	Yes			Yes
3U	Full	No	CalWORKs Legal Immigrant-Family Group – Unemployed (FFP). Provides aid to families in which a child is deprived because of the unemployment of a parent living in the home.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
3W	Full	No	Temporary Assistance to needy Families (TANF) Timed-Out Mixed Case	Yes	Other	No			Yes
30	Full	No	CalWORKs – All Families	Yes	Other	Yes			Yes
32	Full	No	TANF Timed out.	Yes	Other	Yes			Yes
33	Full	No	CalWORKs – Zero Parent	Yes	Other	Yes			Yes
34	Full	No	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.	Yes	Other	Yes			Yes
35	Full	No	CalWORKs – Two Parent	Yes	Other	Yes			Yes
36	Full	No	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and subsequent COLAs were disregarded.	Yes	Disabled	Yes			Yes
37	Full	Yes	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.	Yes	Other	Yes			Yes
38	Full	No	Continuing Medi-Cal Eligibility (FFP). Edwards v. Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC until the family's eligibility or ineligibility for Medi-Cal only has been determined and an appropriate *Notice of Action* sent.	Yes	Other	Yes			Yes
39	Full	No	Initial Transitional Medi-Cal (TMC) (6 months). Provides six months of coverage for those discontinued from CalWORKs or the Section 1931(b) program due to increased earnings or increased hours of employment.	Yes	Other	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
4A	Full	No	Adoption Assistance Program (AAP). Program for AAP children for whom there is a state-only AAP agreement between any state other than California and adoptive parent(s).	Yes	Other	Yes			Yes
4E	Full	No	Hospital Presumptive Eligibility for Former Foster Care Children up to age 26 No income screening	Yes	Other	Yes	1/1/14		Yes
4F	Full	No	Kinship Guardianship Assistance Payment (Kin-GAP). Federal program for children in relative placement receiving cash assistance.	Yes	Foster Care	Yes			Yes
4G	Full	No	Kin-GAP. State-only program for children in relative placement receiving cash assistance.	Yes	Foster Care	Yes			Yes
4H	Full	No	Foster Care children in CalWORKs	Yes	Foster Care	Yes	12/13/10		Yes
4K	Full	No	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.	Yes	Foster Care	Yes		Termed on 6/96	Yes
4L	Full	No	Foster care children in Social Security Act Title XIX, Section 1931 (b) program	Yes	Foster Care	Yes	12/13/10		Yes
4M	Full	No	This program covers former foster care youth who were in foster care on their eighteenth birthday. Coverage extends until the 21st birthday and provides full-scope, no-cost benefits.	Yes	Other	Yes			Yes
4N	Full	No	CalWORKs FC State Cash Aid/ FFP Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
4P	Full	No	CalWORKs Family reunification – All Families (FFP) Provides for the continuance of CalWORKs services (includes Medi-Cal) to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.	No	Other	No	10/1/01		Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
4R	Full	No	CalWORKs Family reunification – Two Parent (FFP) Provides for the continuance of CalWORKs services (includes Medi-Cal) to two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.	No	Other	No	10/1/01		Yes
4S	Full	No	Kin-GAP Title IV-E Federal Cash and Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
4T	Full	No	Children in IV-E Kin-GAP Program.	Yes	Foster Care	Yes	1/1/11		Yes
4W	Full	No	Kin-GAP State Cash Aid/FFP Medi-Cal after full Medi-Cal determination.	Yes	Foster Care	Yes	1/1/12		Yes
40	Full	No	AFDC-FC/Non-Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.	Yes	Foster Care	Yes			Yes
42	Full	No	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.	Yes	Foster Care	Yes			Yes
43	Full	No	AFDC-FC State Cash Aid/FFP Medi-Cal.	Yes	Foster Care	Yes	1/1/12		Yes
44	Restricted to pregnancy-related services	No	Income Disregard Program. Pregnant (FFP) United States Citizen/Permanent Resident Alien/PRUCOL Alien. Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level.	Yes	Other	Yes			No
45	Full	No	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC.	Yes	Other	Yes			Yes
46	Full	No	Out of State Interstate Compact Foster Care children from out of state placed in CA	Yes	Foster Care	No			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
47	Full	No	Income Disregard Program (FFP). Infant – United States Citizen, Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal benefits to infants up to one year old and continues beyond one year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.	Yes	Other	Yes			Yes
49	Full	No	AFDC-FC Title IV-E/Federal Cash and Medi-Cal	Yes	Foster Care	Yes	1/1/12		Yes
5E	Full	No	Healthy Families to the Medi-Cal Presumptive Eligibility (PE) program. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits to certain children under the age of 19. *T21 effective through 3/31/09; T19 effective 4/1/09.*	Yes	Other	Yes	10/25/10		Yes
5K	Full	No	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.	Yes	Foster Care	Yes			Yes
54	Full	No	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to the increased collection of child/spousal support payments but eligible for Medi-Cal only.	Yes	Other	Yes			Yes
59	Full	No	Continuing TMC (6 months). Provides an additional six months of TMC for beneficiaries who had six months of initial TMC coverage under aid code 39	Yes	Other	Yes			Yes
6A	Full	No	Disabled Adult Children (DAC)/Blindness (FFP).	Yes	Other	Yes			Yes
6C	Full	No	Disabled Adult Children (DAC)/Disabled (FFP).	Yes	Disabled	Yes			Yes
6E	Full	No	Continued eligibility for the Disabled (FFP), Covers former SSI beneficiaries who are Disabled (with exception of persons who are deceased or incarcerated in a correctional facility) until the county determines their eligibility.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
6G	Full	No	250 Percent Program Working Disabled. Provides full-scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.	Yes	Disabled	Yes	3/16/09		Yes
6H	Full	No	Federal Poverty Level – Disabled (FPL Disabled). Provides full-scope Medi-Cal (No share of cost) to qualified disabled individuals/couples	Yes	Disabled	Yes			Yes
6J	Full	No	SB87 Pending Disability Program. Provides full scope (no share of cost) benefits to recipients21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and are claiming disability. Medi-Cal coverage continues uninterrupted during the determination period.	Yes	Other	Yes			No
6N	Full	No	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)/No Longer Disabled Recipients (FFP). Former SSI disabled recipients (adults and children not in aid code 6P) who are appealing their cessation of SSI disability.	Yes	Disabled	Yes			Yes
6P	Full	No	PRWORA/No Longer Disabled Children (FFP). Covers children under age 18 who lost SSI cash benefits on or after July 1, 1997, due to PRWORA of 1996, which provides a stricter definition of disability for children.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
6R	Full	Yes	SB87 Pending Disability Program. Provides full scope (no share of cost) benefits to recipients 21 to 65 years of age, who have lost their non-disability linkage to Medi-Cal and are claiming disability. Medi-Cal coverage continues uninterrupted during the determination period.	Yes	Disabled	Yes			No
6V	Full	No	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.	Yes	Disabled	Yes			Yes
6W	Full	Yes	Aid to the Disabled – DDS Waiver (FFP). Covers persons who qualify for the Department of Developmental Services (DDS) Regional Waiver.	Yes	Disabled	Yes			Yes
6X	Full	No	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.	Yes	Disabled	Yes			Yes
6Y	Full	Yes	Aid to the Disabled – Model Waiver (FFP). Covers persons who qualify for the Model Waiver.	Yes	Disabled	Yes			Yes
60	Full	No	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.	Yes	Disabled	Yes			Yes
63	Full	Y/N	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	Yes	Disabled	No			Yes
64	Full	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			Yes
66	Full	No	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. No age limit for this aid code.	Yes	Disabled	Yes			Yes

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
67	Full	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.	Yes	Disabled	Yes			Yes
68	Full	No	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See aid codes 18 and 65 for definition of eligibility for IHSS).	Yes	Disabled	Yes		Phased out from 9/05 to 1/06	Yes
69	Restricted to emergency services only	No	Income Disregard Program. Infant (FFP) – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides Emergency services only for infants under 1 year of age and beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the federal poverty level.	Yes	Other	No			No
7A	Full	No	100 Percent Program. Child (FFP) – United States Citizen, Lawful Permanent Resident/PRUCOL/(IRCA Amnesty Alien [ABD or Under 18]). Provides full benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the federal poverty level.	Yes	Other	Yes			Yes
7J	Full	No	Continuous Eligibility for Children (CEC) program. Provides full-scope benefits to children up to the 19 years of age who would otherwise lose their share of cost	Yes	Other	Yes			Yes
7M	Restricted Valid for Minor Consent Services	Y/N	Minor consent Program. Covers minors age 12 and under 21. Limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, and family planning. Funded 100% through county realigned funds	No	N/A	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
7N	Restricted Valid for Minor Consent Services	No	Minor consent Program (FFP). Covers pregnant female minors under age 21. Limited to services related to pregnancy and family planning. Funded 100% through county realigned funds	No	N/A	Yes			No
7P	Restricted Valid for Minor Consent Services	Y/N	Minor consent Program. Covers minors age 12 and under 21. Limited services related to sexually transmitted diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Funded 100% through county realigned funds	No	N/A	Yes			No
72	Full	No	133 Percent Program. Child-United States Citizen, Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	Other	Yes			Yes
74	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented/ Nonimmigrant Alien (but otherwise eligible) (FFP). Provides Emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	Other	No			No
76	Restricted to 60-day postpartum services	No	60-Day Postpartum Program (FFP). Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for, and received Medi-Cal benefits. They may continue to be eligible for all-postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.	Yes	Other	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
8E	Full	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full scope Medi-Cal benefits to children under the age of 19. *T21 effective through 3/31/09; T19 effective 4/1/09.*	Yes	Other	Yes			Yes
8G	Full	No	Qualified Severely Impaired Working Individual Program Aid Code. Allows recipients of the Qualified Severely Impaired Working Individual Program to continue their Medi-Cal eligibility.	Yes	Other	Yes			Yes
8U	Full	No	CHDP Gateway Deemed Infant. Provides full-scope, no Share of Cost (SOC) Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.	Yes	Other	Yes	10/11/10		Yes
8V	Full	Yes	CHDP Gateway Deemed Infant SOC. Provides full-scope Medi-Cal benefits with a Share of Cost (SOC) for infants born to mothers who were enrolled in Medi-Cal with a SOC in the month of the infant's birth and SOC was met.	Yes	Other	Yes	10/11/10		Yes
8W	Full	No	Medically Indigent (MI)-Accelerated Enrollment (AE)-CHDP Gateway for Medi-Cal. Provides for the pre-enrollment of CHILDREN into the Medi-Cal program that are Screened as No Cost Medi-Cal Eligibles. Provides Temporary, full scope Medi-Cal benefits with no SOC. *Please note: T21 through 3/31/09; however T19 effective 4/1/09.*	Yes	Other	Yes			Yes
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind, or disabled individuals.	Yes	Other	Yes			No

Regular FFP Aid Codes - Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
82	Full	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.	Yes	Other	Yes			Yes
83	Full	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.	Yes	Other	Yes			Yes
86	Full	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meets the eligibility requirements of medically indigent.	Yes	Other	Yes			No
87	Full	Yes	MI-Confirmed Pregnancy (FFP). Covers person's aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.	Yes	Other	Yes			No

Title XIX 100% FFP- Please note: The FFP will be at 100 % from 2014 through 2016. All of the individuals in these aid codes should be placed into the appropriate ACA aid code for ongoing eligibility by March 2015.							**Effective Dates**		
Code	**Benefits**	**SOC**	**Program / Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
L1	Full	No	Adults aged 19 through 64 years of age, enrolled in LIHP MCE program on December 31, 2013 with 0 percent – 138 percent Federal Poverty Level	Yes	Other	Yes	1/1/14		No
N0	Limited	No	Adults aged 19 through 64 years of age, inmates in county jail enrolled in LIHP MCE program on December 31, 2013, with 0 percent – 138 percent Federal Poverty Level (FPL), limited to covered inpatient hospital services provided off the grounds of the correctional facility.	Yes	Other	No	1/1/14		No
N9	Limited	No	Adults aged 19 through 64 years of age, inmates in State prison enrolled in LIHP MCE program on December 31, 2013 with 0 percent – 138 percent FPL, limited to covered inpatient hospital services provided off the grounds of the correctional facility, no SOC.	Yes	Other	No	1/1/14		No

Title XIX 100% FFP - Enhanced Title XIX federal funding is available for those who are "newly eligible" in the adults group. Please note the FFP category will decrease to the following: 100 % for 2014-2016; 95% for 2017; 94% for 2018; 93% 2019; 90% for 2020 and thereafter.							Effective Dates		
Code	**Benefits**	**SOC**	**Program / Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
M1	Full	No	Adult 19 to 65 Yrs at or below 138% FPL: Citizen/Lawfully Present	Yes	Other	Yes	1/1/14		No
M2	Restricted	No	Adult 19 to 65 Yrs at or below 138% FPL: Undocumented-Restricted to emergency and pregnancy related services.	Yes	Other	Yes	1/1/14		No
N5	Limited	No	Medi-Cal benefits limited to covered inpatient hospital only, for adult inmates aged 19 through 64 years of age in state correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/14		No
N6	Restricted	No	This aid code will reflect the new ACA adult group aged 19-64. Aid code provides restricted Medi-Cal benefits, without a share of cost, limited to inpatient hospital emergency related services only, to eligible undocumented adult state inmates who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/14		No
N7	Limited	No	Medi-Cal no SOC for County Adult Inmates. Medi-Cal benefits limited to covered inpatient hospital services only, for adult inmates aged 19 through 64 years of age in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/14		No
N8	Restricted	No	This Aid code will reflect the new ACA adult group aged 19-64. Aid code provides restricted Medi-Cal benefits, without a share of cost, limited to inpatient hospital emergency related services only, who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/14		No

Breast and Cervical Cancer Treatment Program (BCCTP) Aid Codes (Enhanced FFP 65%)Title XIX							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
0M	Full	No	BCCTP-Accelerated Enrollment (AE). Provides AE for temporary full-scope, no SOC Medi-Cal for females under 65 years of age who are diagnosed with breast and/or cervical cancer. Eligibility limited to 2 months	Yes	Other	Yes			Yes
0N	Full	No	BCCTP-AE, Provides AE for temporary full-scope, no SOC Medi-Cal for females under 65 years of age who have diagnosed with breast and/or cervical cancer and are without creditable insurance coverage. No time limit	Yes	Other	Yes			Yes
0P	Full	No	BCCTP-Federal, Provides full-scope, no SOC Medi-Cal for females under 65 years of age who have diagnosed with breast and/or cervical cancer and are without creditable insurance coverage	Yes	Other	Yes			Yes
0U	Restricted to pregnancy and/or emergency services	No	BCCTP Provides services for females with unsatisfactory immigration status, who are under 65 years of age, who have been diagnosed with breast and/or cervical cancer and are found in need of treatment. They are eligible for Federal BCCTP for Emergency services for the duration of treatment. Does not cover individuals with creditable health insurance. State-only cancer treatment payments are 18 months (breast) and 24 months (cervical).	Yes	Other	No			No
0V	Restricted to pregnancy and/or emergency services	No	Post 0U eligibility for federal Medi-Cal Emergency services only and who continue to meet Federal BCCTP criteria. State-only pregnancy-related and LTC; for individuals whose 0U eligibility has expired and who are determined to be still in need of breast or cervical cancer treatment.	Yes	Other	No			No

SCHIP

The State Children's Health Insurance Program (SCHIP) was established by the federal government in the late 1990's to provide health insurance to children in families at or below 200 percent of the federal poverty level. SCHIP allowed states to create new programs to serve these children and families and/or expand their existing Medicaid programs. California elected to create the Healthy Families Program, serving children with family incomes below 250% of the federal poverty level and expand Medi-Cal programs to serve lower income children that would not previously qualify for Medi-Cal.

The HFP was established to provide a basic health, vision, and dental benefit package (provided by HFP health plans) that includes a mental health benefit for children assessed with serious emotional disturbances (SED). Mental health services for children meeting the SED criteria are provided by the county mental health departments. The enhanced Federal Medicaid Assistance Percentage (FMAP) of 65% under Title XXI is provided for HFP health and mental health service expenditures

Healthy Families - MRMIB Title XXI (Enhanced FFP 65%) - SCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program / Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
9H	HF services only (no Medi-Cal)	No	The Healthy Families (HF) Program provides a comprehensive health insurance plan for uninsured children from 1 to 19 years of age whose family's income is at or below 200 percent of the federal poverty level. HF covers medical, dental and vision services to enrolled children.	Yes	N/A	No			No
9R	CCS Services only (no Medi-Cal)	No	CCS-eligible Healthy Families Child. A child in this program is enrolled in a Healthy Families plan and is eligible for all CCS benefits (i.e., diagnosis, treatment, therapy and case management)	Yes	N/A	No			No

MCHIP

California expanded Medicaid (Medi-Cal) eligibility for certain populations of children for the provision of health and mental health services. Known in California as MCHIP, services are reimbursed for "optional targeted low-income children" using the enhanced FMAP of 65% under Title XXI. These children are defined in federal law as targeted low-income children who would not otherwise qualify for Medicaid.

Title XXI Aid Codes (Enhanced FFP 65%) –MCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
E1	Restricted to pregnancy and/or emergency services	No	Unverified citizens. Covers eligible unverified citizen children. One Month Medi-Cal to Healthy Families Bridge. Prenatal and Emergency Services Only. Covers services only to eligible children ages 0-19, who are unverified citizens	Yes	MCHIP	Yes	8/1/08		No
E2	Full	No	CHIP 2101(f) Citizen/Lawfully Present (Age 0-19, No premiums)	Yes	MCHIP	Yes	1/1/14		Yes
E4	Restricted	No	CHIP 2101(f) Undocumented (Age 0-19, No premiums) Restricted to emergency and pregnancy related services, and state-funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
E5	Full	No	CHIP 2101(f) Citizen/Lawfully Present (Age 1-19, With premiums)	Yes	MCHIP	Yes	1/1/14		Yes
E7	Full	No	AIM infant above 250% to 300%	Yes	MCHIP	No	1/1/14		Yes
H0	Full	No	Hospital Presumptive Eligibility for Children age 6-19 (FPL above 108 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
H1	Full	No	Targeted Low Income FPL for infants. Provides full scope, no-cost Medi-Cal for infants who are U.S. citizens, have satisfactory immigration status, or unverified citizenship**. Coverage is up to the month of their first birthday or continues beyond one year, when in an inpatient status that began before the first birthday. Family income is above 200 percent up to 250 percent of the FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H2	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages one through the month of the 6th birthday or continues when in an inpatient status which began before the 6th birthday for family income at or below 133 up to 150 percent of federal poverty level.	Yes	MCHIP	Yes	1/1/13		Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program / Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
H3	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, Medi-Cal coverage with a premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages one through the month of their 6th birthday or continues when in an inpatient status which began before the 6th birthday, with family income above 150 percent up to 250 percent of the FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H4	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, no-cost Medi-Cal coverage to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages six through the month of the 19th birthday or continues when in an inpatient status which began before the 19th birthday for family income above 100 up to 150 percent of federal poverty level.	Yes	MCHIP	Yes	1/1/13		Yes
H5	Full	No	Medi-Cal Targeted Low-Income FPL for Children Program. Provides full scope, Medi-Cal coverage with premium payment to children with U.S. citizenship, satisfactory immigration status, or unverified citizenship; ages six through the month of the 19th birthday or continues when in an inpatient status which began before the 19th birthday, with family income above 150 percent up to 250 percent of FPL.	Yes	MCHIP	Yes	1/1/13		Yes
H6	Full	No	Hospital Presumptive Eligibility for infants (FPL above 208 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
H9	Full	No	Hospital Presumptive Eligibility for Children age 1-6 (FPL above 142 percent up to and including 266 percent FPL).	Yes	MCHIP	Yes	1/1/14		Yes
M5	Full	No	Expansion Child from 6 to 19 Yrs 101% through 133% FPL: Citizen/Lawfully Present.	Yes	MCHIP	Yes	1/1/14		Yes
M6	Restricted	No	Expansion Child from 6 to 19 Yrs 101% through133% FPL: Undocumented Restricted to pregnancy related, emergency, and long term care.	Yes	MCHIP	Yes	1/1/14		No

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
P6	Restricted	No	Children 6 to 19 years of age with 0 percent - 108 percent Federal Poverty Level, Undocumented, restricted to emergency services, pregnancy and long term care services.	Yes	MCHIP	Yes	1/1/14		No
T0	Restricted	No	Infant up to 1 Yr. Undoc 201%-250% FPL (TLIC). Restricted to emergency and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
T1	Full	No	Child from 6 to 19 Yrs: Citizen 151%-250% FPL (TLIC Premiums).	Yes	MCHIP	Yes	1/1/14		Yes
T2	Full	No	Child from 6 to 19 Yrs: Citizen 134%-150% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T3	Full	No	Child from 1 to 6 Yrs: Citizen 151%-250% FPL (TLIC Premiums).	Yes	MCHIP	Yes	1/1/14		Yes
T4	Full	No	Child from 1 to 6 Yrs: Citizen 134%-150% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T5	Full	No	Infant up to 1 Yr. Citizen 201%-250% FPL (TLIC).	Yes	MCHIP	Yes	1/1/14		Yes
T6	Restricted	No	Child from 6 to 19 Yrs: Undoc 151%-250% FPL (TLIC Premiums). Restricted to emergency and pregnancy related services, and state funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
T7	Restricted	No	Child from 6 to 19 Yrs: Undoc 134%-150% FPL (TLIC). Restricted to emergency and pregnancy related services, and state funded long term care services.	Yes	MCHIP	Yes	1/1/14		No
T8	Restricted	No	Child from 1 to 6 Yrs: Undoc 151%-250% FPL (TLIC Premiums). Restricted to emergency and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
T9	Restricted	No	Child from 6 to 19 Yrs: Undoc 134%-150% FPL (TLIC).). Restricted to emergency services and state funded long term care services.	Yes	MCHIP	No	1/1/14		No
5C	Full	No	Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children Provides no-cost, full scope, Medi-Cal coverage with no premium payment, to children with family income at or below 150 percent of the federal poverty level during the transition period until the annual eligibility review.	Yes	MCHIP	Yes	1/1/13		Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
5D	Full	No	Medi-Cal Presumptive Eligibility, Title XXI, HFP Transitional Children Provides full scope Medi-Cal coverage with a premium payment, to children with family income above 150 percent and up to 250 percent of the federal poverty level during the transition period.	Yes	MCHIP	Yes	1/1/13		Yes
7X	Full	No	One-Month Healthy Families (HF) Bridge (FFP). Provides one additional calendar month of health care benefits with no Share of Cost, through the same health care delivery system, to Medi-Cal-eligible children meeting the criteria of the HF Bridging Program.	Yes	MCHIP	Yes			Yes
8X	Full	No	Medically Indigent (MI)-Accelerated Enrollment (AE)-CHDP Gateway for Healthy Families. Provides for the pre-enrollment of CHILDREN into the Medi-Cal program that are Screened as Probable Healthy Families Eligibles. Provides Temporary, full scope Medi-Cal benefits with no SOC.	Yes	MCHIP	Yes			Yes
8N	Restricted to emergency services only	No	133 Percent Program (OBRA). Child Undocumented / Nonimmigrant Alien (but otherwise eligible except for excess property) (FFP). Provides emergency services only for children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	MCHIP	No			No
8P	Full	No	133 Percent Program. Child – United States Citizen (with excess property), Permanent Resident Alien/PRUCOL Alien (FFP). Provides full-scope Medi-Cal benefits to children ages 1 up to 6 and beyond 6 years when inpatient status, which began before 6th birthday, continues, and family income is at or below 133 percent of the federal poverty level.	Yes	MCHIP	Yes			Yes

Title XXI Aid Codes (Enhanced FFP 65%) – MCHIP							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
8R	Full	No	100 Percent Program. Child (FFP) – United States Citizen (with excess property), Lawful Permanent Resident / PRUCOL / (IRCA Amnesty Alien [ABD or Under 18]). Provides full-scope benefits to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.	Yes	MCHIP	Yes	1/1/12		Yes
8T	Restricted to pregnancy and/or emergency services	No	100 Percent Program. Child-Undocumented / Nonimmigrant Status / (IRCA Amnesty Alien [with excess property]). Covers emergency and pregnancy-related services only to otherwise eligible children ages 6 to 19 and beyond 19 when in patient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.	Yes	MCHIP	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
1U	Restricted to pregnancy and/or emergency services	No	Restricted Federal poverty level – Aged (Restricted FPL – Aged) Provides emergency and pregnancy-related benefits (no Share of Cost) to qualified aged individuals/couples who do not have satisfactory immigration status	Yes	Other	Yes			No
3T	Restricted to pregnancy and/or emergency services	No	Initial Transitional Medi-Cal (TMC) (FFP). Provides six months of emergency and pregnancy-related initial TMC benefits (no SOC) for aliens who do not have satisfactory immigration status (SIS) and have been discontinued from Section 1931(b) due to increased earnings from employment.	Yes	Other	Yes			No
3V	Restricted to pregnancy and/or emergency services	No	Section 1931(b) (FFP). Provides emergency and pregnancy-related benefits (no SOC) for aliens without SIS who meet the income, resources and deprivation requirements of the AFDC State Plan in effect July 16, 1996.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
48	Restricted to pregnancy services only	No	Income Disregard Program. Pregnant – Undocumented/Nonimmigrant Alien (but otherwise eligible). Provides family planning, pregnancy-related and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level. Routine prenatal care is non-FFP. Labor, delivery and emergency prenatal care are FFP.	Yes	Other	Yes			No
5F	Restricted to pregnancy and/or emergency services	Y/N	OBRA Aliens. Covers non-immigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.	Yes	Other	Yes			No
5J	Restricted to pregnancy and/or emergency services	No	Pending disability Program. Covers recipients whose linkage has to be re-determined under Senate Bill 87 (SB87) requirements. Services restricted due to unsatisfactory immigration status. Recipients have a potential new linkage of disability with no SOC.	Yes	Other	No			No
5R	Restricted to pregnancy and/or emergency services	Yes	Pending disability Program. Covers recipients whose linkage has to be re-determined under Senate Bill 87 (SB87) requirements. Services restricted due to unsatisfactory immigration status. Recipients have a potential new linkage of disability with a SOC.	Yes	Other	No			No
5T	Restricted to pregnancy and/or emergency services	No	Continuing TMC (FFP). Provides an additional six months of continuing emergency and pregnancy-related TMC benefits (no SOC) to qualifying aid code 3T recipients.	Yes	Other	Yes			No
5W	Restricted to pregnancy and/or emergency services	No	Four Month Continuing (FFP). Provides four months of emergency and pregnancy-related benefits (no SOC) for aliens without SIS who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
55	Restricted to pregnancy and/or emergency services	No	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color Of Law (PRUCOL). LTC services: State-only funds; Emergency and pregnancy-related services: State and federal funds. Recipients will remain in this aid code even if they leave LTC.	Yes	Other	Yes			No
58	Restricted to pregnancy and/or emergency services	Y/N	OBRA Aliens. Covers nonimmigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL or amnesty alien status, but who are otherwise eligible for Medi-Cal.	Yes	Other	Yes			No
6U	Restricted to pregnancy and/or emergency services	No	Restricted Federal Poverty Level – Disabled (Restricted FPL-Disabled) Provides emergency and pregnancy-related benefits (no share of cost) to qualified disabled individuals/couples who do not have satisfactory immigration status.	Yes	Disabled	Yes			No
7C	Restricted to pregnancy and/or emergency services	No	100 Percent Program. Child – Undocumented / Nonimmigrant Status / [IRCA Amnesty Alien (Not ABD or Under 18)]. Covers emergency and pregnancy related services to otherwise eligible children, ages 6 to 19 and beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.	Yes	Other	Yes			No
7K	Restricted to pregnancy and/or emergency services	No	Continuous Eligibility for Children (CEC) program. Provides emergency and pregnancy-related benefits (no share of cost) to children up to 19 years of age who would otherwise lose their no share of cost Medi-Cal	Yes	Other	Yes			No
C1	Restricted to pregnancy and/or emergency services	No	Aid to the Aged – Medically Needy (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Other	Yes			No
C2	Restricted to pregnancy and/or emergency services	Yes	Aid to the Aged – Medically Needy, SOC (FFP). Covers persons 65 years of age or older who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
C3	Restricted to pregnancy and/or emergency services	No	Aid to the Blind – Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			No
C4	Restricted to pregnancy and/or emergency services	Yes	Aid to the Blind – Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.	Yes	Disabled	Yes			No
C5	Restricted to pregnancy and/or emergency services	No	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.	Yes	Other	Yes			No
C6	Restricted to pregnancy and/or emergency services	Yes	AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC required of the beneficiaries.	Yes	Other	Yes			No
C7	Restricted to pregnancy and/or emergency services	No	Aid to the Disabled – Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.	Yes	Disabled	Yes			No
C8	Restricted to pregnancy and/or emergency services	Yes	Aid to the Disabled – Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled – MN.) SOC is required of the beneficiaries.	Yes	Disabled	Yes			No
C9	Restricted to pregnancy and/or emergency services	No	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.	Yes	Other	Yes			No
D1	Restricted to pregnancy and/or emergency services	Yes	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
D2	Restricted to pregnancy and/or emergency services	No	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status	Yes	Other	No			No
D3	Restricted to pregnancy and/or emergency services	Yes	Aid to the Aged – LTC (FFP) Covers persons 65 years of age or older who are medically needy and in LTC status	Yes	Other	No			No
D4	Restricted to pregnancy and/or emergency services	No	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	Yes	Disabled	No			No
D5	Restricted to pregnancy and/or emergency services	Yes	Aid to the Blind – LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	Yes	Disabled	No			No
D6	Restricted to pregnancy and/or emergency services	No	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	Yes	Disabled	No			No
D7	Restricted to pregnancy and/or emergency services	Yes	Aid to the Disabled – LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	Yes	Disabled	No			No
D8	Restricted to pregnancy and/or emergency services	No	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meets the eligibility requirements of medically indigent.	Yes	Other	Yes			No
D9	Restricted to pregnancy and/or emergency services	Yes	MI-Confirmed Pregnancy (FFP). Covers person's aged 21 or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent but are not eligible for 185 percent/200 percent or the MN programs.	Yes	Other	Yes			No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
G2	Restricted; Limited	No	Title XIX/Title XXI, Medi-Cal no SOC for undocumented state juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital emergency and inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in state correctional facilities who receive those services off the grounds of the correctional facility	Yes	Other	No	1/1/12		No
G6	Restricted; Limited	No	Title XIX/Title XXI, Medi-Cal no SOC for undocumented county juvenile inmates. Medi-Cal benefits limited to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G8	Restricted; Limited	Yes	Title XIX/Title XXI, Medi-Cal SOC for undocumented county juvenile inmates. Restricted/Limited- Medi-Cal limited to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	Yes	Other	No	1/1/12		No
G9	Restricted	No	Undocumented State Medical Parolees. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. Aid code G9 will be in the secondary segment in MEDS	Yes	Other	No	1/1/14		No
J3	Restricted	No	Compassionately released/Medical Probation County Inmates. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No
J4	Restricted	Yes	Compassionately released/Medical Probation County Inmates. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	Yes	1/1/14		No

Title XIX (EMERGENCY) FFP 50% and XXI (PREGNANCY) Enhanced FFP 65%							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
J6	Restricted	No	Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
J8	Restricted	No	Compassionately released/Medical Probation County Inmates who reside in LTC facilities. Restricted – Medi-Cal benefits limited to covered emergency and pregnancy-related services only. The county is responsible for the non-federal share.	Yes	Other	No	1/1/14		No
M0	Limited Scope -- Pregnancy Services/ Emergency Services	No	Pregnant Women 126% - 200%: FPL - Undocumented CHDP Funding: Baby using Mom's ID only 50/50 Final FPL 60% - 213% FPL	Yes	Other	Yes	1/1/14		No
M4	Restricted	No	Parent/Caretaker Relative at or below 125% FPL: Undocumented-Restricted to emergency, pregnancy related and long term care services.	Yes	Other	Yes	1/1/14		No
M8	Limited Scope: Pregnancy Services/ Emergency Services	No	Pregnant Women 0% through 125% FPL: Undocumented	Yes	Other	Yes	1/1/14		No

STATE ONLY AID CODES – NO FFP AVAILABLE							Effective Dates		
Code	**Benefits**	**SOC**	**Program/Description**	**MHS**	**MEG**	**DMC**	**SD/MC**	**Inactive in MEDS**	**EPSDT**
53	Restricted to LTC and related services	Y/N	Medically Indigent-LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Skilled Nursing or Intermediate Care Facility (SNF or ICF) and meet all other eligibility requirements of medically indigent, with or without SOC.	No	Other	No			No
65	Full	Y/N	1115 Waiver five months of eligibility for Evacuees of Hurricane Katrina. Applications 8/24/05 to 1/31/06. Final date of any waiver eligibility 5/31/06.	No	Other	No			Yes
0R	Restricted	No	BCCTP-State. Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for all-age males and females (regardless of age or immigration status). These individuals must have a high cost-sharing insurance (over $750/year); have a diagnosis of breast (payment limited to 18 months) and/or cervical (payment limited to for 24 months) cancer.	No	Other	No			No
0T	Restricted	No	BCCTP-State. Provides 18 months of breast cancer treatments and 24 months of cervical cancer treatments for all-age males and females who are not eligible under aid codes 0P, 0R, or 0U regardless of citizenship, that are diagnosed with breast and/or cervical cancer. Does not cover individuals with other creditable insurance.	No	Other	No			No
8Y	Restricted CHDP services only	No	Covers CHDP eligible children who are also eligible for Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services.	No	Other	No			No
81	Full	Y/N	Medically Indigent Adult (MIA)– Adults Aid Paid Pending.	No	Other	No			No
R1	Full	Yes	CalWORKs TCVAP Trafficking Victims Funded 100% through county realigned funds.	No	N/A	Yes			Yes

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ADP BULLETIN

Title		Issue Date: January 13, 2012 Expiration Date: None	Issue No.
Change in Billing Procedures for Methadone Maintenance Treatment Services			12 - 03
Deputy Director Approval Dave Neilsen Deputy Director Program Services Division	Function: [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]	Supersedes Bulletin/ADP Letter No. Supplements but does not supersede #11-01for methadone maintenance treatment services only	

PURPOSE

Effective immediately, Drug Medi-Cal (DMC) methadone maintenance treatment services (MMTS) claims can be submitted to the Short Doyle/Medi-Cal (SDMC) system without proof of billing Other Health Coverage (OHC) insurers. This bulletin provides instructions and deadlines to counties and direct contract service providers for submission and resubmission of claims for MMTS provided from November 1, 2009 forward. Of major importance is the **February 29, 2012**, due date on Page 3 for submitting/resubmitting claims for service dates from November 1, 2009 to June 30, 2010, to ensure the prompt payment of claims.

BACKGROUND

Federal Medicaid and California Medi-Cal laws and regulations require billing a recipient's OHC before billing Medi-Cal. As communicated in the Department of Alcohol and Drug Programs (ADP) Bulletin #11-01, for recipients identified by the Medi-Cal Eligibility Data System (MEDS) as having OHC, the SDMC billing system will deny DMC claim payment if the service provider does not include an Explanation of Benefits (EOB) or if the EOB states that the claim was denied because the services were not provided by an OHC plan provider, and/or because the services were not authorized according to the OHC's requirements.

Bulletin #11-01 required that Medi-Cal service providers bill a recipient's OHC prior to billing Medi-Cal in order to receive payment from the OHC, or a notice of denial from the OHC indicating that:

- The recipient's OHC has been exhausted; or
- The specific service is not a benefit of the OHC.

In many cases, the OHC did not send the appropriate notice, but instead responded by denying the claim because the services were not authorized according to the OHC's requirements. This process not only effectively precluded the Medi-Cal provider from billing DMC, it left the provider with virtually no means of obtaining reimbursement for services provided.

DISCUSSION

Title 42 Code of Federal Regulations Part 433.138 requires that a service provider bill parties who are legally responsible to pay, and California Code of Regulations, Title 22, Section 51005, subdivision (a) requires Medi-Cal recipients to fully utilize benefits available through other programs before utilizing Medi-Cal covered benefits. Therefore, the responsibility to utilize OHC prior to billing Medi-Cal rests with providers and recipients. However, for MMTS, proof of OHC billing will no longer be required as part of the claim adjudication process. When the service provider determines that MMTS are not available through the recipient's OHC, then the service provider may bill DMC. The determination of whether a recipient's OHC covers MMTS can be as simple as asking the recipient if the recipient's OHC covers MMTS.

Subsequent to the release of Bulletin #11-01, the California State Medicaid Plan was amended (Amendment TN No. 10-016, approved March 21, 2011) to require that services such as MMTS be rendered by a consistent provider who has an established relationship with the recipient. MMTS providers have such a relationship with recipients.

CONCLUSION

Technical instructions for these specific claims will be identified in ADP's Companion Guide Appendix (for Version 4010 transactions) and ADP's Companion Guide (for Version 5010 transactions), which will be available upon release of this bulletin, on the SDMC system information webpage at https://mhhitws.cahwnet.gov/systems/sdmc/docs/public/short_doyle_-_medi-cal_phase_ii.asp. As noted in the discussion, providers and recipients remain responsible for utilizing available OHC prior to billing Medi-Cal. However, for MMTS procedure codes, proof of OHC billing will no longer be required as part of the claim adjudication process.

The MMTS (also known as Narcotic Treatment Program (NTP)) procedure codes and modifiers are:

Service Modality Description	Non-Perinatal Program	Perinatal Program
NTP Methadone Dosing	H0020 HG	H0020 HD HG
NTP Individual Counseling	H0004 HG	H0004 HD HG
NTP Group Counseling	H0005 HG	H0005 HD HG

DMC Claim Processing Instructions for MMTS

This bulletin supersedes ADP Bulletin #11-01 only with respect to MMTS.

Counties and direct contract providers may submit replacement claims for any claims for MMTS provided from November 1, 2009, through December 31, 2011, that were denied with reason code "22"; indicating that MEDS reflected OHC available to the client but that the claim did not reflect a billing to the OHC.

Counties and direct contract providers may also submit original claims for any MMTS/DMC services provided from November 1, 2009, through December 31, 2011, that have not previously been billed to DMC, including services that were billed to the OHC and denied for reasons listed as unacceptable in ADP Bulletin #11-01 and services not billed due to provider concerns regarding existing OHC. Counties and direct contract providers are authorized to use delay reason code "10" when submitting such claims later than 30 days after the end of the month of service.

The claims that meet the above-mentioned criteria may be submitted without regard to any time limit that would otherwise apply to them, if they are provided within the following time periods:

- For service dates from November 1, 2009, through June 30, 2010, the original or replacement claims must be submitted or resubmitted to the SDMC system by **February 29, 2012**. If a claim for the same time period is submitted/resubmitted after February 29, 2012, then reimbursement will be from another source through a process that could take up to two years.

- For service dates from July 1, 2010, through December 31, 2011, original or replacement claims must be submitted or resubmitted to the SDMC by June 30, 2012.

Original and replacement claims for MMTS provided on of after January 1, 2012, must be submitted within the timelines generally applicable to DMC claims.

Records Retention

Counties and service providers shall retain all records relevant to the decision and application of the instructions announced in this bulletin, and consistent with the records retention requirements identified in the State Administrative Manual and in the trading partners' Negotiated Net Amount-Drug Medi-Cal contract with the State.

REFERENCES

Social Security Act, Title 19, Sections 1901 and 1902, Subdivision (a)(25)
Title 42 Code of Federal Regulations, Parts 433.138, and 433.139.
Welfare and Institutions Code Sections 14005, 14023.7, 14024, and 14124.90
California Code of Regulations, Title 22, Sections 51005, 50761, and 50763
California State Medicaid Plan (Amendment TN No. 10-016, approved March 21, 2011).

QUESTIONS/MAINTENANCE

Questions concerning the policy change announced in this bulletin may be directed to:

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Program and Fiscal Policy Branch
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Counties having questions concerning the operational and claim processing details in this bulletin may direct them to your assigned Fiscal Management and Accountability Branch (FMAB) analyst. Analyst assignments are posted on ADP's website at: http://www.adp.ca.gov/NNA/files/1011_FMAB_County_Assignment_Listing.xls.

Direct contract provider questions may be submitted to the assigned FMAB direct provider analyst. Analyst assignments are posted on ADP's website at: http://www.adp.ca.gov/NNA/files/1011_DP_Assignments-072011.xls.

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ADP BULLETIN

Title		Issue Date: January 13, 2011 Expiration Date: N/A	Issue No. 11 - 01
Update - Processing Drug Medi-Cal Claims for Clients with Other Heath Coverage			
Deputy Director Approval dave neilsen Deputy Director Program Services Division	Function: [ ]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]Other	Supersedes Bulletin/ADP Letter No. 10-09 and July 28, 2010 letter regarding Drug Medi-Cal and Other Health Coverage	

PURPOSE

This bulletin consolidates the content of two previous communications that have been sent regarding the Drug Medi-Cal (DMC) claim process for clients who have Other Health Coverage (OHC). It combines and revises the information first provided in the Department of Alcohol and Drug Programs (ADP) Bulletin 10-09, and a related letter dated July 28, 2010, to County Administrators and DMC Providers.

This bulletin also provides additional information regarding an appropriate denial/response letter from the OHC, and DMC claim submission for Minor Consent services provided to Medi-Cal Full Scope eligible clients.

DISCUSSION

Federal Medicaid rules and the California Code of Regulations (CCR), Title 22, Section 51005(a) require billing a client's OHC before billing Medi-Cal. For clients whom the Medi-Cal Eligibility Determination System (MEDS) indicates have OHC, the Short-Doyle Medi-Cal (SDMC) billing system denies the DMC claim payment if the service provider does not bill the OHC carrier first and does not indicate the results of that billing in the submitted DMC claim. The results of billing the OHC may be received in electronic or written form. The sections below address several considerations that apply to billing for services provided to clients that are identified by MEDS as having OHC available.

Criteria for Billing DMC Without Billing OHC

1. A county or service provider may submit the DMC claim without having to bill the OHC first in the following two instances:

   a. Client's OHC is Vision, Dental, Hospital Inpatient or Prescription Only: The county or provider may submit the DMC claim without having to bill the OHC first

if a client's OHC is vision, dental, hospital inpatient or prescription only - which does not cover substance use disorder services on an outpatient basis.

b. Minor Consent Program Services: The county or provider may submit the DMC claim without having to bill the OHC first for minor consent services. The Minor Consent program permits youth under 21 years of age who are living with their parent(s) or guardian(s) access to confidential, limited alcohol and other drug treatment services without regard to the parental income and resources. This is in accordance with Family Code Section 6929; Welfare and Institutions Code Section 14010; and Title 22 of the CCR Section 51473.2. The Minor Consent program is funded by the State General Fund.

The SDMC system was modified to allow the above two exceptions as of July 2, 2010.

Delayed or No OHC Response

ADP implemented the following changes to the existing procedures to permit a more efficient process for submitting claims and issuing reimbursement:

1. Providers may presume that a claim for reimbursement submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the service to the other carrier as required, and
    b. At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and
    c. The provider has received none of the following:
        i. Payment for the claim,
        ii. A report (whether in hardcopy, electronic, or other form) of the results of the OHC carrier's adjudication of the claims,
        iii. Any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier.

2. When billing for DMC reimbursement based on a presumed denial as described in #1, above, providers shall report the presumed denial as follows for up to 12 months:
    a. Enter adjustment group code "OA" ("Other Adjustments"),
    b. Enter adjustment reason code "192".

3. Providers may consider a claim for reimbursement for particular services denied by the OHC carrier without submitting a billing claim to the OHC carrier, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
    a. The provider has billed the OHC carrier in the past 12 months, and
    b. In response to the previous attempt to bill the carrier, the provider has received a dated notification in written or electronic form that clearly indicates that the claim

for reimbursement is denied for an appropriate denial reason (see below, under "Appropriate OHC Denial or Adjustment Reasons") and that, for some specified span of time after the notification, claims for services provided under similar circumstances will not be accepted by that carrier, and

c. The services are within the scope of services for which the OHC carrier has indicated that they will not accept claims from the provider in the notification described in #3(b), and
d. The services were provided within the span of time identified in the notification described in #3(b) during which the OHC carrier would not accept the claims.

4. When billing for DMC reimbursement based on denial from a notification as described in #3, above, providers shall prepare their claims by mapping the justification for denial identified in the notification on which they are relying to the most appropriate combination of the following using the standard code sets in force at the time the claim is created or as submitted by the OHC carrier:
   a. Adjustment group code,
   b. Adjustment reason code, and,
   c. If necessary for the adjustment reason code given, health remarks code.

Appropriate OHC Denial or Adjustment Reasons

The Department of Health Care Services (DHCS) is the lead agency for administering California's Medicaid (Medi-Cal) Program. As the lead agency, DHCS provides Medi-Cal claim processing and payment guidance to other state departments. DHCS requires that Medi-Cal providers bill a client's OHC prior to billing Medi-Cal to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

- The recipient's OHC coverage has been exhausted, or
- The specific service is not a benefit of the OHC.

There is another possible outcome of claims submitted to OHC providers. The OHC may cover the service, but only if the client obtains that service from the OHC's facility or through an OHC-approved provider. In such a case, a DMC provider submitting a claim to the OHC may receive a response indicating that the billing is denied because the services were not rendered by an in-network provider and/or because the services were not authorized according to the OHC's coverage requirements. Such a notice of denial may contain statements similar to the following:

- "HMO eligible, but services were not rendered by an HMO facility/provider; therefore, patient is not eligible for HMO benefits", or
- "The claim is denied. The procedure or services performed were not ordered or authorized by a Kaiser Permanente physician."

These are not acceptable denial reasons for submitting claims for DMC reimbursement as required by DHCS because they do not indicate that the OHC coverage has been exhausted, or that the service provided is not a benefit of the OHC. If a client has OHC,

and that OHC covers substance use disorder services, the client must exhaust the benefits available to them from the OHC before submitting the DMC claim for reimbursement.

Counties and providers that submitted DMC claims on or after January 1, 2010, and that were approved for such claims based on an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, must void those claims. If specific services within the approved claim (but not the entire claim) involved an OHC denial reason other than that the OHC coverage has been exhausted, or that the specific service is not a benefit of the OHC, then the claim should be resubmitted without those specific services. Failure to do so could result in an audit finding.

Clients with Multiple OHC Carriers

ADP has received inquires regarding whether DMC providers must bill all OHC carriers when a client has more than one OHC carrier identified in MEDS. As previously stated, DMC providers may bill DMC if they have a denial letter from the OHC stating that the recipient's OHC coverage has been exhausted. This means that each of the client's OHC carriers have been billed and the OHC coverage has been exhausted.

Claim to OHC Receiving Partial Payment

If a county or provider has submitted a claim to an OHC and received partial payment of the claim, they may submit the claim to ADP and are eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

Provider Responsibility to Identify and Bill OHC

It is the responsibility of DMC providers to assess whether the client's OHC includes substance use disorder services before providing a DMC reimbursable service to the client. This can be done by referring the client to the OHC or contacting the OHC on behalf of the client. If a DMC provider chooses to provide the service without assessing OHC first, then it does so at the risk of not being able to obtain DMC reimbursement.

DMC Claim Submission for Confidential Minor Consent Services Provided to Clients Without Minor-Consent-Only Aid Codes and Who Have Other Health Coverage

Minor Consent Medi-Cal aid codes are only assigned to clients that do not already have full scope, no-share-of-cost Medi-Cal eligibility. When a Minor Consent service is provided to a client without a Minor-Consent-Only aid code who has OHC and the OHC carrier is not billed first, the SDMC system will deny the DMC claim because the system treats only those claims submitted for clients with Minor Consent-Only aid codes as claims for confidential Minor Consent services (for which OHC need not be billed.)

ADP is investigating mechanisms to allow providers to specifically identify that DMC claims are for minor consent services. In the interim, for Minor Consent services provided to a client without a Minor-Consent-Only aid code, the DMC provider should submit the DMC claim without billing the OHC carrier first. These claims should be submitted to ADP as if denied by the OHC carrier, with the reason for denial reported as follows:

1. Enter adjustment group code “OA” (“Other Adjustments”),
2. Enter adjustment reason code “192”.

Counties and providers that submitted DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes, which were denied because the OHC carrier was not billed, may submit replacement claims for those claims, following the procedure described above for reporting them as if denied by the OHC carrier.

Counties and providers that chose not to submit DMC claims for services provided as confidential Minor Consent services to clients without Minor-Consent-Only aid codes with OHC because they would have been denied, may now submit these claims following the procedure described above for reporting them as if denied by the OHC carrier. If the claim is submitted more than 30 days after the service date, the claim should use delay reason code “7”.

Records Retention

Trading partners shall retain all records relevant to the application of the rules communicated in this bulletin consistent with the records retention requirements identified in the State Administrative Manual and the trading partner’s DMC or Net Negotiated Amount/DMC contract with the State. This includes retaining documentation in the client files to support when confidential Minor Consent services are provided to clients without Minor-Consent-Only Aid Codes and who have other health coverage.

REFERENCES

California Code of Regulations, Title 22, Section 51005

QUESTIONS / MAINTENANCE

Questions concerning this bulletin may be directed to:

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ADP BULLETIN

Title		Issue Date: Aug 12, 2010	Issue No.
DRUG MEDI-CAL CLAIMS PROCESSING REQUIREMENTS FOR BENEFICIARIES WITH OTHER HEALTH COVERAGE		Expiration Date: N/A	10 - 09
Deputy Director Approval *dave neilsen* *Deputy Director* *Program Services Division*	Function: [X]Information Management [ ]Quality Assurance [ ]Service Delivery [X]Fiscal [ ]Administration [ ]	Supersedes Bulletin/ADP Letter No. N/A	

PURPOSE

This Bulletin provides additional instructions for counties and direct contract providers (referred to in this Bulletin as "trading partners") to submit Drug Medi-Cal (DMC) claims for beneficiaries who have other health coverage (OHC).

DISCUSSION

Under existing billing procedures, claims for certain beneficiaries with other health coverage (outside of Medi-Cal) require providers to first submit a claim for reimbursement to the other health coverage carrier, to receive adjudication results from that carrier, and to include information detailing the adjudication results when claiming DMC reimbursement for the services provided.

After considering input from trading partners, the Department of Alcohol and Drug Programs (ADP) is implementing the following changes to the existing procedures for these claims in order to permit a more efficient process for submitting claims and issuing reimbursement:

1. Providers may presume that a claim for reimbursement submitted to an OHC carrier has been denied, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
   a. The provider has billed the service to the other carrier as required, and
   b. At least 90 calendar days have elapsed since the submission of the claim to the OHC carrier, and
   c. The provider has received none of the following:
      i. Payment for the claim,
      ii. A report (whether in hardcopy, electronic, or other form) of the results of the OHC carrier's adjudication of the claims,

iii. Any communication, in any form, indicating that the claim submission was in an unacceptable form or otherwise in need of correction prior to adjudication by the OHC carrier.

2. When billing for DMC reimbursement based on a presumed denial as described in #1, above, providers shall report the presumed denial as follows for up to 12 months:
   a. Enter adjustment group code "OA" ("Other Adjustments"),
   b. Enter adjustment reason code "192".

3. Providers may consider a claim for reimbursement for particular services denied by the OHC carrier without submitting a billing claim to the OHC carrier, and may submit a claim for DMC reimbursement on that basis, when all of the following are true:
   a. The provider has made an effort to bill the OHC carrier in the past 12 months,
   b. In response to the previous attempt to bill the carrier, the provider has received a dated notification in written or electronic form that clearly indicates that the OHC carrier does not at the time of notification, and will not for services provided in some specified span of time after the notification, accept claims for reimbursement from the provider, either in general or more specifically for particular types or circumstances of service,
   c. The services are within the scope of services for which the OHC carrier has indicated that they will not accept claims from the provider in the notification described in #3(b),
   d. The services were provided within the span of time identified in the notification described in #3(b) during which the OHC carrier would not accept the claims.

4. When billing for DMC reimbursement based on denial from a notification as described in #3, above, providers shall prepare their claims by mapping the justification for denial identified in the notification on which they are relying to the most appropriate combination of the following using the standard code sets in force at the time the claim is created or as submitted by the OHC carrier: Adjustment group code,
   a. Adjustment reason code, and,
   b. If necessary for the adjustment reason code given, health remarks code.

5. Trading partners shall retain all records relevant to the application of the rules communicated in this letter consistent with the records retention requirements identified in the State Administrative Manual and the trading partner's DMC or Net Negotiated Amount/DMC contract with the State.

REFERENCES

DMC Billing Manual

QUESTIONS/MAINTENANCE

For questions about processes and procedures involved in the submission of DMC claims, please contact your assigned Fiscal Management and Accountability Branch analyst. County and Direct Provider analyst assignment listings are available on ADP's DMC billing web page at http://www.adp.ca.gov/dmc_billing.shtml.

DISTRIBUTION

County Alcohol and Drug Program Administrators
Strategic Local Government Services, LLC
Director's Advisory Council
Drug Medi-Cal Direct Contract Providers
Drug Medi-Cal Certified Providers

Drug Medi-Cal Frequently Asked Questions

Questions and Answers Regarding Billing Drug Medi-Cal for Patients Who Have Other Health Coverage

1. Q: Is it true that only a dependence diagnosis qualified a client for DMC services. The definition of "Substance Abuse Diagnosis" on page 3 item 21, states "Substance abuse diagnoses" are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth edition, published by the American Psychiatric Association."

A:Title 22, Section 51341.1 is titled "Drug Medi-Cal Substance Abuse Services". A DSM diagnosis of "substance abuse" qualifies for all aspects of the program.

Title 9 Section 10270 (b)(1) requires documentary evidence of “physical dependence,” an addiction to opiates, except as specified in (d)(5)(A) and (d)(5)(B) of that section.

2. Q: For reimbursement purposes is the admission date the CADDS date or the date of the 1st Service?

A: Title 22 specifies that the admission is the “date of the first face-to-face treatment service”. Title 22 Section 51341.1(b)(1)

The CADDS admission date is determined by the completion of specific activities. It is an administrative date particular to data gathering for ADP. It is not used to determine reimbursement by DMC.

3. Q: Can we admit to treatment under DMC a teenager who has been expelled from school for have a “pipe” but denies that he is a drug user? His mother states that he has used marijuana. The teenager has is Medi-Cal qualified. Will our monitors recoup monies if they provide services to this teenager?

A: As long as the client id DMC qualified, medical necessity established, physical or waiver was in place, treatment plan established, and all other criteria met services can be provided and billed. Title 22 (h)(1)(A)(I) states that the provider will “Develop and use criteria and procedures for the admission of beneficiaries to service,” The criteria for admission to the providers program would depend upon their modality, treatment methodology, etc.

4. Q: If the Treatment Plan is not done within the 1st 30 days, are the 1st 30 days of services unbillable or are they allowed?

A: The sessions for the first 30 days are billable and will not be recouped on a review as long as all the other Title 22 criteria are met.

5. Q: Can we bill for the following services for ODF, NTP, & DCH if they are performed by the case manager?

Client Assessment
Treatment Plan Development / Review
Collateral Services
Crisis Sessions

A: Case management is not reimbursable under Drug Medi-Cal. Title 22 Section 51341.1 defines those services which are billable to Drug Medi-Cal. Case management is not one of those services. Case management is an internal quality control mechanism whose goal is to give a degree of assurance that the care provided the client is appropriate to the diagnosis.

Drug Medi-Cal reimburses for those services provided directly to the client by the program, not the management of those services.

6. Q: Can we bill the client for the paperwork charting for a group or is the service billable only for the time of the group?

A: By the client I assume you mean drug Medi-cal. No you cannot bill for charting only for the counseling session, group or individual.

7. Q: The definition of a collateral service on page 1 Exhibit 1, of Title 22, section 51341.1, states, “Collateral services means face to face sessions with the therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have personal, not official or professional, relationship with the beneficiary.”

It does not state the client has to be present.

A: A collateral service is the only ODF service for which a face to face with the client is not required.

8. Q: What is the length of time that the M.D. has to sign the six months Continuation of Treatment Authorization.

A: The continuation of treatment plan must be signed no sooner than 5 months and no later than 6 months from the beneficiary's admission to treatment date or the date of the most recent (last) justification for continuing services. Title 22 Section 51341.1 (h)(5)(A)(i).

9. Q: Do substance abuse programs have to do anything other than notify Medi Cal beneficiaries of their right to a fair hearing, as specified in Title 22 51341.1 Drug Medi Cal substance abuse services section p)? (We don't have Section 50953 where this is detailed).

A: Yes must notify the beneficiary of their fair hearing rights, in writing as specified in Title 22 Section 51341.1(p). Section 50953 states the procedures that will be followed during the actual fair hearing.

10. Q: Could you please forward or refer me to the document where I could view the language of this section. I cannot find it in any Title 22 documents that I have. It was referenced in a post service post payment utilization review report stating that, "D/MC patients cannot be charged fees over and above $1.00 or a co payment charge, if any, on the beneficiary's Medi Cal card".

A: Title 22 section 51341.1(h) (7) states, “Except where share of cost, as defined in Section 50090, is applicable, providers shall accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services rendered. Providers shall not charge fees to beneficiaries for access to Drug Medi-Cal substance abuse services or for admission to a Drug Medi-Cal Treatment slot.”

Section 50090 states, "Share of cost means a person’s or families net income in excess of their maintenance need that must be paid or obligated toward the cost of health services before the person or family may be certified and received Medi-Cal cards."

11. Q: Can you tell me if there is a limit on the number of individual counseling sessions we can bill Drug Medi Cal for? Someone was stating in a meeting yesterday that we can only bill for 3 within an entire episode of care.

Second question is that I understand that for group counseling the group size must be between 4 and 10 and one must by Medi Cal. Is this correct?

A: Technically there is no limit to the number of individual counseling sessions that can be provided in an ODF modality. However, individual sessions are limited to the 5 exceptions that are listed in Title 22 section 51341.1 (d)(2)(B). Remember that the primarily means of treatment in an ODF program is Group Counseling.

Group counseling groups are limited to more than 4 and no more than 10 individuals. Title 22 section 51341.1 (b)(8)

12. Q: How many group counseling sessions can a client receive in a month?

A: Title 22 51341.1 (d)(2)(a) states “…..each beneficiary shall receive at lest two group counseling sessions per month.” There is no upper limit to the amount of sessions attended, however you can only bill for one group session per client per day.

13. Q: Is there a time requirement for a unit of service attached to Individual Counseling sessions?

A: We are under the impression that they should be :50 minutes in length and if session is under this, adjust accordingly.

Please clarify, as we are experiencing some conflict.

For ODF the maximum payable amount for an individual session would be 50 minutes, for a group session it would be 90 minutes. If sessions exceed these time limits the amount in excess would not be reimbursable. If the sessions are actually less than this time you will be reimbursed for the full amount. However, an adjustment for the actual time will accomplished when the cost-report is processed.

14. Q: We recently got Drug Medi Cal certified, and to our dismay we found that it is actually less funding than we were receiving from the County. We understand that DMC can not be billed for room and board, only TX costs. Are we able to bill the beneficiaries for their room and board outside of TX costs? We are in desperate need of funding, as we are operating on a deficit.

A: Yes you can bill the beneficiaries for room and board. Medi-Cal reimburses for treatment services only.

15. Q: I understand that each adult patient or client entering our program for substance and alcohol abuse services must have a physical examination or show documented proof of a physical examination. Does this apply to adolescents? Is it required that adolescents have a physical examination? Second, what action or what should the response be should a patient or client decline or states they do not want a physical examination?

A: Title 22 Section 51341.1 (h)(1)(A)(iii), requires the provider to complete an assessment of the physical condition of each client within 30 days of admission. This requires either a physical examination of the client or a physician's waiver which specifies the basis for not requiring a physical examination. This applies to all Drug Medi-Cal clients including juveniles.

The client must comply with this provision if Drug Medi-Cal benefits are to be paid. Physicals can only be waived by an MD based on the criteria set in Title 22 Section 51341.1 (h)(1)(A)(iii)(b).

16. Q: I received a call this morning from one of our perinatal providers. They have a mom who sadly just had a still born birth. The mom needs to continue AOD treatment. Is she still considered to be post partum for 60 days? I've looked up the definition of "Postpartum" in Title 22 Sections 50260 and 50262.3a. It only mentions "pregnant women" or women with children and doesn't seem to address the postpartum period.

A: The term "pregnant woman" in Title 22 para.50260 is used to set the criteria for admission to a Peri-natal program. It then goes on to state "shall be eligible for all pregnancy related and postpartum services for a 60 day period, beginning on the last day of pregnancy…..etc. Eligibility for this program ends on the last day of the month in which the 60th day occurs.

17. Q: The case of the second service on the same day.

A: 2nd service means that the client left the facility and returned for a group or individual session (face to face).
The progress note must contain a statement that the return did not create a hardship on the client and that every effort was made to provide all necessary services during one visit.
If the hardship statement is in the progress note then the return can be for an individual intake, treatment planning or discharge session. The return can also be for a group counseling session.
The second service rendered during the same day can never be duplicative.
Title 22 requires that the ADP Form 7700 be in the clients file. If the form is not in the file the service is recoupable. Without the form the provider cannot be paid, so it must exist somewhere.

18. Q: A client attends a group session, however the primary counselor is sick and the group is run by a stand-in. The primary counselor completes the progress note and states that he was not present and writes the stand-in's observation. Otherwise all the required elements of a progress note are present.

A: Title 22 (h)(2)(3)(A) requires "the counselor to record a progress note," it is not specific as to which counselor that should be. However common sense would dictate that it would be a counselor that has knowledge of the session being noted. Given that the stand-in informed the primary of the all the elements necessary for the completion of the note it would not seem to be material that the comment was actually written by the primary or stand-in either would satisfy the standard. Treatment was provided, a progress note was accomplished, and all the requirements of the Title 22 were met.

19. Q: How can a provider receive training. This request usually comes after we have reviewed the program and identified significant deficiencies.

A: By requesting it though e-mail: DMCanswers@adp.state.ca.us

20. Q: Do we have sample forms to assist them in documenting as required by the regulations. Almost every program is interested in this.

A: Yes. See FORMS section.

21. Q: Are there other funding sources to assist or enhance DMC funding for services to be provided to clients with co-occurring disorders.

A: Yes. Talk to your County representative

22. Q: There are always questions, comments, complaints, etc. about the lack of clarity in the regulations, consistency in application of the regulations, county contract oversight and DMC regulations guidance by the counties, and specific questions about admission, treatment planning, and other regulation requirements that are not clear.

A: Ask questions at DMC@adp.ca.gov OR request training.

DMC Provider Resource Tool-Kit Monitoring

Drug Medi-Cal Monitoring

The Interagency Agreement (IA) between the Department of Health Care Services (DHCS) and the Department of Alcohol and Drug Programs (ADP) requires that all Drug Medi-Cal (DMC) programs be subject to utilization review and control. Authority governing utilization controls is provided in the Federal Medicaid Law [(42 USC 1396(a)(30-33)] and Federal Medicaid Regulations, Title 42, Code of Federal Regulations, Sections 456.2 through 456.6. Utilization review provides safeguards against DMC paying for unnecessary services provided by substance abuse programs. ADP developed regulations in C.C. R., Title 22 detailing the minimum requirements that must be met in order for DMC services to be reimbursed to providers. The Title 22 regulations define the roles and Responsibilities of the State, County, and Treatment Provider. Title 22 regulations require that ADP conduct post service, post payment (PSPP) utilization reviews onsite to determine compliance with standards of care and other requirements of the regulations. The PSPP review process is intended to provide statewide quality assurance and accountability for DMC services.

State Role

ADP is responsible for administrative and fiscal oversight, monitoring, and auditing to safeguard California's investment in DMC alcohol and drug treatment services. This is accomplished through the promulgation of the Title 22 DMC regulations and on-site visits to DMC providers by ADP staff. The purpose of these visits is to ensure that DMC compliance measures are in place for each provider participating in DMC programs, to provide technical assistance and training to provider staff, and to initiate the recovery of payments when DMC requirements have not been met. A written report is issued at the conclusion of each on-site visit, detailing the deficiencies found. Title 22 also requires recovery of payment(s) for units of service provided that are out of compliance with the regulations. The county and/or provider are also required to develop and implement a written corrective action plan for every deficiency identified in the report.

County Role

The county is responsible for contracting with the providers, if applicable (programs may be county entities);implementing and maintaining a system of fiscal disbursements and controls; monitoring the billings to ensure that reimbursement is within the rates established for services; and processing claims for reimbursement.

Provider Role

All DMC providers must be certified to participate in the DMC treatment service system and must comply with all DMC requirements. This includes, at a minimum:

- Identifying the DSM diagnostic code;
- Establishing the medical necessity for treatment;
- Following DMC admission criteria and procedures;
- Developing and updating treatment plans;
- Preparing progress notes;
- Providing group, and when it meets certain criteria, individual counseling;
- Justifying the need to continue services; and
- Completing a discharge summary.

Outcome

ADP monitoring and auditing of DMC services results in quality control in publicly funded treatment, assists counties and providers in identifying and resolving compliance issues, and provides training and technical assistance to counties and providers. Where appropriate, the on-site utilization review provides an opportunity for the provider to receive technical assistance in how to reach compliance with the regulations through an exit conference with on-site staff.

DMC Provider Resource Tool-Kit Common Problem

MOST COMMON AREAS OF DEFICIENCY

Below are the most common areas of deficiency that have been found during post service post payment utilization reviews by DMC Monitoring Section staff. This is by no means exhaustive, as there are many ways in which treatment documentation can be found to be deficient. However, the majority of deficiencies fall into the following categories:

1. Admission physical or waiver.

A physical exam conducted by and MD, RN , Nurse Practitioner or Physician's Assistant must be completed within 30 days of the client's admission to the program. The program medical director can waive this requirement after a review of the client's medical history, substance abuse history, and/or the most recent physical examination documentation.

Some of the more common reasons recoupments are made for this part of the admission process are:

- No record of the physical exam in the client file.
- The physical waiver is not clearly worded to identify it as a "physical waiver."
- The physician fails to sign and or date the waiver. The physician does not state the reason the physical exam is being waived. REFERENCE TITLE 22 SECTION 51341.1(h)(iii)

2. Treatment Plans.

For each client a Treatment Plan must be completed within 30 days of the date admission date. The treatment plan must include, a statement of the substance abuse problem to be addressed, the goals to be achieved for each problem, the actions steps to be taken, and the target dates that these goals are to be achieved. The plan needs to describe the services that will be provided (type and frequency of counseling), and the assignment of a primary counselor.

The treatment plan is considered complete and effective on the date of the counselor's signature. Within 15 days of the counselor's signature the program's Medical Director must sign the treatment plan.

The treatment plan must be reviewed and updated within 90 days of the counselor's signature of the previous plan. Again the Medical Director must review, approve and sign the treatment plan within 15 days of the counselor's signature.

The treatment plan must be updated earlier than the 90 days if a change of problem or focus of treatment occurs.

Some of the reasons why recoupments are taken for the treatment plan process.

- Late signatures by the counselor and/or medical director.
- Signatures not dated.
- Frequency/ type of counseling not identified.
- Target Dates not identified.
- Treatment plans are late.
- Primary problem statements/action steps/goals not related to substance abuse. REFERENCE: TITLE 22 SECTION 51341.1 (h)

3. Individual Counseling Sessions.

Group counseling is the treatment methodology for the Outpatient Drug Free modality, individual counseling is only on an exception basis. Individual or group counseling can be used in both Day Care Habilitative and Residential Perinatal modalities since payment is on a daily rate basis.

Individual counseling for ODF can be reimbursed for only for the following reasons.

- Intake Counseling: The process of admitting a client into a substance abuse program. This must be a one-on-one session with a counselor.
  REFERENCE: TITLE 22 SECTION 51341.1 (b)(10)
- Treatment Planning: The development of an initial or follow up treatment plan with a client in a one on one session with the counselor.
- Collateral Counseling: Face to face interviews with significant persons in a client's life. Significant persons are people with a personal rather than a profession relationship with the client. Parole/probation agents, Child Protection Service or Social workers are an example of a professional relationship. These interviews must be conducted at the Drug Medi Cal certified facility.
  REFERENCE: TITLE 22 SECTION 51341.1 (b)(3)
- Crisis Counseling: Face to face with a client in crisis. Crisis means an actual relapse or circumstance which present an imminent threat of relapse. Counseling should be limited to the stabilization of the client's emergency situation.
  REFERENCE: TITLE 22 SECTION 51341.1 (b)(5)
- Discharge Planning: Face to face with a client to discuss post discharge issues.

Common reasons individual counseling sessions are disallowed.

- Session does not meet one of the above criteria.
- Progress note does not identify which of the 5 reason is being used to justify the session.
- Progress note fails to justify crisis intervention.
- Collaterals held with professionals.
- Treatment planning sessions with no treatment plans resulting.
- Intakes being conducted by office staff rather than one-on-one session with a counselor.

4. Group Sign-In Sheets:

Group Counseling Sign In Sheet are required to maintained for all group counseling sessions conducted by all modalities. The sign in sheet must contain the date and duration of the session. The client attending the session must individually sign in on the sheet. The sheet must be maintained by the provider and it is suggested that the sheets be filed in chronological order.

Common problems encountered when examining sign in sheets.

- Time/date/duration of the session is missing.
- Client fails to sign in.
- More than 10 or less than 4 clients in attendance for a group session. (This does not apply to DCH and Peri-Redisdental modalities.
- One person signs in for all participants.
  REFERENCE: TITLE 22 SECTION 51341.1(b)(8)(,(g)(2)

5. Progress Notes.

Progress notes are individual narrative summaries that must include; a description of the client's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals. They must also contain information on the client's attendance including the time, day, month, year of attendance at all group and individual counseling sessions.

Common progress note errors.

- Missing year of session.
- Client progress or lack of progress missing.
- No progress note recorded.
- "Crisis" individual counseling session does not meet the criteria.
- Duration of the counseling session not noted.

Riverside County Department of Mental Health
Substance Abuse Program

DAS Contractor Pre-Admission (Admission Request Form)

FAX Admission Request to: Substance Abuse Administration 951-683-4904

Select Client (Search)

ADMIN ONLY: *Skip fields on screen **ONLY** if not on this form. **Client ID:** _____

Client Name: (Last) _____ (First)_____ **Gender:**_____
(Male,Female,Other)

Admission Tab (Page 1)

Episode # _____

Date of Birth: ____/____/_____

Preadmit/Admission Date: ___/___/_____

Preadmit/Admission Time: ____:_____ am / pm
(Actual Time) (Circle One)

Program: _____
*(Program Name & **ID**)*

Type of Admission: **Pre-Admission**

Admitting Practitioner: _____
(Practitioner Staff # and Name)

Social Security Number: _____-____-_____
(Please make every attempt to obtain client's SSN)
***ADMIN ONLY**: (If none **leave blank** in Registration Screen.)*
***ADMIN ONLY**: (Enter **999-99-9999** in Financial Eligibility screen)*

Demographics Tab (Page 1)

Client's Middle Name: _____

Suffix: ☐ Sr ☐ Jr ☐ III ☐ IV ☐ V ☐ VI

Client's Address: (Street)_____
(Street Number, Name, and Type)
Client's Address: (Line2)_____
(Identify Appt #, Unit #, Floor, etc.)
Client's Address: (Zip Code) _____
*(**DMC Billing**: If Homeless, use Facility Address & Zip Code)*

Client's Primary Phone: ____-____-_____

Client's Secondary Phone: ____-____-_____

Primary Language: _____

Marital Status:
☐ Single/Never Married ☐ Now Married
☐ Registered Domestic Partner ☐ Widowed
☐ Divorced/Annulled ☐ Separated

Demographics Tab (Page 2)

Maiden Name_____

Alias 1 _____

Alias 2 _____

Alias 3 _____

Admission Request

(ADMIN ONLY: Enter data in Avatar MSO> Care Management > Service Authorization – Comments Tab)

Level of Care Requesting: ☐ Detox (SA110) ☐ DDx Detox (SA110) ☐ DC Bed Res (SA209) ☐ FOTP Res (SA211)
START Referral ONLY
☐ Long Term Res (SA210) ☐ Short Term Res (SA212) ☐ Dis. Bed Res (SA215) ☐ Perinatal Res (SA250)
☐ DCR-Adolescent ☐ DCR-Perinatal ☐ DCR-Women w/Children ☐ ODF ☐ ODF/Perinatal ☐ NTP
If 18 to 24 years of age is client EPSDT?

Justification to enter treatment: _____

_____

_____

_____

_____

---------- **ADMIN USE ONLY**----------

☐ **Approved (Auth #_____)** ☐ **Denied** ☐ **Pending**

Reason for Denied/Pending: _____

_____

Signature of Substance Abuse Program Manager/Designee:_____ **Date:**_____

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

DIAGNOSIS

Diagnosis Tab (Page 1)

Type of Diagnosis: Admission

Date of Diagnosis: Auto Populates
(Same as Preadmit/Admission Date)

Time of Diagnosis: ____:____ am / pm
(Actual Time) (Circle One)

Diagnosing Practitioner: Copy Above
(Same as Admitting Practitioner)

Diagnosis Axis I-1 (Check "ONE")

☐ SA303.90 Alcohol Dependence	☐ SA305.00 Alcohol Abuse
☐ SA304.00 Opioid Dependence	☐ SA305.10 Nicotine Dependence
☐ SA304.10 Barbiturates/Sedatives Depen	☐ SA305.20 Cannabis Abuse
☐ SA304.20 Cocaine Dependence	☐ SA305.30 Hallucinogen Abuse
☐ SA304.30 Cannabis Dependence	☐ SA305.40 Barbiturates/Sedative Abuse
☐ SA304.40 Amphetamine Dependence	☐ SA305.50 Opioid Abuse
☐ SA304.50 Hallucinogen / PCP Depen.	☐ SA305.60 Cocaine Abuse
☐ SA304.60 Inhalant Dependence	☐ SA305.70 Amphetamine Abuse
☐ SA304.80 Polysubstance Dependence	☐ SA305.90 Inhalant/PCP/Polysubstance Abuse
☐ SA304.90 Polysubstance/Psychoactive Substance Dependence	

Does client have a secondary diagnosis of "Problem Gambling"? (Y/N) _____
(If Yes, enter Diagnosis Code (312.31 Pathological Gambling) in Diagnosis Axis II-1 field)

Principal Diagnosis *(Use Diagnosis Axis I-1)* ***SUBMIT***

FINANCIAL ELIGIBILITY

Guarantor Name / Guarantor Plan

☐ 505 – ADP CalWORKs / (Non-Contract) ADP CalWORKs →

☐ Insurance Co. Name&Code: _____ → / (Non-Contract) ADP Commercial

☐ 501 – ADP Medi-Cal/(Non-Contract) ADP Drug Medi-Cal →

☐ 506 – ADP Grant / (Non-Contract) ADP Grant

☐ 502 – ADP NNA / (Non-Contract) ADP NNA

SSN: (As stated above enter 999-99-9999 for NONE)

If ADP CalWORKs Selected:

Worker Name and Location _____

If Insurance Co. Selected:
(Submit 3 Subscriber Forms listed below & Copy of Insurance Card)
(Reminder to submit proof of billing, partial payment, and/or VALID denial when received from Insurance Company)

Policy Number _____

Client's Relationship to Subscriber _____

If ADP Medi-Cal Selected:
(MUST Attach printout of DMC eligibility from State website)

CIN# _____ Aid Code _____

OHC? (Y/N) ___ SOC? (Y/N) _____
Enter Guarantor Insurance Co. Name & Code
Policy Number, and Relationship to Subscriber above
(OHC: Reminder to bill other health coverage and provide proof of billing, partial payment, and/or VALID denial from the OHC in order to authorize DMC billing.)

Client's Relationship to Subscriber __**SELF**____

If Insurance the following forms are on file:

Subscriber Assignment of Benefits: (Y / N) _____

Subscriber Release of Info: (Y / N) _____

Subscriber Coordination of Benefits: (Y / N) _____

Riverside County Department of Mental Health
Substance Abuse Program

DAS Contractor
(Extension Request Form)

FAX Extension Request to: Substance Abuse Administration 951-683-4904

Select Client (Search)

Client ID: _____

Client Name: (Last) _____ (First)_____ **Gender:**_____
(Male,Female,Other)

Social Security Number: ____ - ___ - _____ **Date of Birth**: _____/_____/_____

Service Authorization Tab (ADMIN ONLY: Update data in Avatar MSO) **Episode #** _____

Request Date: ____/____/_____

Original Admission Date: ___/___/_____

Program: _____
*(Program Name & **ID**)*

Number of Additional Days/Services Requested: _____

_____

_____

Requesting Practitioner: _____
(Practitioner Staff # and Name)

Current Level of Care: ☐ Detox (SA110) ☐ DDx Detox (SA110) ☐ DC Bed Res (SA209) ☐ FOTP Res (SA211)
START Referral ONLY
☐ Long Term Res (SA210) ☐ Short Term Res (SA212) ☐ Dis. Bed Res (SA215) ☐ Perinatal Res (SA250)
☐ DCR-Adolescent ☐ DCR-Perinatal ☐ DCR-Women w/Children ☐ ODF ☐ ODF/Perinatal ☐ NTP
18 to 24 years of age is client EPSDT? _____

Reason for Extension: _____

_____

_____

_____

_____

_____

Service Authorization Tab

---------- **ADMIN USE ONLY**----------

☐ **Approved (Auth #_____)** ☐ **Denied** ☐ **Pending**

Reason for Denied/Pending: _____

_____

Signature of Substance Abuse Program Manager/Designee:_____ **Date:**_____

Riverside County Department of Mental Health
Substance Abuse Program

Contractor Private Pay Client Registration

FAX form to: Substance Abuse Administration 951-683-4904

Select Client (Search)

ADMIN ONLY: *Skip fields on screen **ONLY** if not on this form. **Client ID:** _____

Client Name: (Last) _____ (First)_____ **Gender:**_____
(Male,Female,Other)

Admission Tab (Page 1)

Episode # _____

Date of Birth: ____/____/_____

Preadmit/Admission Date: ___/___/_____

Preadmit/Admission Time: ____:_____ am / pm
(Actual Time) (Circle One)

Program: _____
(Program Name & ID)

Type of Admission: **First Admission**

Admitting Practitioner: _____
(Practitioner Staff # and Name)

Social Security Number: _____-____-_____
(Please make every attempt to obtain client's SSN)
***ADMIN ONLY**: (If none **leave blank** in Registration Screen.)*
***ADMIN ONLY**: (Enter **999-99-9999** in Financial Eligibility screen)*

Demographics Tab (Page 1)

Client's Middle Name: _____

Suffix: ☐ Sr ☐ Jr ☐ III ☐ IV ☐ V ☐ VI

Client's Address: (Street)_____
(Street Number, Name, and Type)
Client's Address: (Line2)_____
(Identify Appt #, Unit #, Floor, etc.)
Client's Address: (Zip Code) _____
*(**DMC Billing**: If Homeless, use Facility Address & Zip Code)*

Client's Primary Phone: ____-____-_____

Client's Secondary Phone: ____-____-_____

Demographics Tab (Page 2)

Maiden Name_____

Alias 1 _____

INCLUDE CalOMS Admission form with this request.

Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Admission (Contract Provider)

Name _____ _____
(Current Last) (Current First)

Client Number _____

Program ID _____

*ALL FIELDS ON SCREEN MUST BE ANSWERED. FOLLOW ORDER OF FORM.

Client Identification and Demographic Data Tab (Page 1)

Episode # _____

Birth First Name: _____
(If different than current name)

Birth Last Name: _____
(If different than current name)

**Delete Middle Name or Suffix from Current Last Name field if present.*

SSN: ____-____-_____ **or No SSN Code:** _____
(If no SSN identified enter on line above one of the following reasons)
99900 = Client Declined to State
99902 = None or Not Applicable
99904 = Client Unable to Answer**

Zip Code at Current Residence: _____ **or**
☐ *00000=Homeless*
☐ *XXXXX=Client Declined to State*
☐ *ZZZZZ=Client Unable to Answer***

Place of Birth – County: _____
(Enter CA County ONLY, or "Other" if born outside of CA)

Place of Birth – State: _____
(Enter U.S.A. State ONLY, or "Other" if born outside of U.S.A.)

Driver's License/State Id Card Number: _____ **or**
☐ *99900 = Client Declined to State*
☐ *99902 = None or Not Applicable*
☐ *99904 = Client Unable to Answer***

Driver's License/State Id Card State: _____ **or**
☐ *99900 = Client Declined to State*
☐ *99902 = None or Not Applicable*
☐ *99904 = Client Unable to Answer***

Mother's First Name: _____
(If unknown use "Mother")

Client Identification and Demographic Data Tab (Page 1-3) (Must select at least **ONE** Race)

Race: **Enter 1 – 5** to select up to five races in order of client preference, i.e. **1 = primary race**, **2 = secondary race**, **etc**. In order to provide the most accurate information, CalOMS encourages selecting actual races rather than using the "Mixed Race" category.

	Hawaiian		Japanese		Korean		Laotian
	Samoan		Vietnamese		Other Asian		Other Race
	Mixed Race		Alaskan Native		White		Black/African
	American Indian		Filipino		Asian Indian		Cambodian
	Chinese				Guamanian		

Client Identification and Demographic Data Tab (Page 3)

Ethnicity (select one)
☐ Not Hispanic
☐ Mexican/Mexican America
☐ Cuban
☐ Puerto Rican
☐ Other Hispanic/Latino

Veteran (Y/N) _____ **or**
☐ Client Declined to State
☐ Client Unable to Answer**

Disability/Disabilities (select all that apply)
☐ None
☐ Visual
☐ Hearing
☐ Speech
☐ Mobility
☐ Mental
☐ Developmentally Disabled
☐ Other (not AOD)
☐ Client Declined to State
☐ Client Unable to Answer**

Consent: Is there a signed consent form for future contact on the file within your agency? (Y/N) _____

Lesbian, Gay, Bisexual, Transgender (LGBT):
☐ Heterosexual / Straight
☐ Lesbian (female)
☐ Gay (male)
☐ Bisexual
☐ Unsure / Questioning
☐ Declined to State
☐ Transgender

Transaction Data Tab

Admission Transaction Type: *(Refer to the CalOMS Data Collection Guide)*
☐ Initial Admission *(New Admission or 30+ Days Interruption in Treatment Service)*
☐ Transfer or Change in Service *(Transfer/Change with less than 30 Days Interruption in Treatment Services)*

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Admission Data Tab

Source of Referral (select one)
- ☐ Individual includes self referral
- ☐ Alcohol/Drug abuse program
- ☐ Other health care provider
- ☐ School/Education
- ☐ Employer/EAP
- ☐ 12 Step Mutual Aid
- ☐ SACPA/Prop 36/OTP/Probation or Parole
- ☐ Post-Release Community Supervision (AB109)
- ☐ DUI/DWI
- ☐ Adult Felon Drug Court
- ☐ Dependency Drug Court
- ☐ Non-SACPA Court/Criminal Justice
- ☐ Other Community Referral
- ☐ Child Protective Services

Days Waited to Enter Treatment: *(0-999)* _____ **or**
(How many days were you on a waiting list before you were admitted to this treatment program?)
- ☐ *99901 = Not Sure/Don't Know*
- ☐ *99904 = Client Unable to Answer***

Number of Prior Episodes *(0-99)* _____ **or**
(Number of prior episodes in any alcohol or drug treatment / recovery program in which client has participated)
- ☐ *99900 = Client Declined to State*
- ☐ *99901 = Not Sure/Don't Know*
- ☐ *99904 = Client Unable to Answer***

CalWORKs Recipient
(Y/N) _____ **or** _____Not Sure/Don't Know

Substance Abuse Treatment Under CalWORKs
(Y/N) _____ **or** _____Not Sure/Don't Know

County Paying for Services: _____
(Gibson House = Riverside, Cedar House = Riverside, All others select "None or Not Applicable")

Special Services Contract ID: _____
(Gibson House = 4-digit code, Cedar House = 4-digit code, All others enter 99902)

Alcohol and Drug Use Tab (Page 1) (Primary Drug must be selected and cannot be NONE)

Drug Problem: Enter 1 **AND** 2 to Select for **Primary Drug (1)** and **Secondary Drug (2)** of Choice (Code).

	Alcohol		Marijuana/Hashish		Other Hallucinogens*		Over-the-Counter*
	Barbiturates*		Methamphetamine		Other Opiates or Synthetic*		OxyCodone/Oxy Contin
	Cocaine/Crack		None		Other Sedatives or Hypnotics*		PCP
	Ecstasy		Non-Prescription Methadone		Other Stimulants*		Tranquilizers (e.g. Benzodiazepine)*
	Heroin		Other Amphetamines*		Other Tranquilizers*		
	Inhalants*		Other Club Drugs*		Other **(specify)***		

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Secondary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Primary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Primary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Age of First Use
(5-105) _____ **or**_____ (99904 = Client Unable to Answer**)

Secondary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Secondary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Age of First Use
(5-105) _____ **or** _____ (99904 = Client Unable to Answer**)

Indicate **Alcohol Frequency *ONLY*** if the Primary & Secondary drugs are **NOT** alcohol.
Number of days in the **past 30 days** that the client has used alcohol?: (0-30) _____

Needle Use (Past 30 Days): (0-30) _____ or ☐ 99900 Client Declined to State
☐ 99904 Client Unable to Answer**

Needle Use in the Last 12 Months: (Y/N) _____ **or** _____ *99904 = Client Unable to Answer***

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Employment Data Tab

Enrolled in School (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Highest School Grade Completed: (0-29)_____ **or**
- ☐ 30+ Years
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Employment Status
- ☐ Employed Full Time (35 hrs or more)
- ☐ Employed Part Time (less than 35 hrs)
- ☐ Unemployed, looking for work
- ☐ Unemployed – (Not Seeking)
- ☐ Not in the Labor Force (Not Seeking)

Enrolled in Job Training (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Work Past 30 Days: *(0-30)* _____ **or**
- ☐ *99900 = Client Declined to State*
- ☐ *99904 = Client Unable to Answer***

Criminal Justice Data Tab

Criminal Justice Status
- ☐ Not Applicable
- ☐ Under parole supervision by CDC
- ☐ On parole from any other jurisdiction
- ☐ On probation from any other jurisdiction
- ☐ Admitted under diversion from any court under CA Penal Code, Section 1000
- ☐ Incarcerated
- ☐ Awaiting trial, charges, or sentencing
- ☐ Client Unable to Answer**

CDCR Number: _____ **or**
*Leave blank if Youth.
- ☐ 99900 = Client Declined to State
- ☐ 99901 = Not Sure/Don't Know
- ☐ 99902 = None or Not Applicable
- ☐ 99904 = Client Unable to Answer**

Number of Arrests Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Jail Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Prison Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Parolee Services Network(PSN):
(Y/N) ____ **or** _____ 99904 = Client Unable to Answer**

FOTP Parolee:
(The Ranch **ONLY** can answer, all others use "N")
(Y/N) _____ **or** _____ 99904 = Client Unable to Answer**

FOTP Priority Status
(The Ranch **ONLY** can answer, all others Leave Blank)
- ☐ Completed "Forever Free" and released and enrolled in
- ☐ Any woman paroling from CIW
- ☐ Completed "Forever Free" and goes direct to FOTP facility
- ☐ None or Not Applicable
- ☐ Client Unable to Answer**

Medical/Physical Health Data Tab (Page 1)

Medi-Cal Beneficiary
(Y/N) _____ **or** _____99904 = Client Unable to Answer**

Emergency Room Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Hospital Overnight Stay Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Medical Problems Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Pregnant At Admission
(Y/N) _____ **or** _____ Not Sure/Don't Know

Medication Prescribed as Part of Treatment
(NTP programs select 'Methadone', all others 'None')
- ☐ None
- ☐ Methadone
- ☐ LAAM
- ☐ Buprenorphine (Subutex)
- ☐ Buprenorphine (Suboxone)
- ☐ Other

Communicable Diseases: Tuberculosis
(Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Communicable Diseases: Hepatitis C
(Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Communicable Diseases: Sexually Transmitted Diseases
(Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Tested (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Test Results (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Mental Illness Tab

Mental Illness Diagnosis
(Y/N)_____ **or** _____ Not Sure/Don't Know

Emergency Room Use / Mental Health Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Psychiatric Facility Use Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Mental Health Medication
(Y/N) _____ **or** _____ Client Unable to Answer**

Family/Social Data Tab

Social Support: (0-30) _____
*(Number of days in the **Past 30 Days** has the client participated in any social support recovery activities, including 12-step meeting, religious/faith recovery meetings, and interactions with family members or friends supportive of recovery.)*

Current Living Arrangements
- ☐ Homeless
- ☐ Dependent Living
- ☐ Independent Living

Living with Substance "User" Past 30 Days:
(0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Family Conflict Past 30 Days: (0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Number of Children Age 17 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Age 5 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else and Parental Rights Terminated:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

* **ADMIN ONLY** function
** Note that **99904** (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Annual Update

Name _____ _____
(Current Last) (Current First)

Client Number _____

Program ID _____

*ALL FIELDS ON SCREEN MUST BE ANSERED. FOLLOW ORDER OF FORM.

Cal-OMS Annual Update Tab

Episode # _____

Date of Birth: ____/____/_____

Annual Update Date: ____/____/_____

Current First Name: _____

Current Last Name: _____

SSN: ____-____-_____ **or No SSN Code:** _____
(If no SSN identified enter on line above one of the following reasons)
99900 = Client Declined to State
99902 = None or Not Applicable
99904 = Client Unable to Answer**

Consent: Is there a signed consent form for future contact on the file within your agency? (Y/N) _____

Disability/Disabilities (select all that apply)
- ☐ None
- ☐ Visual
- ☐ Hearing
- ☐ Speech
- ☐ Mobility
- ☐ Mental
- ☐ Developmentally Disabled
- ☐ Other (not AOD)
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Zip Code at Current Residence: _____ **or**
- ☐ *00000=Homeless*
- ☐ *XXXXX=Client Declined to State*
- ☐ *ZZZZZ=Client Unable to Answer***

Alcohol and Drug Use Data Tab

Drug Problem: Enter 1 **AND** 2 to Select for **Primary Drug (1)** and **Secondary Drug (2)** of Choice (Code).

	Alcohol		Marijuana/Hashish		Other Hallucinogens*		Over-the-Counter*
	Barbiturates*		Methamphetamine		Other Opiates or Synthetic*		OxyCodone/Oxy Contin
	Cocaine/Crack		None		Other Sedatives or Hypnotics*		PCP
	Ecstasy		Non-Prescription Methadone		Other Stimulants*		Tranquilizers (e.g. Benzodiazepine)*
	Heroin		Other Amphetamines*		Other Tranquilizers*		
	Inhalants*		Other Club Drugs*		Other **(specify)***		

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Secondary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Primary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Primary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Secondary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Secondary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Indicate **Alcohol Frequency *ONLY*** if the Primary & Secondary drugs are **NOT** alcohol.
Number of days in the past 30 days that the client has used alcohol?: (0-30) _____

Needle Use (Past 30 Days): (0-30) _____ or ☐ 99900 Client Declined to State
☐ 99904 Client Unable to Answer**

Needle Use in the Last 12 Months: (Y/N) _____ **or** _____ *99904 = Client Unable to Answer***

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Employment Data Tab

Employment Status
- ☐ Employed Full Time (35 hrs or more)
- ☐ Employed Part Time (less than 35 hrs)
- ☐ Unemployed, looking for work
- ☐ Unemployed – (Not Seeking)
- ☐ Not in the Labor Force (Not Seeking)

Work Past 30 Days: *(0-30)* _____ **or**
- ☐ *99900 = Client Declined to State*
- ☐ *99904 = Client Unable to Answer***

Enrolled in School (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Enrolled in a Job Training (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Highest School Grade Completed: (0-29)_____ **or**
- ☐ 30+ Years
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Criminal Justice Data Tab

Number of Arrests Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Jail Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Prison Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Medical/Physical Health Data Tab

Emergency Room Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Hospital Overnight Stay Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Medical Problems Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Pregnant At Any Time During Treatment
(Y/N) _____ **or** _____ Not Sure/Don't Know

HIV Tested (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Test Results (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Mental Illness Tab

Mental Illness Diagnosis
(Y/N)_____ **or** _____ Not Sure/Don't Know

Emergency Room Use / Mental Health Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Psychiatric Facility Use Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Mental Health Medication
(Y/N) _____ **or** _____ Client Unable to Answer**

Family/Social Data Tab

Social Support: (0-30) _____
*(Number of days in the **Past 30 Days** has the client participated in any social support recovery activities, including 12-step meeting, religious/faith recovery meetings, and interactions with family members or friends supportive of recovery.)*

Current Living Arrangements
- ☐ Homeless
- ☐ Dependent Living
- ☐ Independent Living

Living with Substance "User" Past 30 Days:
(0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Family Conflict Past 30 Days: (0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Number of Children Age 17 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Age 5 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else and Parental Rights Terminated:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

** Note that **99904** (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Standard Discharge

Name _____ _____
(Current Last) (Current First)

Client Number _____

Program ID _____

*ALL FIELDS ON SCREEN MUST BE ANSWERED. FOLLOW ORDER OF FORM.

Discharge Tab

Episode # _____

Date of Birth: ____/____/_____

Date of Discharge: ____/____/_____

Discharge Time: ____:_____ am / pm
(Actual Time) (Circle One)

Type of Discharge: **Reason Not Available**

Discharge Practitioner: _____
(Discharging Staff # and Name)

Discharge Remarks/Comments:

_____

_____

Cal-OMS Discharge Tab

Discharge Status
- ☐ Completed treatment/recovery plan, Goals/Referred
- ☐ Completed treatment/recovery, Goals/Not Referred
- ☐ Left before completion w/ Satisfactory Progress/Referred
- ☐ Left before completion w/ Unsatisfactory Progress/Referred

Disability/Disabilities (select all that apply)
- ☐ None
- ☐ Visual
- ☐ Hearing
- ☐ Speech
- ☐ Mobility
- ☐ Mental
- ☐ Developmentally Disabled
- ☐ Other (not AOD)
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Consent: Is there a signed consent form for future contact on the file within your agency? (Y/N) _____

Current First Name: _____

Current Last Name: _____

SSN: ____-____-_____ **or No SSN Code:** _____
(If no SSN identified enter on line above one of the following reasons)
99900 = Client Declined to State
99902 = None or Not Applicable
99904 = Client Unable to Answer**

Zip Code at Current Residence: _____ **or**
- ☐ *00000=Homeless*
- ☐ *XXXXX=Client Declined to State*
- ☐ *ZZZZZ=Client Unable to Answer***

Alcohol and Drug Use Data Tab

Drug Problem: Enter 1 **AND** 2 to Select for **Primary Drug (1)** and **Secondary Drug (2)** of Choice (Code).

	Alcohol		Marijuana/Hashish		Other Hallucinogens*		Over-the-Counter*
	Barbiturates*		Methamphetamine		Other Opiates or Synthetic*		OxyCodone/Oxy Contin
	Cocaine/Crack		None		Other Sedatives or Hypnotics*		PCP
	Ecstasy		Non-Prescription Methadone		Other Stimulants*		Tranquilizers (e.g. Benzodiazepine)*
	Heroin		Other Amphetamines*		Other Tranquilizers*		
	Inhalants*		Other Club Drugs*		Other **(specify)***		

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Secondary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Primary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Primary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Secondary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Secondary Drug?)

Route of Administration
- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Alcohol and Drug Use Data Tab (continued)

Indicate **Alcohol Frequency *ONLY*** if the Primary & Secondary drugs are **NOT** alcohol.
Number of days in the **past 30 days** that the client has used alcohol?: (0-30) _____

Needle Use (Past 30 Days): (0-30) _____ or ☐ 99900 Client Declined to State
☐ 99904 Client Unable to Answer**

Employment Data Tab

Employment Status
- ☐ Employed Full Time (35 hrs or more)
- ☐ Employed Part Time (less than 35 hrs)
- ☐ Unemployed, looking for work
- ☐ Unemployed – (Not Seeking)
- ☐ Not in the Labor Force (Not Seeking)

Work Past 30 Days: *(0-30)* _____ **or**
- ☐ *99900 = Client Declined to State*
- ☐ *99904 = Client Unable to Answer***

Enrolled in School (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Enrolled in a Job Training (Y/N) _____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Highest School Grade Completed: (0-29)_____ **or**
- ☐ 30+ Years
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Criminal Justice Data Tab

Number of Arrests Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Jail Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Prison Days Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Medical/Physical Health Data Tab

Emergency Room Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Hospital Overnight Stay Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Medical Problems Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Pregnant At Any Time During Treatment
(Y/N) _____ **or** _____ Not Sure/Don't Know

HIV Tested (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

HIV Test Results (Y/N) ____ **or**
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Mental Illness Tab

Mental Illness Diagnosis
(Y/N)_____ **or** _____ Not Sure/Don't Know

Emergency Room Use / Mental Health Past 30 Days:
(0/99) ____ **or** _____ 99904 = Client Unable to Answer**

Psychiatric Facility Use Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Mental Health Medication
(Y/N) _____ **or** _____ Client Unable to Answer**

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Family/Social Data Tab

Social Support: (0-30) _____
*(Number of days in the **Past 30 Days** has the client participated in any social support recovery activities, including 12-step meeting, religious/faith recovery meetings, and interactions with family members or friends supportive of recovery.)*

Current Living Arrangements
- ☐ Homeless
- ☐ Dependent Living
- ☐ Independent Living

Living with Substance "User" Past 30 Days:
(0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Family Conflict Past 30 Days: (0-30) _____ **or**
- ☐ 99900 = Client Declined to State
- ☐ 99904 = Client Unable to Answer**

Number of Children Age 17 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Age 5 or Younger:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Number of Children Living with Someone Else and Parental Rights Terminated:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

** Note that **99904** (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Youth/Detox

(Circle One)

Standard Discharge

Name _____ _____
(Current Last) (Current First)

Client Number _____

Program ID _____

*ALL FIELDS ON SCREEN MUST BE ANSWERED. FOLLOW ORDER OF FORM.

Discharge Tab

Episode # _____

Date of Birth: ____/____/_____

Date of Discharge: ____/____/_____

Discharge Time: ____:_____ am / pm
(Actual Time) (Circle One)

Type of Discharge: **Reason Not Available**

Discharge Practitioner: _____
(Discharging Staff # and Name)

Discharge Remarks/Comments:

_____

_____

Cal-OMS Youth/Detox Discharge Tab (Page 1-2)

Discharge Status

- ☐ Completed treatment/recovery plan, Goals/Referred
- ☐ Completed treatment/recovery, Goals/Not Referred
- ☐ Left before completion w/ Satisfactory Progress/Referred
- ☐ Left before completion w/ Unsatisfactory Progress/Referred

Consent: Is there a signed consent form for future contact on the file within your agency? (Y/N) _____

Disability/Disabilities (select all that apply)

- ☐ None
- ☐ Visual
- ☐ Hearing
- ☐ Speech
- ☐ Mobility
- ☐ Mental
- ☐ Developmentally Disabled
- ☐ Other (not AOD)
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Current First Name: _____

Current Last Name: _____

Drug Problem: Enter 1 **AND** 2 to Select for **Primary Drug (1)** and **Secondary Drug (2)** of Choice (Code).

	Alcohol		Marijuana/Hashish		Other Hallucinogens*		Over-the-Counter*
	Barbiturates*		Methamphetamine		Other Opiates or Synthetic*		OxyCodone/Oxy Contin
	Cocaine/Crack		None		Other Sedatives or Hypnotics*		PCP
	Ecstasy		Non-Prescription Methadone		Other Stimulants*		Tranquilizers (e.g. Benzodiazepine)*
	Heroin		Other Amphetamines*		Other Tranquilizers*		
	Inhalants*		Other Club Drugs*		Other **(specify)***		

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Secondary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Primary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Primary Drug?)

Route of Administration

- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Secondary Drug

Frequency: (0-30) _____ or _____(99902 = Not Applicable)
(How many days in the **past 30 days** has the client used the Secondary Drug?)

Route of Administration

- ☐ Oral
- ☐ Smoking
- ☐ Inhalation
- ☐ Injection (IV or Intramuscular)
- ☐ None or Not Applicable
- ☐ Other

Client Name: _____ _____ Client Number: _____ Prog ID: _____
(Current Last) (Current First)

Cal-OMS Youth/Detox Discharge Tab (Page 2 continued)

Indicate **Alcohol Frequency *ONLY*** if the Primary & Secondary drugs are **NOT** alcohol.
Number of days in the past 30 days that the client has used alcohol?: (0-30) _____

Pregnant At Any Time During Treatment

(Y/N) _____ **or** _____ Not Sure/Don't Know

Employment Status

- ☐ Employed Full Time (35 hrs or more)
- ☐ Employed Part Time (less than 35 hrs)
- ☐ Unemployed, looking for work
- ☐ Unemployed – (Not Seeking)
- ☐ Not in the Labor Force (Not Seeking)

Enrolled in School (Y/N) _____ **or**

- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Number of Arrests Past 30 Days:
(0/30) ____ **or** _____ 99904 = Client Unable to Answer**

Mental Illness Diagnosis
(Y/N)_____ **or** _____ Not Sure/Don't Know

Social Support: (0-30) _____
*(Number of days in the **Past 30 Days** has the client participated in any social support recovery activities, including 12-step meeting, religious/faith recovery meetings, and interactions with family members or friends supportive of recovery.)*

Current Living Arrangements

- ☐ Homeless
- ☐ Dependent Living
- ☐ Independent Living

** Note that **99904** (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

Riverside County Department of Mental Health
Substance Abuse Program

CalOMS Administrative Discharge

Name _____ _____
(Current Last) (Current First)

Client Number _____

Program ID _____

*ALL FIELDS ON SCREEN MUST BE ANSWERED. FOLLOW ORDER OF FORM.

Discharge Tab

Episode # _____

Date of Birth: ____/____/_____

Date of Discharge: ____/____/_____

Discharge Time: ____:_____ am / pm
(Actual Time) (Circle One)

Type of Discharge: **Reason Not Available**

Discharge Practitioner: _____
(Discharging Staff # and Name)

Discharge Remarks/Comments:

_____

_____

Cal-OMS Youth/Detox Discharge Tab (Page 1-2)

Discharge Status

- ☐ Left before completion w/Satisfactory Progress/Not Referred
- ☐ Left before completion w/Unsatisfactory Progress
- ☐ Death
- ☐ Incarceration

Disability/Disabilities (select all that apply)

- ☐ None
- ☐ Visual
- ☐ Hearing
- ☐ Speech
- ☐ Mobility
- ☐ Mental
- ☐ Developmentally Disabled
- ☐ Other (not AOD)
- ☐ Client Declined to State
- ☐ Client Unable to Answer**

Current First Name: _____

Current Last Name: _____

Primary Drug (Code) Problem

☐	Alcohol	☐	Marijuana/Hashish	☐	Other Hallucinogens*	☐	Over-the-Counter*
☐	Barbiturates*	☐	Methamphetamine	☐	Other Opiates or Synthetic*	☐	OxyCodone/Oxy Contin
☐	Cocaine/Crack	☐	None	☐	Other Sedatives or Hypnotics*	☐	PCP
☐	Ecstasy	☐	Non-Prescription Methadone	☐	Other Stimulants*	☐	Tranquilizers (e.g. Benzodiazepine)*
☐	Heroin	☐	Other Amphetamines*	☐	Other Tranquilizers*		
☐	Inhalants*	☐	Other Club Drugs*	☐	Other **(specify)***		

Primary Drug Name: _____
*(Required if Drug Problem is marked with *)*

Pregnant At Any Time During Treatment (Y/N) _____ **or** _____ Not Sure/Don't Know

** Note that **99904** (Client Unable to Answer) is **ONLY** used in Detox facilities or if client's disability states mentally impaired.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

PROVIDER REPORT OF DRUG MEDI-CAL CLAIMS ADJUSTMENTS

COUNTY CODE:_____ **PROVIDER #:**_____ **PROGRAM CODE:**_____

COUNTY NAME:_____ **PROVIDER NAME:**_____

FISCAL YEAR:_____/_____ **ADDRESS:**_____

SERVICE FUNCTION CODE:_____ **CITY/STATE/ZIP:**_____ **PAGE**_____**OF**_____

CLIENT NAME	CLIENT CHART #	837P CLAIM I.D. NUMBER	CLAIM LINE #	ADJUSTMENT DATES FROM	TO	AR **	CLAIM FOR MO/YR	U/S ADJUST.	TOTAL DOLLARS ADJUSTED
							PAGE TOTALS		
							GRAND TOTALS		

****Adjustment Reason is:**

1. Beneficiary not D/MC eligible.
2. Service not provided.
3. Service not D/MC eligible.
4. Location of service not D/MC certified.
5. Medical necessity not established.
6. DSM code not identified or incorrect.
7. Incorrect use of "Good Cause" code.
8. Incorrect use of "duplicate/multiple billing" code.
9. Admission criteria time frames not met.
10. Treatment plan time frames not met.
11. Continuing services/treatment time frames not met.
12. Reimbursement in excess of allowable maximum.
13. Ineligible group counseling session.
14. Ineligible individual counseling session.
15. Ineligible daycare habilitative unit of svs.
16. Service paid for by other source.
17. Service should be billed to other coverage.
18. Other (explain)

(State use only!)

[ ] settled in cost reports

[ ] County billed unit rate from cost report

[ ] Sent to Acctg for invoicing

Date to acctg:

Total $ Amount

[ ] Total $ amount will be deducted from next monthly claim received by ADP

$_____ was deducted from Month/Year claim_____

Date taken:_____ Analyst Initials:_____

AUTHORIZED SIGNATURE: _____ **DATE:** _____

ADP 5035C (Rev 10/08)

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY | DEPARTMENT OF HEALTH CARE SERVICE

GOOD CAUSE CERTIFICATION
Retroactive Eligibility - Delay Reason Code 8

_____ requests a waiver of the 30-day Drug Medi-Cal billing limitation for the claims listed below.
COUNTY/DIRECT PROVIDER

EDI File Name: _____

Attachment Control Number: _____

By signing below, I certify that I have reviewed the claims in the above-named EDI file using the Attachment Control Number listed above, and that each such claim is being submitted more than 30 days after the end of the month of service due to delay or error in the certification or determination of the Medi-Cal eligibility by the State or county for the client to whom services identified on that claim were provided. I also certify that each of those claim(s) are being submitted not later than 60 days after that delay or error was resolved by the State or county, and that documentation substantiating those circumstances for each client are on file with the above named county or direct provider and will be made available to the California Department of Health Care Services (DHCS) on request for auditing and monitoring purposes. I further acknowledge that I understand that DHCS will rely on this certification in determining that this late submission is acceptable under Title 22 of the California Code of Regulations, Section 51008.5.A14.

Signature: COUNTY/DIRECT PROVIDER REPRESENTATIVE	Phone Number ( )

STATE USE ONLY

REVIEWED AND APPROVED FOR DELAY REASON CODE 8

Analyst Name: _____

DRC Release Date:_____

Signature: DHCS - FMAB-SUD MANAGER

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

COMPLETION INSTRUCTIONS FOR GOOD CAUSE CERTIFICATION 6065B

GENERAL

The DHCS Good Cause Certification form is used by a Drug Medi-Cal provider to request a waiver of the 30-day Drug Medi-Cal billing limitation.

* A Good Cause Certification form must be completed and submitted to DHCS for Delay Reason Code 8.

* Retain a copy of the form at the provider site for auditing or monitoring purposes. Note: For county-contracted providers, send the original form to the county.

DELAY REASON CODE 8 (see California Code of Regulations, Title 22, Section 51008.5 for usage restrictions and time limits)

Determination by the DHCS Director, or the Director's delegate, that the provider was prevented from submitting the claims on time due to circumstances beyond the control of the county/provider regarding delay or error in the certification of Medi-Cal eligibility of the beneficiary by the state or county. This includes retroactive Medi-Cal eligibility.

HEADING INSTRUCTIONS

a. COUNTY/DIRECT PROVIDER: if submitter is a county, enter the county name; if submitter is a direct provider, enter the direct provider name.

c. EDI FILE NAME: enter the name of the ITWS 837P file.

d. ATTACHMENT CONTROL NUMBER: enter the unique tracking number for this certification and the associated documentation. This number must be provided as the Attachment Control Number in the Claim Supplemental Information segment on the electronic claim(s) to which this certification applies to associate this documentation with the claim(s).

SIGNATURE BLOCK INSTRUCTIONS

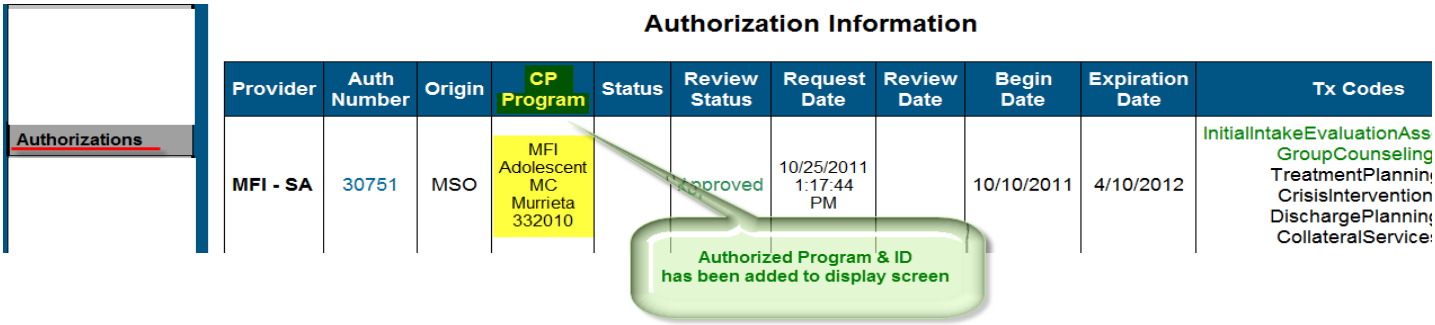
a. SIGNATURE: only authorized county or direct provider representatives should sign.

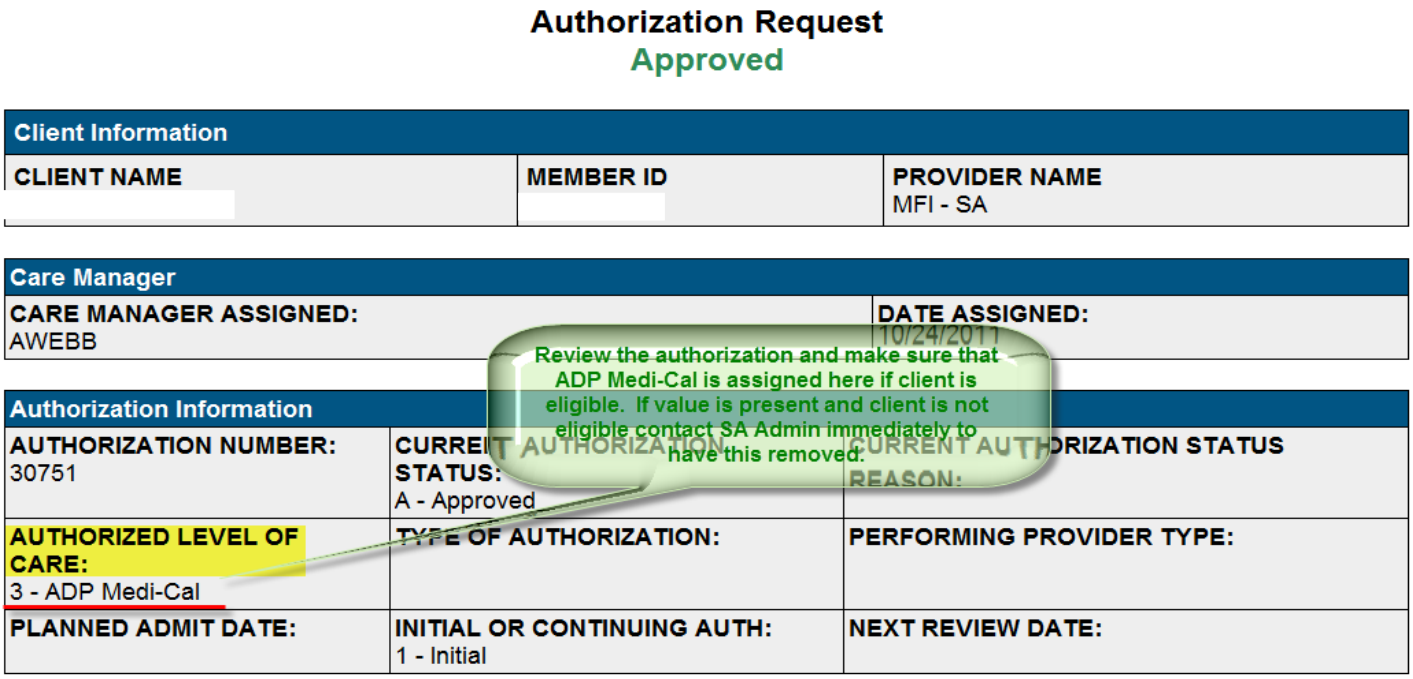
b. PHONE NUMBER: enter the area and code and phone number of the representative signing the form.

c. DATE: enter the date the form was signed by the authorized representative.

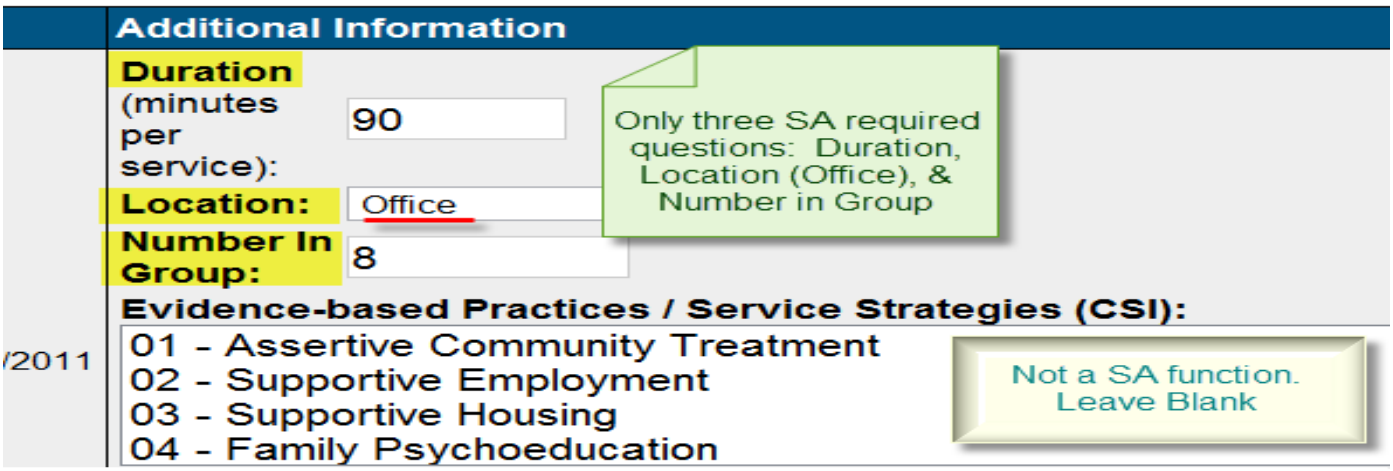
d. STATE USE ONLY: submitters should not enter any information in this area. It is for State use only.

PROVIDER CONNECT UPDATES 02/14/2012

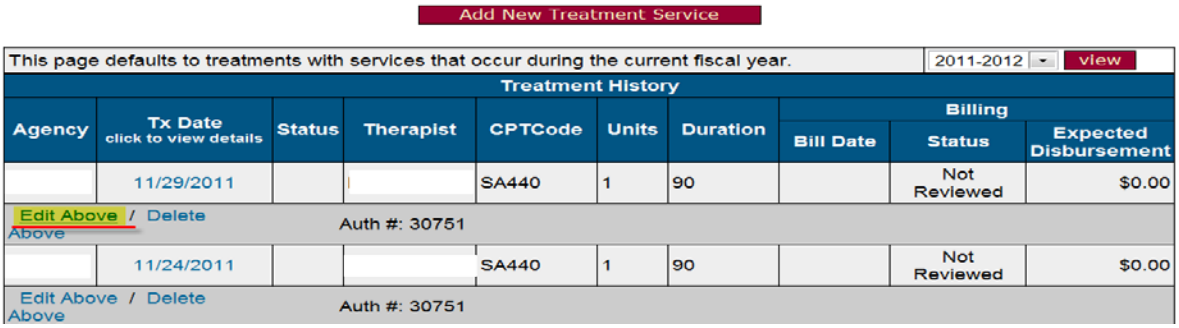




Reminder: Only <u>three highlighted questions</u> required for SA contracted services.

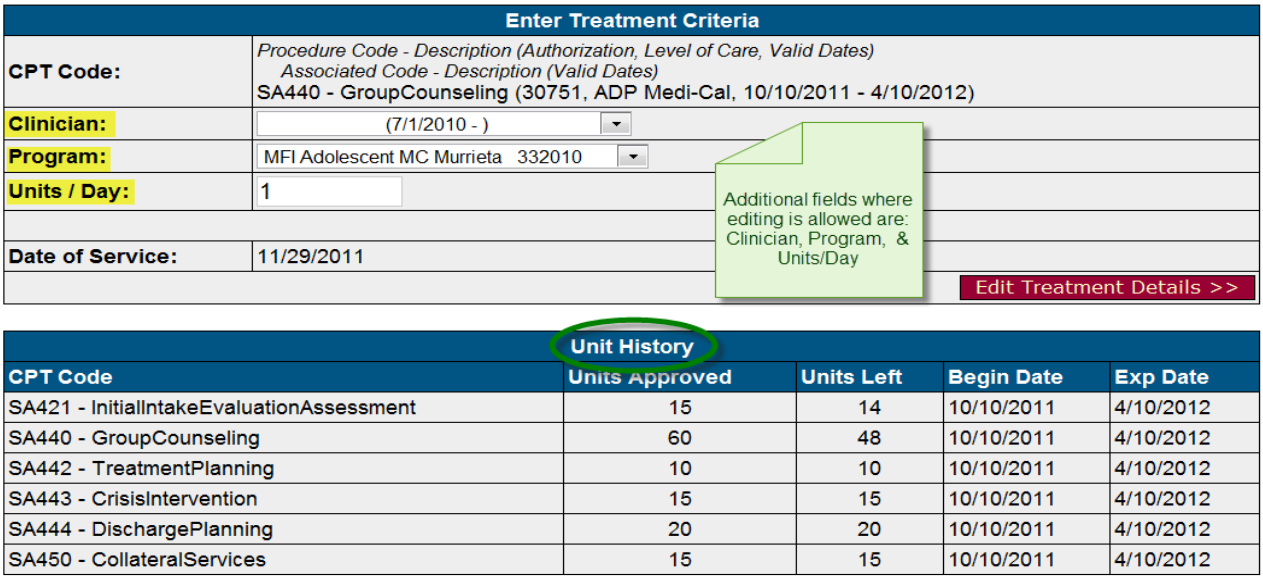


More fields added where editing is allowed.

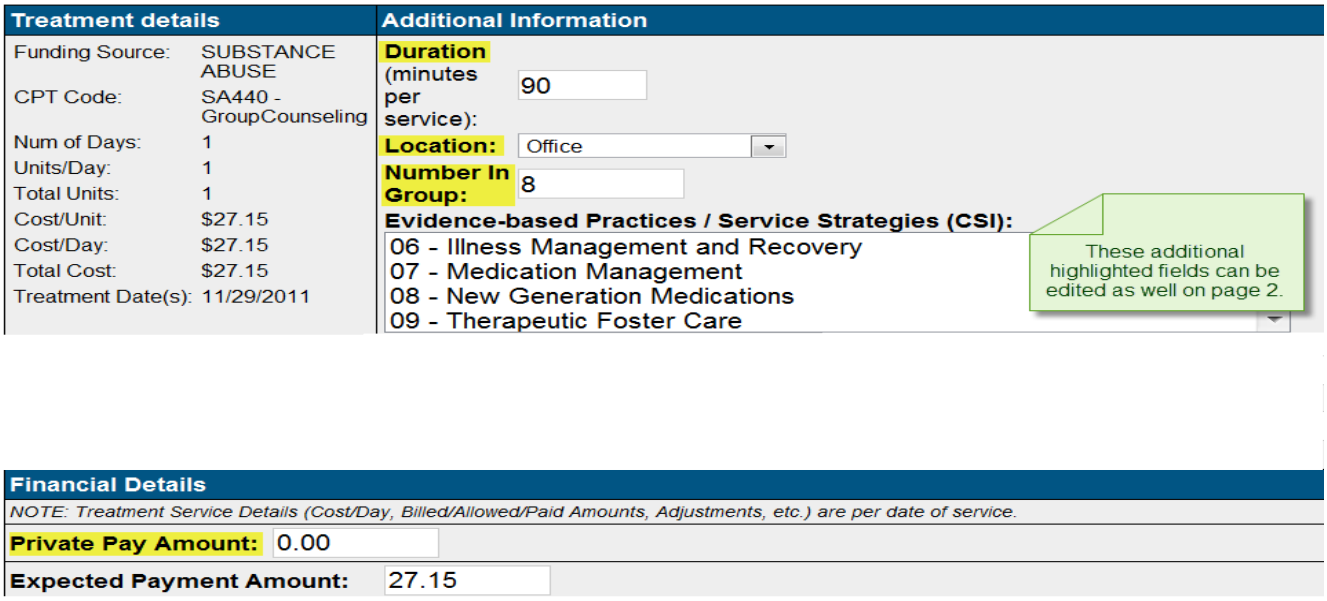


The allowed fields are highlighted below.

Page 1.



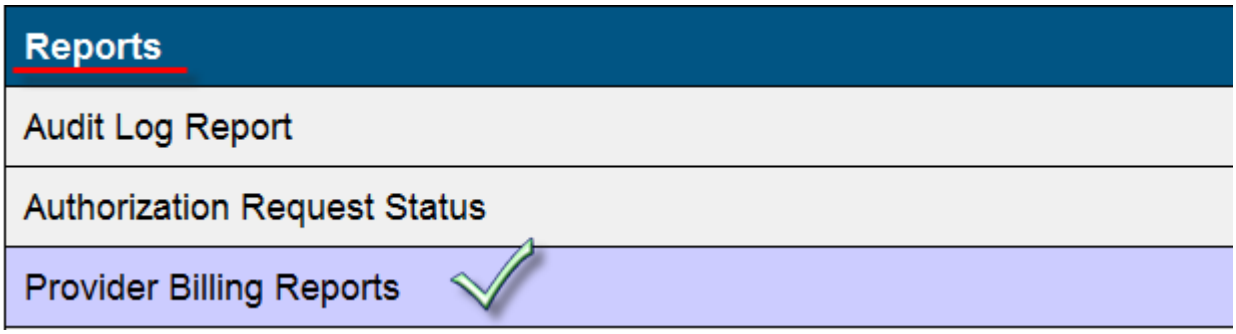
Page 2.



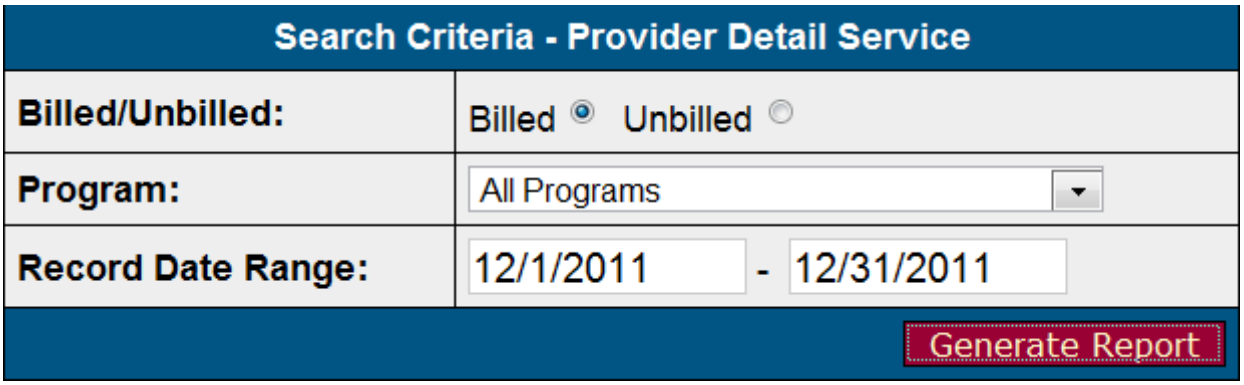
Update Treatment >> File.

Added Reports

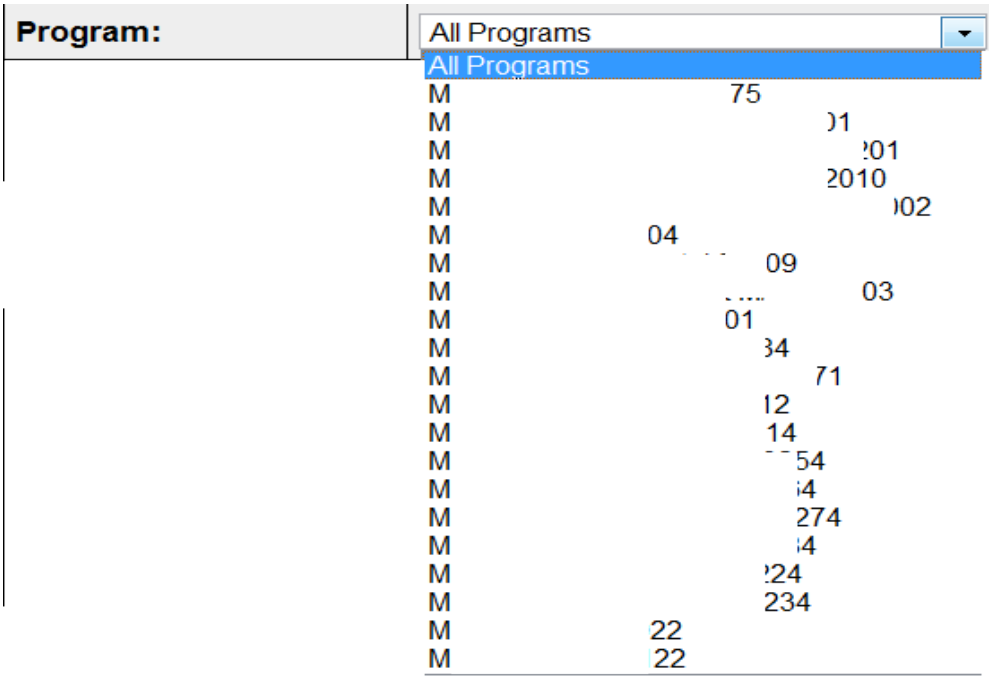
Provider Billing Reports has two options Detail or Summary.



DETAIL



For Program you can select "All Programs" within your agency or look at one program ID at a time.



Report "**Detail**" view of billed services.

Back **ProviderConnect - Provider Detail Service Report** 2/10/2012 2:48:48 PM Lookup Client | Main Menu | Log Out

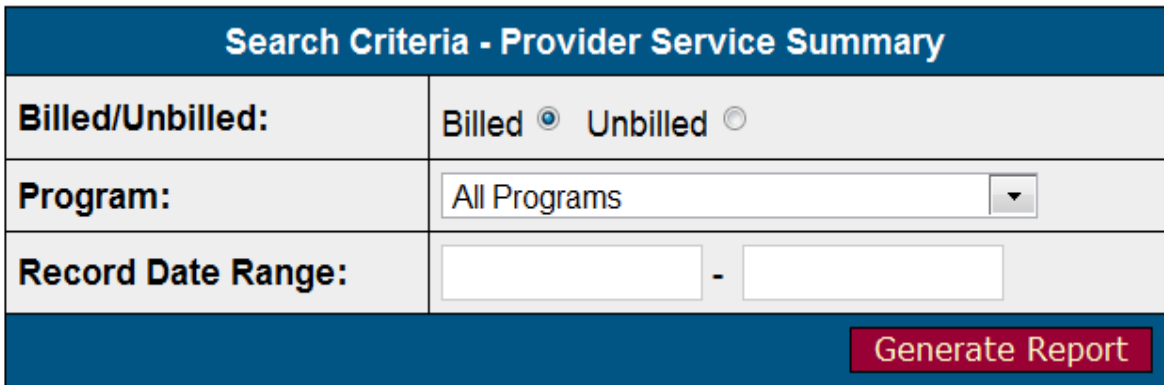
	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1.		Program Name & ID	960	S , C	10487	12/27/2011	Perinatal DCR Treatment Day (Individual)	1	180	Office	M	$70.14		Billed
2.			960	S , C	10487	12/22/2011	Perinatal DCR Treatment Day (Individual)	1	180	Office	M	$70.14		Billed

Report "**Detail**" view of unbilled services.

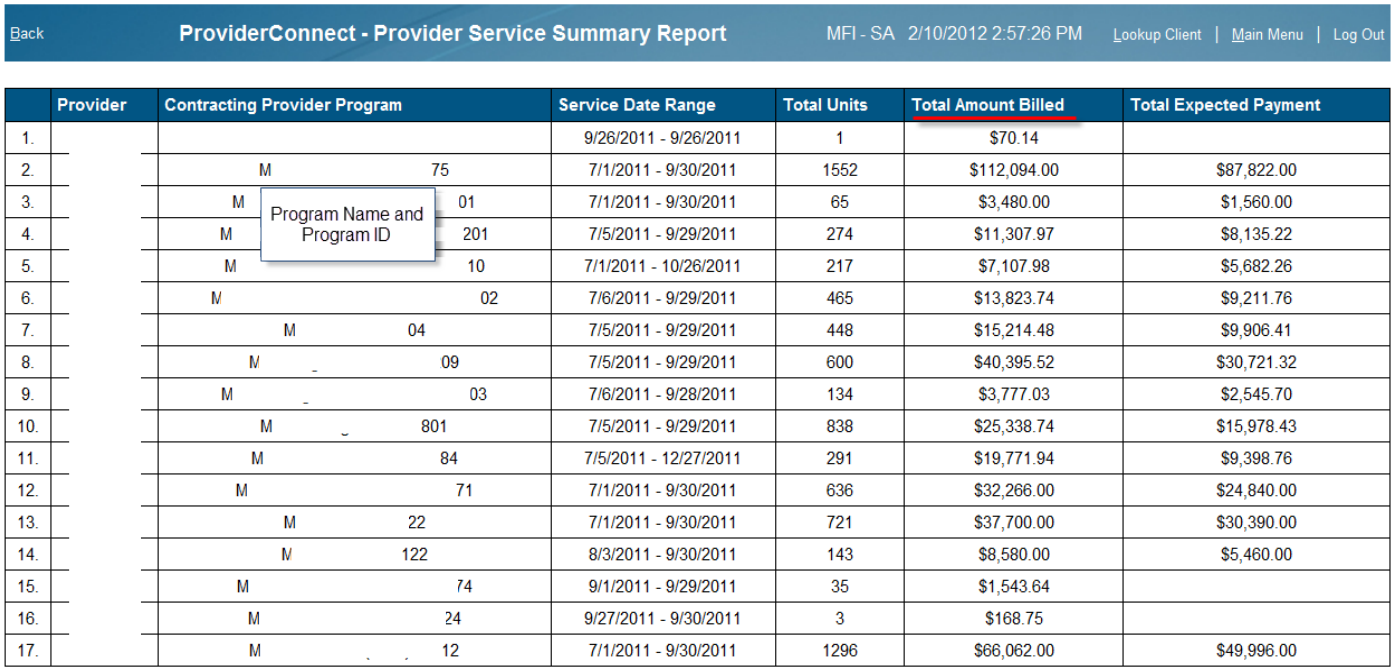
Back **ProviderConnect - Provider Detail Service Report** MFI - SA 2/10/2012 2:54:23 PM Lookup Client | Main Menu | Log Out

	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1.			970	H , A	30751	11/1/2011	GroupCounseling	1	90	Office	M	$27.15	N/A	Unbilled
2.			970	H , A	30751	11/3/2011	GroupCounseling	1	90	Office	M	$27.15	N/A	Unbilled
3.			970	H , A	30751	11/8/2011	GroupCounseling	1	90	Office	M	$27.15	N/A	Unbilled

SUMMARY

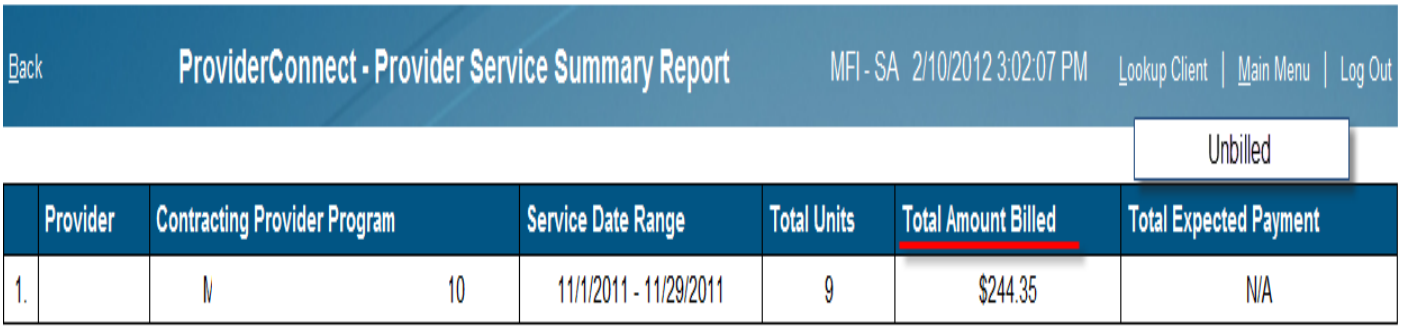


Report "**Summary**" view of billed services.



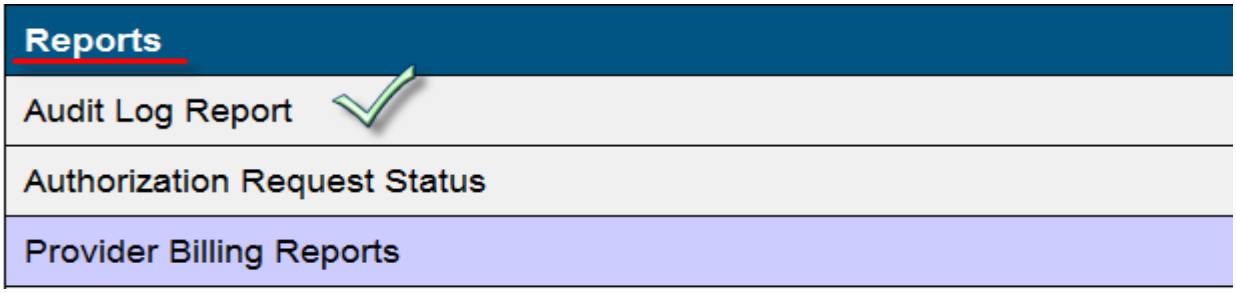
	Provider	Contracting Provider Program	Service Date Range	Total Units	Total Amount Billed	Total Expected Payment
1.			9/26/2011 - 9/26/2011	1	$70.14	
2.		M 75	7/1/2011 - 9/30/2011	1552	$112,094.00	$87,822.00
3.		M 01	7/1/2011 - 9/30/2011	65	$3,480.00	$1,560.00
4.		M 201	7/5/2011 - 9/29/2011	274	$11,307.97	$8,135.22
5.		M 10	7/1/2011 - 10/26/2011	217	$7,107.98	$5,682.26
6.		M 02	7/6/2011 - 9/29/2011	465	$13,823.74	$9,211.76
7.		M 04	7/5/2011 - 9/29/2011	448	$15,214.48	$9,906.41
8.		M 09	7/5/2011 - 9/29/2011	600	$40,395.52	$30,721.32
9.		M 03	7/6/2011 - 9/28/2011	134	$3,777.03	$2,545.70
10.		M 801	7/5/2011 - 9/29/2011	838	$25,338.74	$15,978.43
11.		M 84	7/5/2011 - 12/27/2011	291	$19,771.94	$9,398.76
12.		M 71	7/1/2011 - 9/30/2011	636	$32,266.00	$24,840.00
13.		M 22	7/1/2011 - 9/30/2011	721	$37,700.00	$30,390.00
14.		M 122	8/3/2011 - 9/30/2011	143	$8,580.00	$5,460.00
15.		M 74	9/1/2011 - 9/29/2011	35	$1,543.64	
16.		M 24	9/27/2011 - 9/30/2011	3	$168.75	
17.		M 12	7/1/2011 - 9/30/2011	1296	$66,062.00	$49,996.00

Report "**Summary**" view of unbilled services.

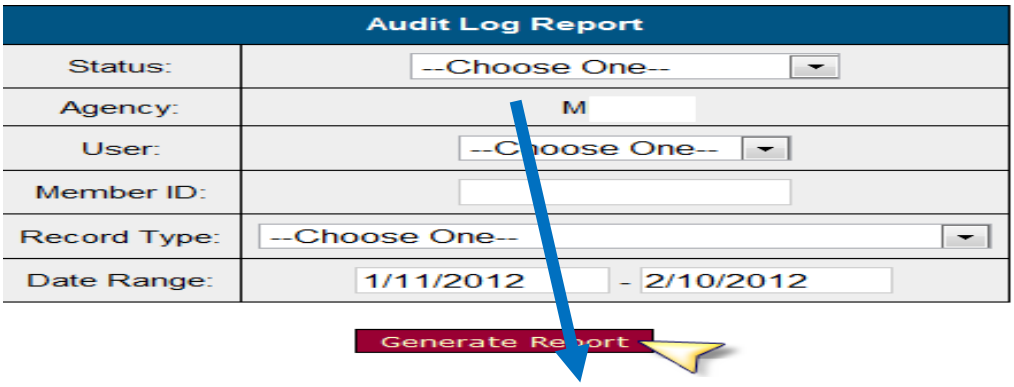


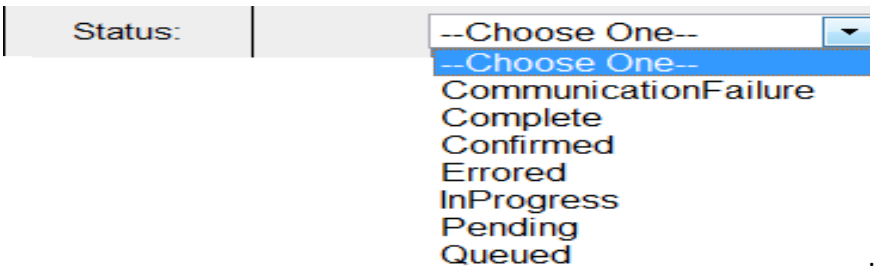
	Provider	Contracting Provider Program	Service Date Range	Total Units	Total Amount Billed	Total Expected Payment
1.		M 10	11/1/2011 - 11/29/2011	9	$244.35	N/A

Audit Log Reports



Several status' to choose from.





"**Errored**" status selected for sample.

"**Complete**" status selected for sample.