



MEDI-CAL UPDATE

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Program and Eligibility

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Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update may not always contain a "Billing and Policy" section.



The energy challenge facing California is real. The Department of Health Services encourages practical and feasible energy saving measures while considering the health and safety of clients, workers and family members.

HIPAA Transactions and Code Sets: Medi-Cal Implementation Plan

Medi-Cal is making every effort to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA). However, some of the HIPAA transactions and code set projects will not meet the October 16, 2003 implementation deadline. The following information describes what components of the HIPAA standards Medi-Cal will and will not implement by October 16, 2003. Providers must continue to follow existing billing instructions until otherwise notified in future *Medi-Cal Updates*. To accommodate the size and complexity of the transaction and code set projects, Medi-Cal will implement the HIPAA standards in multiple phases, which will extend beyond the October 16, 2003 compliance deadline. Therefore, it is important for providers to review monthly *Med-Cal Updates* over the coming year for detailed HIPAA billing instructions and implementation schedules.

Medi-Cal has tentatively scheduled the first implementation phase to become effective September 22, 2003. The following information provides more details about this first implementation of HIPAA standards.

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HIPAA (continued)

Transaction Standards Schedule

Medi-Cal will implement the following standards:

Transaction	Description	Standard Version	Implementation Date
* ASC X12N 837	Health Care Claims <ul style="list-style-type: none"> • Professional • Institutional 	004010X098A1 004010X096A1	September 22, 2003
** NCPDP	Retail Pharmacy Drug Claims	5.1 online 1.1 batch Compound Drug	April 29, 2002 April 29, 2002 September 22, 2003
ASC X12N 835	Health Care Claim Payment/Advice	004010X091A1	October 1, 2003 (For claims adjudicated on or after September 22, 2003)
ASC X12N 270/271	Health Care Eligibility Benefit Inquiry and Response	004010X092A1	After October 2003
ASC X12N 276/277	Health Care Claim Status Inquiry and Response	004010X093A1	After October 2003
ASC X12N 278	Health Care Services Review	004010X094A1	After October 2003
ASC X12N 820	Health Care Plan Payment	004010X061A1	Not applicable to Fee-For-Service Medi-Cal
ASC X12N 834	Health Care Plan Enrollment	004010X095A1	Not applicable to Fee-For-Service Medi-Cal

* Accredited Standards Committee (ASC X12N)

** National Council for Prescription Drug Programs (NCPDP)

Health Care Claims (ASC X12N 837)

Medi-Cal will begin accepting the ASC X12N 837 standard transaction (including Addenda) formats for Professional (004010X098A1) and Institutional (004010X096A1) claims September 22, 2003. Non-standard and proprietary electronic claim formats will be phased out after October 2003. During this phase-out, it is anticipated that some field values of the non-standard and proprietary electronic claim formats will be modified. Revised non-standard and proprietary Computer Media Claims (CMC) technical specifications identifying these changes will be made available in a future *Medi-Cal Update* and on the Medi-Cal Web site at www.medi-cal.ca.gov.

Some functionality of the ASC X12N 837 standard transaction will be implemented after October 2003, such as claim replacement (adjustments/voids), increased claim line limits (up to 50 lines for Professional and up to 999 lines for Institutional), provider-generated coordination of benefits for Medicare/Medi-Cal crossover claims and claims requiring attachments. Current Medi-Cal CMC specifications for electronic claim line limits, paper billing requirements and instructions for adjustments, voids and Medicare/Medi-Cal crossover claims will remain in effect.

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HIPAA (continued)

HIPAA mandates the use of standard code sets for transactions. These standard code sets include national drug codes, ICD-9-CM codes, CPT-4 codes and HCPCS codes. HIPAA also mandates the standardization of internal (administrative) code sets, such as condition codes, revenue codes, Place of Service codes, delay reason codes, patient status codes, etc. State-only local codes currently applied within Medi-Cal will be phased out. The conversion of local codes for medical service codes and internal or administrative codes will be similar to the current annual HCPCS update process in which code application is effective based on the date of service.

Medi-Cal will adopt the HIPAA standards for the following code sets on both electronic and paper claim forms:

Category/Type	Converted HIPAA Code Set	Implementation Plan	Implementation Date
Modifiers	HCPCS	Some local modifiers will be eliminated or converted to national codes	September 22, 2003
Chiropractic	NA	Benefit described by local code X1200 will be eliminated	September 22, 2003
Orthotics and Prosthetics	HCPCS Level II	End date use of local codes. National codes are already in use	September 22, 2003 (local codes will be turned off)
Vaccines and Immunizations	CPT-4 HCPCS Level I	Local codes will be end-dated. Convert to CPT-4 codes	September 22, 2003
HCPCS 2003	NA	2003 HCPCS Level I and II updates will be adopted	September 22, 2003
Condition Codes	Refer to values in the ASC X12 837I Implementation Guide	Full conversion of local codes to national codes on UB-92 Inpatient/Outpatient claim types	September 22, 2003
Occurrence Codes	Refer to values in the ASC X12 837I Implementation Guide	National code set standard implementation for the UB-92 Inpatient/Outpatient claim type	Already implemented
Value Codes	Refer to values in the ASC X12 837I Implementation Guide	Full conversion of local codes to national codes on UB-92 Inpatient/Outpatient claim types	September 22, 2003

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HIPAA (continued)

Category/Type	Converted HIPAA Code Set	Implementation Plan	Implementation Date
Revenue Codes	Refer to values in the ASC X12 837I Implementation Guide	Full conversion of local codes to national codes on UB-92 Inpatient/Outpatient claim types	September 22, 2003
Surgical Codes	ICD-9 Volume 3 Procedure Codes	Full conversion of HCPCS Level I CPT-4 surgical codes on the UB-92 Inpatient claim type to ICD-9 Volume 3 surgical procedure codes	September 22, 2003
Accident Injury Codes	Refer to values in the ASC X12 837I and 837P Implementation Guides	National code set standard implementation	Already implemented
Place of Service Codes	For institutional claims, refer to the ASC X12 837I Implementation Guide For professional claims, refer to the ASC X12 837P Implementation Guide	Full conversion of local codes to national codes on <u>all</u> claim types <u>except Pharmacy</u> (NCPDP patient locator codes are already in use)	September 22, 2003
Vision Qualifier Codes	Only used on proprietary claim format	Code set conversion	After October 2003
Delay Reason Codes	Refer to values in the ASC X12 837I and 837P Implementation Guides	Medi-Cal is adopting the industry standard nomenclature for this code set, formerly known as billing limit exception codes. Full conversion of local codes to national codes on <u>all</u> claim types <u>except Pharmacy</u> (NCPDP codes are already in use)	September 22, 2003

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HIPAA (continued)

Category/Type	Converted HIPAA Code Set	Implementation Plan	Implementation Date
Patient Status Codes	Refer to values in the ASC X12 837I and 837P Implementation Guides	Full conversion of local codes to national codes on <u>all</u> claim types <u>except Long Term Care (LTC) and Pharmacy</u> (NCPDP codes are already in use)	September 22, 2003 (with the exception of LTC patient status codes, which will be converted after October 2003)

Medi-Cal will continue to phase in the conversion of all other local codes not identified above after October 2003. To ensure timely reimbursement, providers should continue to follow existing Medi-Cal billing instructions until otherwise instructed.

Provider feedback is critical to the success of code conversion. As Medi-Cal continues reviewing the correlation between local and national codes, providers, provider groups and associations will be encouraged to participate in feedback forums. Further details will be published as this effort progresses. Medi-Cal is planning to publish code conversion correlation tables early this summer to facilitate provider transition and preparedness.

Medi-Cal’s claims system is expanding to accommodate the use of up to four modifiers per claim line. However, the policy of multiple modifiers is still being evaluated and developed. As policies are defined for using multiple modifiers, billing instructions for both electronic and paper claim billing will be developed and released in a future *Medi-Cal Update* and on the Medi-Cal Web site.

Medi-Cal anticipates significant changes for both electronic and paper billing submission requirements over the course of the year. These changes will be communicated in *Medi-Cal Updates*, the Medi-Cal Web site and provider training sessions. Please check the Medi-Cal Web site and provider bulletins regularly for the latest information regarding these changes.

Retail Pharmacy Claims

Medi-Cal began accepting retail pharmacy drug claims in both the National Council for Prescription Drug Programs (NCPDP) Version 5.1 (Telecommunication) and Version 1.1 (Batch) on April 29, 2002. NCPDP Version 3.2 (Telecommunication) will be phased out. In addition, CMC Medi-Cal Proprietary Pharmacy Version (Batch) is no longer accepted. To correspond with the data element changes mandated by the NCPDP electronic standard, the paper Medi-Cal *Pharmacy Claim Form* (30-1) was modified. The previous version (Version 5) of the claim form was discontinued effective October 1, 2002.

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HIPAA (continued)

Medi-Cal will begin accepting retail pharmacy compound drug claims in the NCPDP Version 5.1 (Telecommunication) standard September 22, 2003. Draft Technical Specifications will be posted to the Medi-Cal Web site later this spring. To correspond with the data element changes mandated by the NCPDP electronic standard for compound drugs, a new paper Medi-Cal *Pharmacy Compound Drug Claim Form* (30-4) will be implemented. Additional information regarding compound drug electronic submission, the new claim form and associated billing instructions will be communicated in future *Medi-Cal Updates* and on the Medi-Cal Web site. Please check the Medi-Cal Web site and provider bulletins regularly for the latest information regarding these changes.

At this time, Medi-Cal system modifications to accept NCPDP eligibility and prior authorization transactions are being evaluated. Implementation dates have not been scheduled.

Remittance Advice (Health Care Claim Payment/Advice) for all Claim Types (ASC X12N 835)

Medi-Cal will begin generating the ASC X12N 835 004010X091A1 standard transaction (including Addenda) format for the claims remittance advice October 1, 2003 for claims adjudicated on or after September 22, 2003. Providers who elect to receive an electronic remittance advice in the 835 standard transaction format will be able to download the remittance advice from the Internet Bulletin Board System (IBBS) beginning October 1, 2003. In addition to the Adjustment Reason codes required in the standard transaction format, Medi-Cal has elected to provide the situational Health Care Remarks codes as well. The Health Care Remarks codes provide an additional level of detail not contained in the Adjustment Reason codes. Medi-Cal has begun correlating the Adjustment Reason codes and Remarks codes with the Remittance Advice Details (RAD) codes currently used on the paper remittance advice. It is not anticipated that all RAD code correlations to Remarks codes will be finalized by October 1, 2003. However, Medi-Cal plans to publish code conversion correlation tables this spring to facilitate provider transition and preparedness.

Providers who currently receive electronic remittance advice via the Automated Remittance Details Services (ARDS) may continue to do so. There will be modifications to ARDS after October 2003, which will be communicated in a future *Medi-Cal Update* and on the Medi-Cal Web site.

Health Care Eligibility Benefit Inquiry and Response (ASC X12N 270/271)

Medi-Cal will not implement the ASC X12N 270/271 standard transactions by October 2003. Medi-Cal currently uses the fields associated with the ASC X12N 270/271 standard transactions for processing eligibility information in real time. The current Medi-Cal system was developed using the ASC X12N 270/271 3070 version transaction standard. At a later date, the system will be updated to the 004010X092A1 implementation guide specifications and a new batch eligibility transaction will be developed.

No major changes will be made to these interactive eligibility verification applications: Automated Eligibility Verification System (AEVS), Point of Service (POS) device and Web application. However, the Claims and Eligibility Real-Time System (CERTS) software will be phased out by October 2003.

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HIPAA *(continued)***Health Care Claim Status Inquiry and Response (ASC X12N 276/277)**

Medi-Cal will not implement the ASC X12N 276/277 batch standard on the IBBS by October 2003. At a later date, the existing Automated Provider Services Web claims status application will be modified to accept the national claims status codes. Potential changes to the claim status transactions on the Provider Telecommunications Network (PTN) are being evaluated at this time.

Health Care Services Review/Treatment Authorization Request (ASC X12N 278)

Medi-Cal will not implement the ASC X12N 278 standard transaction by October 2003. Medi-Cal continues to develop and enhance the functionality of the Web-based electronic Treatment Authorization Request (eTAR). This application reflects format and content requirements of the ASC X12N 278 transaction standard, but it is not HIPAA-compliant. Medi-Cal will assess and evaluate the changes mandated in the Addenda for this transaction. Eventually, implementation of the ASC X12N 278 transaction will be available via the Internet and electronic batch transactions.

Health Care Plan Payment (ASC X12N 820)

Because Fee-For-Service Medi-Cal does not currently perform the business function defined in the federal regulation for the ASC X12N 820 standard transaction, it is not applicable to the EDS claims processing system and will not be implemented.

Health Care Plan Enrollment (ASC X12N 834)

Because Fee-For-Service Medi-Cal does not currently perform the business function defined in the federal regulation for the ASC X12N 834 standard transaction, it is not applicable to the EDS claims processing system and will not be implemented.

Functional Acknowledgement (not mandated by HIPAA)

Medi-Cal currently provides a proprietary acknowledgement for all electronic submissions that gives more information than the non-mandated standard 997 Functional Acknowledgement. Therefore, Medi-Cal has opted to continue use of the proprietary acknowledgement for all electronic transactions, including the new ASC X12N 837 version 4010A1.

Unsolicited Claim Status (not mandated by HIPAA)

Medi-Cal does not plan to use the ASC X12N 277 version 3070 Health Care Payer Unsolicited Claim Status to convey pended claim information in an unsolicited manner. Pended claim information can still be obtained from the paper RAD or from ARDS.

Other Non-Mandated Transactions

There are several other non-mandated transactions such as the ASC X12N 277 (Health Care Claim Acknowledgement) and the ASC X12N 824 (Implementation Reporting Guide) that HIPAA-covered entities may opt to implement to report various transaction level errors. Medi-Cal will not be adopting any of these non-mandated transactions at this time.

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HIPAA *(continued)***Testing**

Medi-Cal is not currently prepared to accept or acknowledge test transactions from its trading partners. However, electronic billing activation and media testing for the ASC X12N 837 Professional (004010X098A1) and Institutional (004010X096A1) standard transactions will be required for all CMC submitters.

Medi-Cal will perform beta testing for transaction submission, system processing and remittance advice generation with a pre-determined select group of providers, submitters, vendors and clearinghouses. Beta tests are currently scheduled for mid to late summer for both the ASC X12N 835 and ASC X12N 837 transactions. More information regarding testing will be provided in future *Medi-Cal Updates* and on the Medi-Cal Web site.

Technical Specifications (Companion Guides)

Medi-Cal is adopting the industry standard nomenclature for technical specifications. As a result, X12N-based specifications will now be referred to as Companion Guides. NCPDP-based specifications will continue to be referred to as Technical Specifications.

Currently, Medi-Cal draft Companion Guides are available on the Medi-Cal Web site by clicking “HIPAA Update” and then “Draft HIPAA ASC X12N Technical Specifications.” Medi-Cal does not expect substantive changes to the draft specifications and encourages providers, submitters, vendors and clearinghouses to review them and prepare for internal testing based on these guides. These drafts will be finalized following the testing phase scheduled for June through September. The Companion Guides will be published in their final form by October 2003.

As stated earlier, Medi-Cal plans to post draft NCPDP Telecommunications 5.1 compound drug Technical Specifications to the Medi-Cal Web site later this spring. Similar to the Companion Guide schedule, the specifications will be finalized following the testing phase slated for late summer, and published in their final form by October 2003.

Medi-Cal is introducing a new protocol for communicating changes to draft Companion Guides and Technical Specifications. During the draft timeframe, corrections will be addressed on a monthly basis, as needed. A change log will also be included to identify at a glance which sections have been refreshed. Please check the Medi-Cal Web site regularly for the latest information regarding these publications.

Frequently Asked Questions

Medi-Cal has developed a Frequently Asked Questions section regarding HIPAA, which can be accessed on the Medi-Cal Web site by clicking “HIPAA Update” and then the “HIPAA Frequently Asked Questions.” Providers are encouraged to check the Web site for weekly updates. For more information about HIPAA and Medi-Cal’s implementation plan, call the Provider Support Center (PSC) at 1-800-541-5555 and select prompt option “4.”