SUBSTANCE USE DISORDER TREATMENT SERVICES PROVIDER MANUAL
ADDENDUM

Sage – The Patient Information Management System: Services, Data, and Claims

System Transformation to Advance Recovery and Treatment, Los Angeles County's Substance Use Disorder Organized Delivery System

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

COMPANION GUIDE

HIPAA 837P

Health Insurance Portability and Accountability Act
Industry-wide standards for health care electronic billing, data privacy and security provisions for medical information.
Additional information to SDMC Drug Medi-Cal Medicare NTP(OTP) Claiming Instructions

June 2024 (Version 2.8)

Disclosure Statement

This document represents the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control implementation instructions for electronic claim transactions. It is believed to be compliant with all ASC X12 intellectual property requirement.

Document Revision History

Version	Release Date	Comments
1.0	11/20/2017	Sage Project – Initial Document Release
2.0	10/23/2018	Sage Project – Updated Document Release
2.1	07/23/2019	Sage Project – Updated Document Release
2.2	11/05/2020	Updated CTP05-1 segment for NDC in Loop 2410
2.3	05/07/2021	Updated LX Segment Counter(s) to bill multiple NDC codes
2.4	10/20/2021	Added Place of Service codes, Telehealth/Telephone Modifiers
2.5	03/10/2023	PRV - Billing Provider Specialty, SBR09 - Claim Filing Code
2.6	08/15/2023	DMC Medicare NTP(OTP) Claiming Instructions
2.7	01/31/2024	SV103 - Professional Service
2.8	06/18/2024	Procedure Code Modifier Order

Preface

This Companion Guide to the version 5010 ASC X12N Implementation Guides and associated errata adopted under Health Insurance Portability and Accountability Act (HIPAA) clarifies and specifies the data content when exchanging electronically with Los Angeles County "LAC" Substance Abuse Prevention Control Department "SAPC". Transmissions based on this Companion Guide, used in tandem with the v5010 ASC X12N Implementation Guides, are compliant with both ASC X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

This Companion Guide addresses specific SAPC business processes required for transmitting claims data to the SAPC Sage System. In addition to the SAPC business requirements, all 837 Professional transactions submitted to Sage must be compatible with all HIPAA requirements. It is assumed that trading partners are familiar with ASC X12 transactions and does not attempt to instruct trading partners in the creation of an entire HIPAA transaction.

This Companion Guide is subject to change. If you have any questions, please contact SAPC.
Sage@ph.lacounty.gov

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Section 1. Introduction

Scope

This Companion Guide is intended to be used by SAPC contracted providers in support of the following ASC X12 transaction implementations mandated under HIPAA:

- ASC X12 Health Care Claim: Professional (837) as specified in guide 005010X222 and 005010X222A1 (837P)

These guides are available for purchase from ASC X12 at http://store.X12.org/

Overview

Section 2 provides information about establishing a trading partner relationship with SAPC.

Section 3 provides a Process Flow of the claiming transactions.

Section 4 identifies Electronic Data Interchange (EDI) related contacts within SAPC.

Section 5 provides operational information.

Section 6 provides the SAPC specific business rules and limitations.

Section 7 provides the SAPC technical requirements for file exchange and the envelope segments.

Section 8 provides the SAPC requirements and usage for the 837 claiming transactions.

Section 9 identifies the SAPC acknowledgment transactions.

Appendix A provides sample 837 transactions.

References

This information must be used in conjunction with the ASC X12 Implementation Guides. They are available at http://www.wpc-edi.com/.

Section 2. Getting Started

Trading Partner Registration

Trading Partners

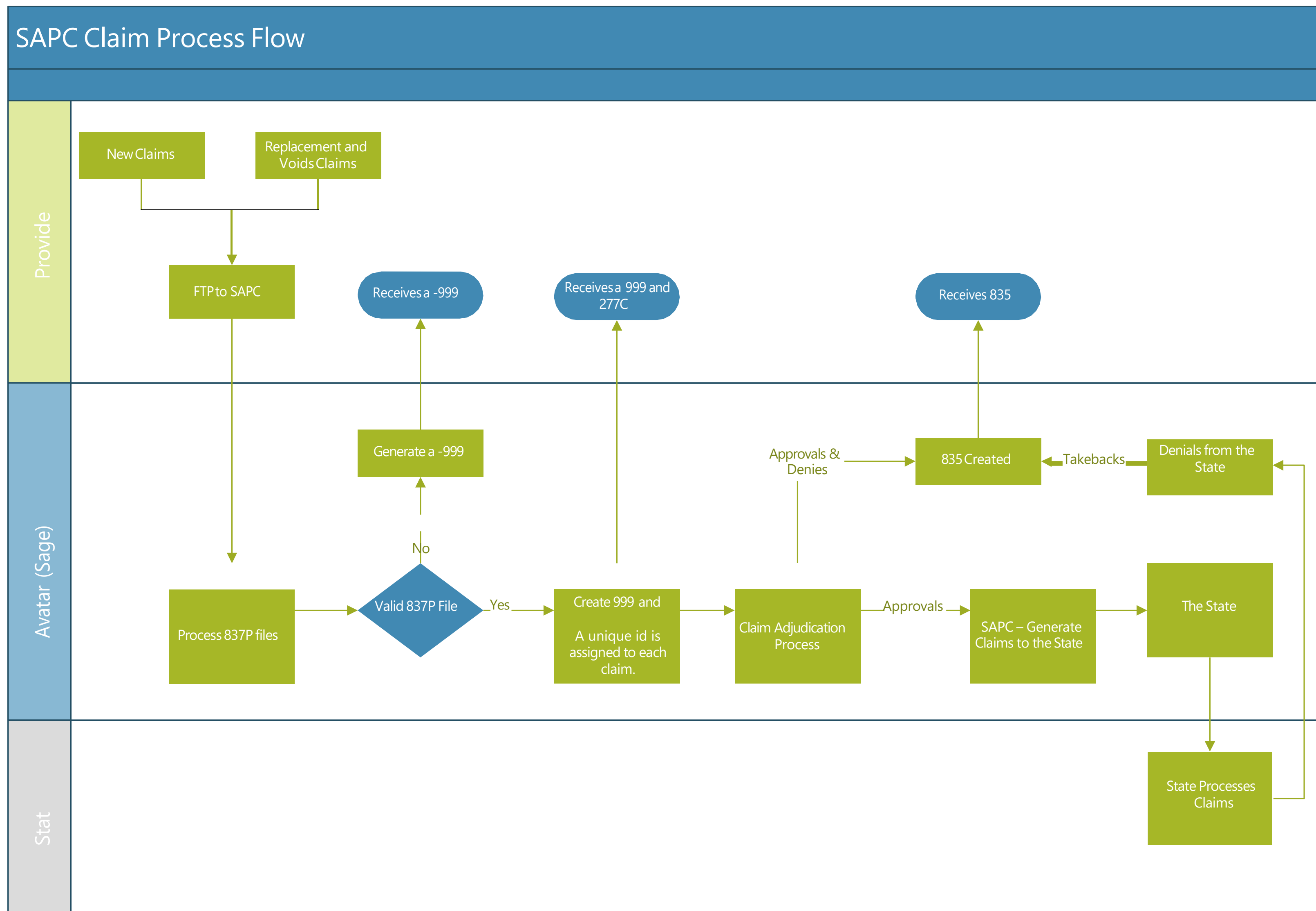
An EDI Trading Partner is defined as any SAPC customer (provider, billing service, software vendor, financial institution, etc.) that transmits to, or receives from SAPC any standardized electronic data (i.e. HIPAA claim or remittance advice transactions).

You can find additional information on registering for EDI by contacting SAPC at following address:

Attn: SAPC EDI Coordinator
County of Los Angeles, SAPC
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, CA 91803

(626) 299-4551
sapc_support@ph.lacounty.gov

Section 3. Process Flow



Section 4. Contract Information

EDI Customer Service/Technical Assistance

SAPC EDI Coordinator
(626) 299-4551
sapc_support@ph.lacounty.gov

County of Los Angeles, SAPC
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, CA 91803

Section 5. Operational Information

Hours of Operation

Unless otherwise notified claims processing will occur between 8:00AM to 5:00PM PST, Monday through Friday.

Section 6. SAPC/Sage Business Rules and Limitations

Business rules for inbound 837P Transactions

1. All clients must be created in Sage prior to claiming. The client must be identified by a unique Client ID assigned by Sage. The client ID number must be prefixed with the letters 'MSO' in loop 2010BA/NM109 Subscriber Primary Identifier field.

2. Financial Eligibility must be entered in Sage for each client prior to claiming. Each client must have the correct guarantors associated with the client's admission. In addition, the following fields must be completed prior to claiming:

    - Client's Relationship to Subscriber
    - Subscriber's First Name
    - Subscriber's Last Name
    - Subscriber's Gender
    - Subscriber's Date of Birth
    - Subscriber's Address Information
    - Subscriber's Client Index Number (CIN), if DMC Enrolled. If Patient is non-DMC, leave blank.
    - Verified Eligibility with a date prior to the date of service on the claim
    - Subscriber's Assignment of Benefits
    - Subscriber's Release of Information

3. A diagnosis must be entered on the "Provider Diagnosis ICD 10" form on SAGE.

4. All provider facilities must be set up in Sage. Each facility is required to have a unique NPI number for electronic billing. The NPI number will be used to identify the facility providing services to the client.

5. SAPC requires an authorization for all services in the 2400/REF02 segment. While there are two types of authorizations (Member Auths and Provider Auths). A provider will put only one authorization on a claim line.

- Provider Authorizations, or P-Auths, are specific to a Contracting Provider and to a Funded Program/Funding Source. Generally, Provider Authorizations will be published by SAPC for each fiscal year. In FY18-19 and beyond, these authorizations are typically used for incentive payments. These Authorizations always start with the letter 'P' and can be billed without further authorization subject to rules established by SAPC and Drug Medi-Cal for client eligibility.

- Member Authorizations or Service Authorization, are specific to a client and a Contracting Provider. They are used to authorize all treatment services. Member Authorizations are also tied to a Funded Program/Funding Source and will ensure verifications are conducted during patient enrollment. Member Authorizations are requested via the Sage system. Member Authorizations are always all numeric. Providers should only submit claims on approved member authorizations in the 837 file, as claims on Member Authorizations that are not approved will automatically be denied.

6. The Rendering Provider, or Practitioner, must be set up and associated in Sage with the Provider prior to billing. All Rendering Providers must have a NPI set up in Sage. The NPI number will be used to match the clinician on the inbound claim with the clinician associated with the Provider in Sage. Rendering Provider updates should be communicated to SAPC on a timely basis.

7. The Rendering Provider's Discipline will be determined based on the information stored in Sage. Beginning January 1, 2023, all peer support claims must include rendering Peer Support Specialists provider's taxonomy code of "175T00000X" for reimbursement. SAPC will utilize the Rendering Provider's taxonomy in the PRV segment for all services beginning FY23-24. Any updates to the Practitioner's Discipline will need to be communicated to SAPC on a timely basis.

8. Group Claims

   - Services for group claims are subject to the group billing calculation established by SAPC and Drug Medi-Cal. The amount reported on the claim must be the results of this calculation. Providers can only claim the portion of the service that applies to the client being claimed.

9. Procedure Code Modifier Order

   For a transaction to be HIPAA-compliant, a procedure code cannot use more than four modifiers. The following modifier order must be used when submitting claims to SAPC.

   A. Specified Modifier Order

   - ASAM Level of Care (LOC)
   - Special Population (Youth, Perinatal)
   - Place of Service (Telehealth)
   - Lockout (XU, XE, 59, 27)
   - Clinical Trainee/Student

   Run the MSO PROVIDER CONFIG REPORT FY2023+ in PCNX to see a listing of the complete HCPC/CPT code set with relevant modifiers that your site has been configured to claim. This report will support your agency in identifying the code and modifier combinations to use for services.

B. Trainee Modifiers Specifics

1. Clinical Trainee/Student Modifier will always be the last modifier and if a modifier needs to be dropped to accommodate it, the place of service (telehealth 93 ,95, SC, GQ) modifier will be dropped.
2. HL/GC will not be used in conjunction with Clinical/Student Trainee Modifiers

C. Modifiers to Drop if Needed.

In rare situations that a service would exceed four modifiers per procedure code in each transaction, do not use telehealth modifiers. If not using telehealth modifiers is not enough to keep transaction under four modifiers, do not to include modifiers HL (Intern) and GC (Resident). If more modifiers need to be dropped, remove modifiers that do not affect payment determination. For a complete listing of modifiers please refer to the modifiers subtab located on the http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins

10. All services for fiscal year 23-24 and later, must be reported in 'UN' (units) as the Unit or Basis of Measurement Code in SV103. For Residential day rate claims, one day equals 1 unit.

    - For group services delivered through 06/30/2023 services must be reported in 'MJ' (minutes) as the Unit or Basis of Measurement Code in SV103.

11. The following elements are used by Sage to identify and validate the client:

    - Client ID – 2010BA/NM109 Subscriber Primary Identifier. The Subscriber Primary number will be assigned by SAPC during the admission process. The Subscriber Primary number must have a prefix of 'MSO' in front of client ID to avoid billing errors.
    - Gender – 2010BA DMG03 Subscriber Gender Code.
    - Date of Birth – 2010BA DMG02 Subscriber Birth Date.

12. Services per claim

    - SAPC allows to submit claims as one service per claim or multiple services per claim. Supplemental codes must be entered on the same claim number as the primary code. OTPs submitting OHC Medicare claims for additional Medi-Cal reimbursement must also be submitted as multiple services per claim.

13. SAPC Health Care Claim Payment/Advice (835)

    - Providers will receive an 835 for all Approved and Denied claims at the time that the claim is adjudicated, and the provider receives payment.
    - Providers will receive a separate 835 with just denied claims.
    - Per the national HIPAA 835 guide, Sage uses the Claim Status Code values 1, 2 and 3 (CLP02) when adjudicating original claims, regardless of whether the claim was approved or denied. Sage does not return the Claim Status Code 4 when a claim is denied.

14. Retroclaim Adjudication

    - Drug Medi-Cal claims that are subsequently denied by the State will result in a second 835, known as a retroclaim adjudication. Retroclaim adjudication 835s follow all the standard HIPAA 835 requirements for reversals and corrections.

15. Replacement Claims

- Replacement claims must reference the Sage Original Reference Number in the REF segment of the 2100 loop of the 835. This reference number is used by Sage to match the replacement claim to the original claims.
  Example: REF*F8*123456.
- You can only replace an original claim one time. If you need to make an additional replacement, replace the replacement claim, not the original.
- Any amount differences between the original amount approved and paid by Sage will be adjusted on the next 835.

16. Voided Claims

- A void of an approved claim will result in a retro claim adjudication ("takeback") on the subsequent 835.
- Do not send voided claims in response to SAPC/Sage denials, i.e., any claim that was not paid in the initial adjudication cycle.
- Voided claims can only be submitted after the claim has been adjudicated in Sage and the Provider has received an 835 with the Sage assigned claim ID number.

17. Telehealth and Telephone Services

Services provided using telehealth or telephone must have the appropriate modifier in the SV101 line and the appropriate place of service code in the SV105 line.

	Place of Service Code	Modifier
Telehealth	02, 10	GT, 95, GQ
Telephone	02	SC, 93

Examples:

Telehealth:
SV1*HC:S5000:UA:HG:GT*19.12*UN*1*02**1
SV1*HC:99368:U7:GQ*204.35*UN*1*10**1
SV1*HC:90849:U7:95*102.17*UN*1*02**1

Telephone 02 SC
SV1*HC:S5000:UA:HG:SC*19.12*UN*1*02**1
SV1*HC:T1013:U7:93*59.44*UN*4*02**1

Section 7. File Exchange/File Structure/Control Segments

File Exchange

Test and Production 837P files should be placed on secured File Transfer Protocol (FTP) in your agency's specific 837 folder. SAPC will provide a Username and Password for this secure site. 277CA and 835 files will be returned in the same site in your agency's 835 folder accessible. It is provider's responsibility to email the SAPC EDI Coordinator when files are uploaded.

File Requirements

837 claims file cannot contain carriage returns. The data must be wrapped as in a true EDI file.

ISA-IEA on Inbound Transactions

ISA – Interchange Control Header		
ISA01	Authorization Information Qualifier	SAPC expects ‘00’.
ISA03	Security Information Qualifier	SAPC expects ‘00’.
ISA05	Interchange ID Qualifier	SAPC expects ‘30’.
ISA06	Interchange Sender ID	The Provider’s Federal Tax ID with no dash followed by 6 spaces
ISA07	Interchange ID Qualifier	SAPC expects ‘30’.
ISA08	Interchange Receiver ID	SAPC’s Federal Tax ID Number with no dash followed by 6 spaces
ISA16	Component Element Separator	All outbound EDI will use the colon (“:”) as the Component Element Separator.

GS-GE on Inbound Transactions

SAPC accepts only one Functional Group per Interchange

GS – Function Group Header		
GS01	Functional Identifier Code	HC = Health Care Claim 837
GS02	Application Senders Code	The Provider’s Federal Tax ID Number
GS03	Applications Receiver Code	Sage’s Federal Tax ID Number
GS08	Version / Release / Industry Identifier Code	005010X222A1 = Standards Approved for Publication by ASC X12

ST-SE on Inbound Transactions

ST – Transaction Set Header		
ST01	Transaction Set Identifier Code	837 = Health Care Claim
ST02	Transaction Set Control Number	ST Segment Counter starting at 1 for every ISA/GS Segment
ST03	Implementation Convention Reference	This field contains the same value as GS08

Section 8. Transaction Specific Information

Health Care Claim Processional (837P)

Segment ID	HIPAA Field Name	Default Value	Comments
Submitter Name - Loop 1000A			
NM1 – Submitter Name			
NM101	Entity Identifier Code	41	41 = Submitter
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Submitter Last or Organization Name		
NM104	Submitter First Name		
NM105	Submitter Middle Name		
NM108	Identification Code Qualifier	46	Established Trading Partners
NM109	Submitter Identifier		Federal Tax ID
PER – Submitter EDI Contact Information			
PER01	Contact Function Code	IC	IC = Information Contact
PER02	Submitter Contact Name		
PER03	Communication Number Qualifier	TE	TE = Telephone Number
PER04	Communication Number		
PER05	Communication Number Qualifier		
PER06	Communication Number		
PER07	Communication Number Qualifier		
PER08	Communication Number		

RECEIVER NAME - LOOP 1000B

NM1 – Receiver Name			
NM101	Entity Identifier Code	40	40 = Receiver
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Receiver Name		Los Angeles County SAPC
NM104	Name First		
NM108	Identification Code Qualifier	46	46 = Electronic Transmitter Identification Number (ETIN)
NM109	Receiver Primary Identifier		SAPC001

BILLINGPROVIDERHIERARCHICALLEVEL

HL – Billing Provider Hierarchical Level (2000A)			
HL01	Hierarchical ID Number		The first HL01 within each ST-SE envelope must begin with 1, and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	20	Information Source
HL04	Hierarchical Child Code	1	Additional Subordinate HL Data Segment in This Hierarchical Structure.
Billing Provider Name (2010AA)			
NM101	Entity Identifier Code	85	85 = Billing Provider
NM102	Billing Provider Entity Type Qualifier		1 = Person 2 = Non-Person Entity
NM103	Billing Provider Last or Organization Name		
NM104	Billing Provider First Name		
NM105	Billing Provider Middle Name		
NM107	Billing Provider Name Suffix		
NM108	Identification Code Qualifier		
NM109	Billing Provider Identifier		NPI Number
N3 – Billing/Provider Address Information			
N301	Billing Provider Address Line		
N302	Billing Provider Address Line		
N4 – Billing/Provider City/State/Zip Code			
N401	Billing Provider City Name		
N402	Billing Provider State or Province Code		
N403	Billing Provider Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		

REF – Billing Provider Tax Information			
REF01	Reference Identification Qualifier	EI	EI = Employer's Identification Number SY = Social Security Number
REF02	Reference Identification		Tax ID
PER – Billing Provider Contact Information			
PER01	Contact Function Code	IC	IC = Information Contact
PER02	Billing Provider Contact Name		
PER03	Communication Number Qualifier	TE	TE = Telephone
PER04	Communication Number		
PER05	Communication Number Qualifier		
PER06	Communication Number		
PER07	Communication Number Qualifier		
PER08	Communication Number		

SUBSCRIBER HIERARCHICAL LEVEL - LOOP 2000B

HL – Billing Provider Hierarchical Level (2000B)			
HL01	Hierarchical ID Number	2	HL Segment Counter starting at 1 for the initial HL segment and increment by one in each subsequent HL segment within the ST/SE
HL02	Hierarchical Parent ID Number		Hierarchical ID number of the HL segment to which the current HL segment is subordinate
HL03	Hierarchical Level Code	22	22 = Subscriber
HL04	Hierarchical Child Code		Hierarchical Child Code indicates whether there are subordinates (or child) HL segments related to the current HL segment
SBR – Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		See EDI Guide for Table
SBR02	Individual Relationship Code	18	18 = Client's relationship to subscriber
SBR03	Insured Group or Policy Number		
SBR04	Insured Group Name		
SBR05	Insurance Type Code		
SBR09	Claim Filing Indicator Code	MC	MC = Medi-Cal

SUBSCRIBER NAME - LOOP 2010BA

NM1 – Subscriber Name			
NM101	Entity Identifier Code	IL	
NM102	Entity Type Qualifier		
NM103	Subscriber Last Name		
NM104	Subscriber First Name		
NM105	Subscriber Middle Name		
NM107	Subscriber Name Suffix		
NM108	Identification Code Qualifier		
NM109	Subscriber Primary Identifier		SAPC Assigned Subscriber Patient ID Number and not the Patient's CIN. Note: This segment must begin with MSO followed by the patient ID number. Example: MSO315411.

PAT – Patient Information			
PAT01	Individual Relationship Code		
PAT02	Patient Location Code		
PAT03	Employment Status Code		
PAT04	Patient Location Code		
PAT05	Date Time Period Format Qualifier		
PAT06	Date Time Period		
PAT07	Unit or Basis for Measurement Code		
PAT08	Weight		
PAT09	Yes/No Condition or Response Code		The "Y" code indicates that the patient is pregnant. The pregnancy indicator is required where the client is known to the provider to be either pregnant or postpartum as defined in 22 CCR § 51341.1(b) (18). The indicator will be used for statistical purposes, and for adjudicating claims for which the client's perinatal eligibility is relevant.

N3 – Subscriber Address			
N301	Subscriber Address Line		
N302	Subscriber Address Line		

N4 – Subscriber City/State/Zip Code			
N401	Subscriber City Name		
N402	Subscriber State Code		
N403	Subscriber Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		
DMG – Subscriber Demographic Information			
DMG01	Date Time Period Format Qualifier	D8	
DMG02	Subscriber Birth Date		
DMG03	Subscriber Gender Code		
REF – Subscriber Secondary Information			
REF01	Reference Identification Qualifier		
REF02	Reference Identification		

PAYER NAME - LOOP 2010BB

NM1 – Payer Name			
NM101	Entity Identifier Code	PR	Payer
NM102	Entity Type Qualifier	2	Non-Person Entity
NM103	Payer Name		SAPC
NM108	Identification Code Qualifier		PI
NM109	Payer Identifier		SAPC001
N3 – Payer Address			
N301	Payer Address Line		1000 FREMONT AVE
N302	Payer Address Line		
N4 – Payer City/State/Zip Code			
N401	Payer City Name		ALHAMBRA
N402	Payer State Code		CA
N403	Payer Postal Zone or ZIP Code		918039998
N404	Country Code		
N407	Country Subdivision Code		

CLM – Claim Information			
CLM01	Claim Submitter's ID		
CLM02	Total Claim Charge Amount		
CLM03	Not Used		Not Used
CLM04	Not Used		Not Used
CLM05-1	Facility Code Value		
CLM05-2	Facility Code Qualifier		
CLM05-3	Claim Frequency Code		
CLM06	Provider or Supplier Signature Indicator		
CLM07	Medicare Assignment Code		
CLM08	Benefits Assignment Certification Indicator		
CLM09	Release of Information Code		
CLM10	Patient Signature Source Code		
CLM11-1	Related Causes Code		
CLM11-2	Related Causes Code		
CLM11-3	Related Causes Code		
CLM11-4	Auto Accident State or Province Code		
CLM11-5	Country Code – Not Used		Not Used
CLM12	Special Program Indicator – Not Used		Not Used
CLM16	Participation Agreement		Not Used
CLM20	Delay Reason Code		
DTP – Date – Admission			
DTP01	Date/Time Qualifier	435	
DTP02	Date Time Period Format Qualifier		
DTP03	Date Time Period		
DTP – Date – Discharge			
DTP01	Date/Time Qualifier	096	
DTP02	Date Time Period Format Qualifier		
DTP03	Date Time Period		
AMT – Patient Amount Paid			
AMT01	Amount Qualifier Code	F5	F5 = Patient Amount Paid
AMT02	Patient Amount Paid		Total Amount Paid by Client

HI – Health Care Diagnosis Code			
HI01	Principal Diagnosis	ABK	ABK=Principal Diagnosis DSM-5/ ICD-10 Codes
HI01	Diagnosis Code		Industry Code
HI02	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI02	Diagnosis Code		Industry Code
HI03	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI03	Diagnosis Code		Industry Code
HI04	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI04	Diagnosis Code		Industry Code
HI05	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI05	Diagnosis Code		Industry Code
HI06	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI06	Diagnosis Code		Industry Code
HI07	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI07	Diagnosis Code		Industry Code
HI08	Diagnosis Type Code	ABF	ABF=Diagnosis ICD-10 Codes
HI08	Diagnosis Code		Industry Code
NM1 Rendering Provider Name (2310B)			
NM101	Entity Identifier Code		82
NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Rendering Provider Last Name		
NM104	Rendering Provider First Name		
NM108	Identification Code Qualifier	XX	Clinical NPI Number
NM109	Rendering Provider Identifier		
Rendering Provider Specialty			
PRV01	Rendering Provider Code	PE	Performing
PRV02	Reference Identification Qualifier	PXC	Health Care Provider Taxonomy Code
PRV03	Rendering Provider Taxonomy Code		10-digit code of specialization
Service Facility Location Name (2310C) –			
NM101	Entity Identifier Code		77
NM102	Entity Type Qualifier		1 = Person / 2 = Non-Person Entity
NM103	Rendering Provider Last or Organization Name		Client's Program for The Episode
NM108	Identification Code Qualifier	XX	
NM109	Identification Code		Location NPI
N3 – Service Facility Location Address			
N301	Laboratory or Facility Address Line		
N302	Laboratory or Facility Address Line		

N4 – Service Facility Location City/State/Zip			
N401	Laboratory or Facility City Name		
N402	Laboratory or Facility State or Province Code		
N403	Laboratory or Facility Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		
OTHER SUBSCRIBER INFORMATION – LOOP 2320 – Medi-Cal is Secondary Ins			
SBR – Other Subscriber Information			
SBR01	Payer Responsibility Sequence Number Code		
SBR02	Individual Relationship Code		
SBR03	Insured Group or Policy Number		
SBR04	Other Insured Group Name		
SBR05	Insurance Type Code		
SBR09	Claim Filing Indicator Code		16 - Medicare Advantage Plan CI - Commercial Insurance
AMT – Coordination of Benefits (COB) Total Non-Covered Amount			
AMT01	Amount Qualifier Code	D	Payor Amount Paid
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
AMT – Remaining Patient Liability			
AMT01	Amount Qualifier Code	EAF	Patient Liability
AMT02	Monetary Amount		
AMT03	Credit/Debit Flag Code		
OI – Other Insurance Coverage Information			
OI03	Benefits Assignment Certification Indicator		
OI04	Patient Signature Source Code		
OI06	Release of Information Code		

OTHERSUBSCRIBERNAME - LOOP 2330BA			
NM1 – Other Subscriber Name			
NM101	Entity Identifier Code	IL	
NM102	Entity Type Qualifier		
NM103	Subscriber Last Name		
NM104	Subscriber First Name		
NM105	Subscriber Middle Name		
NM107	Subscriber Name Suffix		
NM108	Identification Code Qualifier		
NM109	Subscriber Primary Identifier		
N3 – Other Subscriber Address			
N301	Payer Address Line		
N302	Payer Address Line		
N4 – Other Subscriber City/State/Zip Code			
N401	Payer City Name		
N402	Payer State Code		
N403	Payer Postal Zone or ZIP Code		
N404	Country Code		
N407	Country Subdivision Code		

OTHER PAYER - LOOP 2330B			
NM1 – Other Payer Name			
NM101	Entity Identifier Code	PR	PR = Payer
NM102	Entity Type Qualifier	2	2 = Non-Person Entity
NM103	Other Payer Last or Organization Name		
NM108	Identification Code Qualifier		
NM109	Other Payer Primary Identifier		

Service Line Number (Loop 2400)			
LX – Service Line Number			
LX01	Assigned Number		LX Segment Counter starting at 1 for the initial LX segment and increment by one in each subsequent LX segment within Claim Information

To bill multiple NDC codes, create a new LX Segment Counter(s). Please see example at the following link:

https://www.dhcs.ca.gov/formsandpubs/Documents/BHIN-20-064-Exhibit-A.pdf

SV1 – Professional Service			
SV101	Procedure Modifier	HC	HC = HCPCS Codes **This must be HC for processing into MSO.**
SV101	Procedure Code		**This must be defined in the MSO CPT code table, or the service is rejected on MSO inbound.**
SV101	Product or Service ID Qualifier		
SV101	Procedure Modifier		
SV101	Procedure Modifier		
SV102	Line-Item Charge Amount		Total Service Charge
SV103	Unit or Basis for Measurement Code	UN	Must be UN for all services on or after 07/01/2023
SV104	Service Unit Count		Total Service Units If Units Based Service
SV105	Place of Service Code	02	Refer to the Rates and Standards Matrix Billing Rules for all appropriate place of service codes
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV107	Diagnosis Code Pointer		Diagnosis Code Pointer Based on Client's Diagnosis **If an invalid diagnosis reference is encountered, the entire claim will be rejected by MSO inbound.**
SV109	Emergency Indicator		
SV111	EPSDT Indicator		
SV112	Family Planning Indicator		
SV115	Co-Pay Status Code		

A complete list of CPT/HCPC by ASAM Level of Care is available on our SAPC Public Bulletin Webpage at the following link (Please refer to the rates bulletin for the appropriate fiscal year):

http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins

DTP - Date - Service Date			
DTP01	Date Time Qualifier	472	472 = Service
DTP02	Date Time Period Format Qualifier		D8 = Date expressed in CCYYMMDD, RD8 = Range of dates expressed in CCYYMMDD-CCYYMMDD
DTP03	Service Date		**This is required for the service to file in the MSO 'Claim Processing (HCFA)' option ('Service Detail' tab).**
CN1 - Contract Information			
CN101	Contract Type Code		
CN102	Not Used		Not Used
CN103	Not Used		Not Used
CN104	Reference Identification		**Reference Contract Number**
REF - Prior Authorization - Required			
REF01	Reference Identification Qualifier	G1	G1 = Prior Authorization Number
REF02	Prior Authorization or Referral Number		Prior Authorization or Referral Number
Line Note			
NTE01	Note Reference	DCP	ADD - Additional Information DCP - Goals, Rehabilitation Potential, Discharge Plans
NTE02	Description		Value

NATIONAL DRUG CODE (NDC) IDENTIFICATION INFORMATION - LOOP 2410			
LIN – Drug Identification			
LIN01			
LIN02	Product/Service ID Qualifier	N4	Qualifier
LIN03	National Drug CD		11 -digit NDC without hyphens or spaces
CTP – Drug Quantity			
CTP01			
CTP02			
CTP03			
CTP04	National Drug Unit Count		Quantity (number of units)
CTP05	Measurement code		Composite Unit of Measure
CTP05-1	F2, - International Unit, GR - Gram, ML - Milliliter, UN - Unit, ME - Milligram		Unit or Basis of Measurement code

A complete list of NDC Codes is available in our Rate Matrix (Please refer to the rates bulletin for the appropriate fiscal year): http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins

Example of National Drug Code: LIN**N4*63323024910~

CTP****07*ML~

LINE ADJUDICATION INFORMATION - LOOP 2430 - OHC / MEDI-CAL Claims			
SVD - Line Adjudication Information			
SVD01	Other Payer Primary Identifier		
SVD02	Service Line Paid Amount		
SVD03	Product or Service ID Qualifier		
SVD03	Procedure Modifier		
SVD03	Procedure Modifier		
SVD03	Procedure Modifier		
SVD03	Procedure Code		
SVD03	Procedure Modifier		
SVD03	Procedure Code Description		
SVD05	Paid Service Unit Count		
SVD06	Bundled or Unbundled Line Number		
CAS - Line Adjustment			
CAS01	Claim Adjustment Group Code		PR/CO/OA
CAS02	Adjustment Reason Code		
CAS03	Adjustment Amount		
CAS04	Adjustment Quantity		
CAS05	Adjustment Reason Code		
CAS06	Adjustment Amount		
CAS07	Adjustment Quantity		
CAS08	Adjustment Reason Code		
CAS09	Adjustment Amount		
CAS10	Adjustment Quantity		
CAS11	Adjustment Reason Code		
CAS12	Adjustment Amount		
CAS13	Adjustment Quantity		
CAS14	Adjustment Reason Code		
CAS15	Adjustment Amount		
CAS16	Adjustment Quantity		
CAS17	Adjustment Reason Code		
CAS18	Adjustment Amount		
CAS19	Adjustment Quantity		
DTP - Line Check or Remittance Date			
DTP01	Date Time Qualifier	573	573 = Date Claim Paid
DTP02	Date Time Period Format Qualifier	D8	D8 = Date expressed in CCYYMMDD
DTP03	Adjudication or Payment Date		

Section 9. Acknowledgement and Reports

Acknowledgements

- SAPC returns an Interchange Acknowledgment (TA1) segment when requested, based on the value transmitted in ISA14.
- SAPC provides Implementation Acknowledgment transactions (999) for inbound Functional Groups (i.e. 837s), if requested.
- SAPC provides the Health Care Claim Acknowledgment transaction (277CA) for claims. Ensure your eHR is configured to read 277CA. Only accepted claims will be assigned a SAGE claim ID.
- SAPC does not request the Interchange Acknowledgments (TA1) segment on outbound interchanges.
- SAPC accepts, but does not require or process, Implementation Acknowledgment (999) transactions for all outbound Functional Groups.

Linking an 837 to the 277CA

As per the HIPAA Technical Report for the 277CA transaction, the 277CA file reports the 837's BHT03 Originator Application Transaction Identifier value in the Claim Transaction Batch Number (2200B – TRN02) of the 277CA. To successfully link an 837 to the correct 277CA, the 837 must contain a unique value in the BHT03 for every 837-file generated.

277CA Claim Status Codes

The following are most common rejection Claim Status Codes returned on the Sage 277CA:

Inbound 837P Claim Rejections	Claim Status Codes on Sage 277CA
Client's date of birth not match	A7:0
Void or Replacement Claim with invalid Payer Claim Control #	A7:0
Void or Replacement Claim where Client ID/MSO # on the Void or Replacement does not match the Client ID/MSO # of the original claim	A7:0
Date of Service is a future date	A7:0
Procedure code not defined in SAGE MSO HCPC/CPT table	A7:21 & A7:454
Client ID with the 'MSO' prefix but does not exist in SAGE	A7:33
Client ID without the 'MSO' prefix	A7:33
Total claim charge amount not equal sum of line-item charge amount	A7:178
Claim is out of balance – service line paid amount + all service line adjustment amounts do not equal the line-item charge amount	A7:400
Diagnosis Code Not Defined in SAGE Diagnosis Table	A7:477
A claim will be rejected if an ICD-9 diagnosis indicator is received and the service date (outpatient) or discharge/thru date (inpatient) are on or after the ICD-10 cutover date.	A7:477
Submitter ID NOT found	A7:478
Other Payer Primary ID is missing or invalid or the value sent in the 2330 loop does not match the value sent in the 2430 loop	A7:479

A complete list of codes and modifiers are available at the following websites:

http://www.x12.org/codes/health-care-claim-status-category-codes/
http://www.x12.org/codes/health-care-claim-status-codes/

Section 10. Remittance (835)

BPR - Financial Information		
BPR01	Transaction Handling Code	C=Payment Accompanies Remittance Advice D=Make Payment Only H=Notification Only I=Remittance Information Only P=Pre-notification of Future Transfers U=Split Payment and Remittance X=Handling Party's Option to Split Payment and Remittance
BPR02	Monetary Amount	
BPR03	Credit/Debit Flag Code	C=Credit D=Debit
BPR04	Payment Method Code	ACH=Automated Clearing House (ACH) BOP=Financial Institution Option CHK=Check FWT=Federal Reserve Funds/Wire Transfer - Non-repetitive NON=Non-Payment Data
BPR05	Payment Format Code	
BPR06	(DFI) ID Number Qualifier	
BPR07	(DFI) Identification Number	
BPR08	Account Number Qualifier	
BPR09	Account Number	
BPR10	Originating Company Identifier	
BPR11	Originating Company Supplemental Code	
BPR12	(DFI) ID Number Qualifier	
BPR13	(DFI) Identification Number	
BPR14	Account Number Qualifier	
BPR15	Account Number	
BPR16	Date	
TRN - Re-association Trace Number		
TRN01	Trace Type Code	1
TRN02	Reference Identification	EFT or Check Number
TRN03	Originating Company Identifier	
TRN04	Reference Identification	

REF - Version Identification		
REF01	Reference Identification Qualifier	F2
REF02	Reference Identification	AVATAR MSO 2017
DTM - Production Date		
DTM01	Date/Time Qualifier	405
DTM02	Date	

PAYER IDENTIFICATION - LOOP 1000A		
N1 - Payer Identification		
N101	Entity Identifier Code	
N102	Name	COUNTY OF LOS ANGELES SAPC
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payer Address		
N301	Address Information	
N302	Address Information	
N4 - Payer City, State, ZIP		
N401	City Name	
N402	State or Province Code	
N403	Postal Code	Must include Zip + 4-digit code
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Additional Payer Identification		
REF01	Reference Identification Qualifier	2U=Payer Identification Number EO=Submitter Identification Number HI=Health Industry Number (HIN) NF=National Association of Insurance Commissioners (NAIC) Code
REF02	Reference Identification	

PER - Payer Contact Information		
PER01	Contact Function Code	CX=Payers Claim Office
PER02	Name	
PER03	Communication Number Qualifier	TE=Telephone Number
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Email Address
PER06	Communication Number	
PER07	Communication Number Qualifier	
PER08	Communication Number	
PER - Payer Technical Contact Information		
PER01	Contact Function Code	BL - Technical Department
PER02	Name	
PER03	Communication Number Qualifier	EM=Email Address TE=Telephone Number UR=Uniform Resource Locator (URL)
PER04	Communication Number	
PER05	Communication Number Qualifier	EM=Email address EX=Telephone Extension FX=Facsimile TE=Telephone Number UR=Uniform Resource Locator (URL)
PER06	Communication Number	
PER07	Communication Number Qualifier	EM=Email address EX=Telephone Extension FX=Facsimile UR=Uniform Resource Locator (URL)
PER08	Communication Number	

PAYEE IDENTIFICATION - LOOP 1000B		
N1 - Payee Identification		
N101	Entity Identification Code	PE
N102	Name	
N103	Identification Code Qualifier	
N104	Identification Code	
N3 - Payee Address		
N301	Address Information	
N302	Address Information	

N4 - Payee City, State, Zip Code		
N401	City Name	
`N402	State or Province Code	
N403	Postal Code	Must include Zip + 4-digit code
N404	Country Code	
N405	Location Qualifier	
N406	Location Identifier	
N407	Country Subdivision Code	
REF - Payee Additional Identification		
REF01	Reference Identification Qualifier	TJ - Federal Tax ID
REF02	Reference Identification	

LOOP 2000		
LX - Header Number		
LX01	Assigned Number	

CLAIM PAYMENT INFORMATION - LOOP 2100		
CLP - Claim Payment Information		
CLP01	Claim Submitter's Identifier	
CLP02	Claim Status Code	1=Processed as Primary 2=Processed as Secondary 3=Processed as Tertiary 4=Denied 19=Processed as Primary, Forwarded to Additional Payer(s) 20=Processed as Secondary, Forwarded to Additional Payer(s) 21=Processed as Tertiary, Forwarded to Additional Payer(s) 22=Reversal of Previous Payment 23=Not Our Claim, Forwarded to Additional Payer(s) 25=Predetermination Pricing Only - No Payment
CLP03	Monetary Amount	
CLP04	Monetary Amount	

CLP05	Monetary Amount	12=Preferred Provider Organization (PPO) 13=Point of Service (POS) 14=Exclusive Provider Organization (EPO) 15=indemnity Insurance 16=Health Maintenance Organization (HMO) Medicare Risk 17=Dental Maintenance Organization AM=Automobile Medical CH=Champus DS=Disability HM=Health Maintenance Organization LM=Liability Medical MA=Medicare Part A MB=Medicare Part B MC=Medicaid OF=Other Federal Program TV=Title V VA=Veterans Affairs Plan WC=Workers' Compensation Health Claim ZZ=Mutually Defined
CLP06	Claim Filing Indicator Code	
CLP07	Reference Identification	
CLP08	Facility Code Value	
CLP09	Claim Frequency Type Code	
CLP10	Patient Status Code	
CLP11	Diagnosis Related Group (DRG) Code	
CLP12	Quantity	
CLP13	Percentage as Decimal	
NM1 - Patient Name		
NM101	Entity Identifier Code	QC = Patient
NM102	Entity Type Qualifier	1 = Person
NM103	Name Last or Organization Name	
NM104	Name First	
NM105	Name Middle	
NM106	Name Prefix	
NM107	Name Suffix	
NM108	Identification Code Qualifier	MI=Member Identification Number
NM109	Identification Code	Client ID in Sage
REF - Other Claim Related Identification		
REF01	Reference Identification Qualifier	F8 - Original Reference Number
REF02	Reference Identification	This identifier is required for Corrected Claims, Voids, and Replacement

DTM - Statement From or To Date		
DTM01	Date/Time Qualifier	232=Claim Statement Period Start 233=Claim Statement Period End
DTM02	Date	YYYYMMDD
AMT - Claim Supplemental Information		
AMT01	Amount Qualifier Code	AU=Coverage Amount D8=DiscountAmount F5=Patient Amount Paid
AMT02	Monetary Amount	

SERVICE PAYMENT INFORMATION - LOOP 2110		
SVC - Service Payment Information		
SVC01	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC01-1	Product/Service ID Qualifier	HC - HCPC/CPT Codes
SVC01-2	Product/Service ID	
SVC01-3	Procedure Modifier	
SVC01-4	Procedure Modifier	
SVC01-5	Procedure Modifier	
SVC01-6	Procedure Modifier	
SVC01-7	Description	
SVC02	Monetary Amount	
SVC03	Monetary Amount	
SVC04	Product/Service ID	
SVC05	Quantity	
SVC06	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	
SVC06-01	Product/Service ID Qualifier	
SVC06-02	Product/Service ID	
SVC06-03	Procedure Modifier	
SVC06-04	Procedure Modifier	
SVC06-05	Procedure Modifier	
SVC06-06	Procedure Modifier	
SVC06-07	Description	
SVC07	Quantity	

DTM - Service Date		
DTM01	Date/Time Qualifier	472
DTM02	Date	YYYYMMDD
CAS - Service Adjustment		
CAS01	Claim Adjustment Group Code	
CAS02	Claim Adjustment Reason Code	
CAS03	Monetary Amount	
CAS04	Quantity	
CAS05	Claim Adjustment Reason Code	
CAS06	Monetary Amount	
CAS07	Quantity	
CAS08	Claim Adjustment Reason Code	
CAS09	Monetary Amount	
CAS10	Quantity	
CAS11	Claim Adjustment Reason Code	
CAS12	Monetary Amount	
CAS13	Quantity	
CAS14	Claim Adjustment Reason Code	
CAS15	Monetary Amount	
CAS16	Quantity	
CAS17	Claim Adjustment Reason Code	
CAS18	Monetary Amount	
CAS19	Quantity	
REF - Service Identification		
REF01	Reference Identification Qualifier	BB - Authorization Number
REF02	Reference Identification	
AMT - Service Supplemental Amount		
AMT01	Amount Qualifier Code	B6=Allowed - Actual
AMT02	Monetary Amount	
LQ - Health Care Remark Codes		
LQ01	Code List Qualifier Code	
LQ02	Industry Code	

PLB - Provider Adjustment		
PLB01	Reference Identification	
PLB02	Date	YYYYMMDD
PLB03	Adjustment Identifier	50=Late Charge 51=Interest Penalty Charge 72=Authorized Return 90=Early Payment Allowance AM=Applied to Borrower's Account AP=Acceleration of Benefits B2=Rebate B3=Recovery Allowance BD=Bad Debt Adjustment BN=Bonus C5=Temporary Allowance CR=Capitation Interest CS=Adjustment CT=Capitation Payment CV=Capital Pass thru CW=Certified Registered Nurse Anesthetist Pass thru DM=Direct Medical Education Pass thru E3=Withholding FB=Forwarding Balance FC=Fund Allocation GO=Graduate Medical Education Pass thru IP=Incentive Premium Payment IR=Internal Revenue Service Withholding IS=Interim Settlement J1=Non-reimbursable L3=Penalty L6=Interest Owed LE=Levy LS=Lump Sum OA=Organ Acquisition Pass thru OB=Offset for Affiliated Providers PI=Periodic Interim Payment PL=Payment Final RA=Retro-activity Adjustment RE=Return on Equity SL=Student Loan Repayment TL=Third Party Liability WO=Overpayment Recovery WU=Unspecified Recovery ZZ=Mutually Defined
PLB03-1	Adjustment Reason Code	**Required when a control, account or tracking number applies to this adjustment. **Use when necessary to assist the receiver in identifying, tracking, or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information. **IMPLEMENTATION NAME: Provider Adjustment Identifier

PLB03-2	Reference Identification	**Required when a control, account or tracking number applies to this adjustment. **Use when necessary to assist the receiver in identifying, tracking, or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information. **IMPLEMENTATION NAME: Provider Adjustment Identifier
PLB04	Monetary Amount	**This is the adjustment amount for the preceding adjustment reason. **Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements. **IMPLEMENTATION NAME: Provider Adjustment Amount
PLB05	ADJUSTMENT IDENTIFIER	
PLB05-1	Adjustment Reason Code	
PLB05-2	Reference Identification	
PLB06	Monetary Amount	
PLB07	ADJUSTMENT IDENTIFIER	
PLB07-1	Adjustment Reason Code	
PLB07-2	Reference Identification	
PLB08	Monetary Amount	
PLB09	ADJUSTMENT IDENTIFIER	
PLB09-1	Adjustment Reason Code	
PLB09-2	Reference Identification	
PLB10	Monetary Amount	
PLB11	ADJUSTMENT IDENTIFIER	
PLB11-1	Adjustment Reason Code	
PLB11-2	Reference Identification	
PLB12	Monetary Amount	
PLB13	ADJUSTMENT IDENTIFIER	
PLB13-1	Adjustment Reason Code	
PLB13-2	Reference Identification	
PLB14	Monetary Amount	

Appendix A

837P Examples

Drug Medi-Cal Claim

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171026*^*00501*261616027*1*T*:~
GS*HC*951234567*68029013*20171026*161627*261616027*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20171026*161627*CH~
NM1*41*2*RECOVERING, INC.*****46*951234567~
PER*IC*BILLING DEPARTMENT*TE*2135551234~
NM1*40*2*Los Angeles County SAPC*****46*SAPC001~
HL*1**20*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
N3*1234 32ND STREET~
N4*LYNWOOD*CA*902629998~
REF*EI*951234567~
PER*IC*BILLING MANADER*TE*2135551234~
HL*2*1*22*0~
SBR*P*18**LACSAPC*****MC~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*3250 Wilshire Blvd*Apt 1709~
N4*Los Angeles*CA*900209998~
DMG*D8*20000101*F~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
CLM*16027*60***11:B:1*Y*A*Y*Y~
HI*ABK:099320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*175T00000X~
NM1*77*2*RECOVERY LYNWOOD****XX*1751934005~
N3*11234 32ND STREET~
N4*Lynwood*CA*90262998~
LX*1~
SV1*HC:99203:U8*60*UN*2*02**1~
DTP*472*D8*20170901~
REF*G1*P1271~
LX*2~
SV1*HC:99203:U8*60*UN*2***1~
DTP*472*D8*20170902~
REF*G1*P1271~
NTE*DCP*99~
SE*32*000000001~
GE*1*261616027~
IEA*1*261616027~
```

Submitter's Federal Tax ID

Treating Facility's NPI

'MSO' and Sage Client ID

Rendering Provider's NPI

Rendering Providers Specialty

Place of Service Code

Authorization Number Assigned by Sage

Service Line Number

OHC (Other Health Care)-Medi-Cal

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171026*^*00501*261616027*1*T*:~
GS*HC*951234567*68029013*20171026*161627*261616027*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20171026*161627*CH~
NM1*41*2*RECOVERING, INC.*****46*951234567~
PER*IC*BILLING DEPARTMENT*TE*2135551234~
NM1*40*2*Los Angeles County SAPC*****46*SAPC001~
HL*1**20*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
N3*1234 32ND STREET~
N4*LYNWOOD*CA*902629998~
REF*EI*951234567~
PER*IC*BILLING MANADER*TE*2135551234~
HL*2*1*22*0~
SBR*S*18**LACSAPC*****MC~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*118336 STREET TO NOWHERE~
N4*Los Angeles*CA*9000051744~
DMG*D8*20001122*M~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
CLM*13032*59***11:B:1*Y*A*Y*Y~
HI*ABK:099320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*175T00000X~
SBR*P*18**AETNA INSURANCE - RISK HMO*****CI~
AMT*D*39~
AMT*EAF*20~
OI***Y***Y~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*118336 STREET TO NOWHERE~
N4*Los Angeles*CA*9000051744~
NM1*PR*2*AETNA INSURANCE - RISK HMO*****PI*60054~
LX*1~
SV1*HC:H0049:U8*59*UN*2*02**1~
DTP*472*D8*20170707~
REF*G1*P1136~
NTE*DCP*99~
SVD*60054*39*HC:H0049:U8**2~
CAS*CO*45*20~
DTP*573*D8*20170901~
SE*41*000000001~
GE*1*261616027~
IEA*1*261616027~
```

Drug Medi-Cal is identified as the secondary insurance in SBR01.

The OHC payer is identified as the Primary. The coordination benefits (COB) amount paid.

Other Payer Name – NM109 contains the Payer's ID

Service Line Adjudication Information: Identifies the payer, amount paid by the payer for the service, the claim adjustment reason code (CARC), and the Remittance Date.

Drug Medi-Cal with Patient Payment (Share of Cost)

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171026*^*00501*261616027*1*T*:~
GS*HC*951234567*68029013*20171026*161627*261616027*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20171026*161627*CH~
NM1*41*2*RECOVERING, INC.*****46*951234567~
PER*IC*BILLING DEPARTMENT*TE*2135551234~
NM1*40*2*Los Angeles County SAPC*****46*SAPC001~
HL*1**20*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
N3*1234 32ND STREET~
N4*LYNWOOD*CA*902629998~
REF*EI*951234567~
PER*IC*BILLING MANADER*TE*2135551234~
HL*2*1*22*0~
SBR*P*18**LACSAPC*****MC~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*3250 Wilshire Blvd*Apt 1709~
N4*Los Angeles*CA*900209998~
DMG*D8*20000101*F~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
CLM*16027*60***11:B:1*Y*A*Y*Y~
AMT*F5*20~
HI*ABK:099320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*175T00000X~
LX*1~
SV1*HC:99203:U8*60*UN*2*02**1~
DTP*472*D8*20170901~
REF*G1*P1271~
NTE*DCP*99~
SE*32*000000001~
GE*1*261616027~
IEA*1*261616027~
```

$20.00 Patient Payment

Voids and Replacements

Replacement of an Approved Claim

```
ISA*00*1111111111*00*1111111111*30*951234567      *30*680290013      *171026*^*00501*261616027*1*T*:~
GS*HC*951234567*68029013*20171026*161627*261616027*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20171026*161627*CH~
NM1*41*2*RECOVERING, INC.*****46*951234567~
PER*IC*BILLING DEPARTMENT*TE*2135551234~
NM1*40*2*Los Angeles County SAPC*****46*SAPC001~
HL*1**20*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
N3*1234 32ND STREET~
N4*LYNWOOD*CA*902629998~
REF*EI*951234567~
PER*IC*BILLING MANADER*TE*2135551234~
HL*2*1*22*0~
SBR*P*18**LACSAPC*****MC~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*3250 Wilshire Blvd*Apt 1709~
N4*Los Angeles*CA*900209998~
DMG*D8*20000101*F~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
CLM*16027*60***11:B:7*Y*A*Y*Y~
AMT*F8*3656~
HI*ABK:099320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*175T00000X~
LX*1~
SV1*HC:99203:U8*60*UN*2*02**1~
DTP*472*D8*20170901~
REF*G1*P1271~
NTE*DCP*99~
SE*32*000000001~
GE*1*261616027~
IEA*1*261616027~
```

CLM05-3 must have a value of 7 (Replacement)
REF02 -Payer Claim Control Number from the 835 of the claim being replaced.

Void an Approved Claim

```
ISA*00*1111111111*00*1111111111*30*951234567      *30*680290013      *171026*^*00501*261616027*1*T*:~
GS*HC*951234567*68029013*20171026*161627*261616027*X*005010X222A1~
ST*837*000000001*005010X222A1~
BHT*0019*00*12345H*20171026*161627*CH~
CCCCCCCCCCCCCCCCCC PER*IC*BILLING
DEPARTMENT*TE*2135551234~
NM1*40*2*Los Angeles County SAPC*****46*SAPC001~
HL*1**20*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
N3*1234 32ND STREET~
N4*LYNWOOD*CA*902629998~
REF*EI*951234567~
PER*IC*BILLING MANADER*TE*2135551234~
HL*2*1*22*0~
SBR*P*18**LACSAPC*****MC~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
N3*3250 Wilshire Blvd*Apt 1709~
N4*Los Angeles*CA*900209998~
DMG*D8*20000101*F~
NM1*PR*2*SAPC*****PI*SAPC001~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
CLM*16027*60***11:B:8*Y*A*Y*Y~
AMT*F8*3657~
HI*ABK:099320~
NM1*82*1*COUNSLER*JIM****XX*1245319599~
PRV*PE*PXC*175T00000X~
LX*1~
SV1*HC:99203:U8*60*UN*2*02**1~
DTP*472*D8*20170901~
REF*G1*P1271~
NTE*DCP*99~
SE*32*000000001~
GE*1*261616027~
IEA*1*261616027~
```

CLM05-3 must have a value of 8 (Void)
REF02 -Payer Claim Control Number from the 835 of the claim being voided.

Substance Abuse Prevention and Control
COUNTY OF LOS ANGELES
Public Health

277CA Examples

277CA

```
ISA*00*          *00*          *30*951234567      *30*680290013      *171107*0939*^*00501*000000003*1*T*:~
GS*HC*951234567*68029013*20171107*093907*3*X*005010X222A1~
ST*277*0003*005010X214~
BHT*0085*08*3*20171107*093907*TH~
HL*1**20*1~
NM1*AY*2*Los Angeles County SAPC*****FI*68290013~
TRN*1*20171107093907~
DTP*050*D8*20171107~
DTP*009*D8*20171107~
HL*2*1*21*1~
NM1*41*2*RECOVERING, INC.*****46*951234567~
TRN*2*12345H~
STC*A2:20*20171107*WQ*60~
QTY*90*1~
AMT*YU*60~
HL*3*2*19*1~
NM1*85*2*RECOVERY LYNWOOD*****XX*1751934005~
TRN*1*0~
STC*A2:20**WQ*60~
QTY*QA*1~
AMT*YU*60~
HL*4*3*PT~
NM1*IL*1*CLIENT*TREATMENT****MI*MSO109994~
TRN*2*36044~
STC*A2:20*20171107*WQ*60~
REF*1K*1~
DTP*472*D8*20170911~
SE*26*0003~
GE*1*3~
IEA*1*000000003~
```

2200B Loop - Information Receiver Application Trace ID

- TRN01 – Provider Reference ID from the 837P -- BHT03
- STC01 – Claim Status Category Code*
- QTY01 – 90=Acknowledged Quantity /AA=Unacknowledged Quantity
- AMT01—YU=Total Accepted Amount / YY= Total Rejected Amount

2200D Loop – Claim Status Tracking

- TRN02 – Provider's Claim ID from the 837P - CLM01
- STC02 – Claim Status Category Code*
- REF02 – Claims Reference Assigned by Sage.
- DTP03 – Claim Level Service Date

*A full list of Claim Status Category Codes are available at the following website https://x12.org/codes/claim-status-category-codes

Claim Status Category Code
A2 – Acknowledgement/Accepted into Sage for adjudication

835 Examples

Standard 835

Approved Claim

```
ISA*00*          *00*          *ZZ*680290013      *ZZ*951234567      *171107*1440*!*00501*000000001*1*P*:~
GS*HC*680290013*951234567*20171107*144012*1*X*005010X222A1~
ST*835*0010~
BPR*I*60*C*CHK************20171107~
TRN*1*278560*1953893470~
REF*F2*AVATAR MSO 2017~
DTM*405*20171107~
NM1*PR*COUNTY OF LOS ANGELES SAPC~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
PER*CX*CONTRACT NAME*TE*8008751850*EM*GRODRIGUEZ@PH.LACOUNTY.GOV~
PER*BL*SAPC EDI HELP DESK*EM*GRODRIGUEZ@PH.LACOUNTY.GOV~
N1*PE*RECOVERY, INC.*XX*1751934005~
REF*TJ*951234567~
LX*1~
CLP*36044*1*60*60**16*1*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*3~
REF*F8*14877~
DTM*232*20170911~
DTM*233*20170911~
AMT*AU*60~
SVC*HC:99203:UA:HG:HA:HD*60*60**6~
DTM*472*20170911~
REF*BB*P1538~
AMT*B6*60~
SE*24*0010~
GE*1*1~
IEA*1*000000001~
```

REF02 -Payer Claim Control Number (PCCN). This Control Number is required for Voids and Replacements.

Denied Service

```
CLP*56050*1*60*0**16*2*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*3~
REF*F8*14877~
DTM*232*20170911~
DTM*233*20170911~
SVC*HC:99203:UA:HG:HA:HD*60*0**0**6~
DTM*472*20170911~
CAS*CO*96*60~
REF*BB*P1538~
LQ*HE*N216~
```

CAS02 - Service denied with Claim Adjustment Reason Code* (CARC) CO96 – Non-covered charge(s). At least one Remark Code must be used.

LQ02 – Remark Code** N216 – We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.

*Complete list of Claim Adjustment Reason Codes is available at:
https://x12.org/codes/claim-adjustment-reason-codes
**Complete list of Remark Codes is available at:
https://x12.org/codes/remittance-advice-remark-codes

State Denial and Takeback

```
ISA*00*          *00*          *ZZ*680290013      *ZZ*951234567      *171109*2205*!*00501*000000055*1*P*:~
GS*HP*951234567*680290013*20171019*220515*1*X*005010X222A1~
ST*835*0137~
BPR*I*0*C*NON************20171019~
TRN*1*34_DENIED_1378*1953893470~
REF*F2*AVATAR MSO 2017~
DTM*405*20171019~
NM1*PR*COUNTY OF LOS ANGELES SAPC~
N3*1000 FREMONT AVE~
N4*ALHAMBRA*CA*918039998~
PER*CX*CONTRACT NAME*TE*8008751850*EM*GRODRIGUEZ@PH.LACOUNTY.GOV~
PER*BL*SAPC EDI HELP DESK*EM*GRODRIGUEZ@PH.LACOUNTY.GOV~
N1*PE*RECOVERY, INC.*XX*1751934005~
REF*TJ*951234567~
LX*1~
CLP*3048*22*-28*-28**HM*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*12~
REF*F8*288~
DTM*232*20170904~
DTM*233*20170904~
SVC*HC:90846:U8*-28*-28**1~
DTM*472*20170904~
REF*BB*P1136~
AMT*B6*-28~
CLP*3048*1*28*0**HM*288*11*1~
NM1*QC*1*CLIENT*TREATMENT****MI*12~
REF*F8*288~
DTM*232*20170904~
DTM*233*20170904~
SVC*HC:90846:U8*28*0**0**1~
DTM*472*20170904~
CAS*CO*177*28*1~
REF*BB*P1136
PLB*1619008380*20180630*FB:34_DENIED_137*-28~
SE*24*0137~
GE*1*1~
IEA*1*000000055~
```

This 835 only contains a takeback due to a State Denial and is processed as a $0.00 payment with a future deduction listed in the PLB segment.

The first loop of 2100 – 2110 segments contain a negative transaction to takeback funds previously paid for this claim.
The CLP and SVC segments contain a negative payment of -$28.00.

The second loop of 2100 – 2110 segments contain the denial of the claim. The CAS segment contains the CARC from Drug Medi-Cal.

PLB Segment shows the amount of a future takeback. This amount will be deducted from the next 835(s) until full amount has been consumed.

Appendix B

Drug Medi-Cal

Claiming Opioid Treatment Services (OTP) for Medicare eligible Medi-Cal Beneficiaries (Medi/Medi)

Contents

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Last updated: 6/17/2024
Contact: MedCCC@dhcs.ca.gov

Claiming OTP Drug Medi-Cal services for Medi/Medi Beneficiaries

Drug Medi-Cal (DMC) Narcotic Treatment Program (NTP) also called Opioid Treatment Program (OTP) services are billable to Medicare effective January 1, 2020. Medicare pays OTP claims in a weekly bundle. To be reimbursed by Short Doyle Medi-Cal (SDMC), DMC trading partners must report any Medicare payment amount as Other Health Coverage (OHC) at the claim line level. All OTP services provided for the respective week should be entered at the service line level. Please see Behavioral Health Information Notice 21-065 for more information.

SDMC claiming guidelines:

- Trading partner enters total amount of Medicare reimbursement on Drug Medi-Cal claim COB segments for total weekly claim for Medi/Medi beneficiaries at the **claim line level only**.

- Enter appropriate service lines under the claim line for each dose and counseling service performed during the 7-days covered by Medicare.

- SDMC will apply OHC COB amount by service line from the first date of service (first day of the seven-day period) then apply balance over next services billed until the entire OHC amount is expended then reimburse any balance to the trading partner.

Example:

Claim Line on 837P	Include the total Medicare reimbursement for 7-days from June 2nd thru June 8th in COB segment of claim line
Service Line 1	Dose June 2nd
Service Line 2	Dose June 3rd
Service Line 3	Counseling Session June 3rd
Service Line 4	Dose June 4th
Service Line 5	Dose June 5th
Service Line 6	Counseling Session June 5th
Service Line 7	Dose June 6th
Service Line 8	Dose June 7th
Service Line 9	Dose June 8th

1. The service dates on the service lines in the claim must match the service dates of the Medicare 7-day claim.
2. Multiple doses can be entered as a single service line if the dates of the doses are within the date range of the Medicare claim.
3. The first date of service can begin the week regardless of the calendar day/week/month. The claim covers 7 days.
    a. A week can begin on the first day of treatment.

b. A week can begin on a certain day for all claims (IE Mondays) and as long as beneficiary had one service in the week from Monday to Sunday the week can be billed for starting on the defined day.
4. Note that HCPCS code H0020 may be submitted using a date range. All days within the range will count toward the 7-day bundle.

Links to Medicare Resources

Opioid Treatment Programs (OTP) | CMS

Tip Sheet for Opioid Treatment Program (OTP) Providers Serving Dually Eligible Individuals: State Coverage of the Medicare Part B Deductible (cms.gov)

Opioid Treatment Programs (OTPs) Medicare Billing & Payment Booklet (cms.gov)

Frequently Asked Questions

1. **Question: Will SDMC deny Medi/Medi OTP claims with more than 7 dates of service? Can the claim have less than 7 dates of service within a 7-day period?**

Answer: SDMC will deny any service line that is more than 7 calendar days from the first service line's date of service. The count of dates begins with the date of service on the first service line regardless of if it is approved or denied. It is acceptable to have less than 7 dates of service on a claim.

2. **Question: If Medicare denies a claim for OTP medications, can these be billed to Drug Medi-Cal?**

Answer: Yes, if the claim is not paid, or partially paid, by Medicare the claim can be submitted to Drug Medi-Cal. See Section 7 of the Drug Medi-Cal Companion Guide for details on how to submit the claim.

OHC amounts are not required for drug types 3 (Disulfiram – aka Antabuse), 6 (Acamprosate Tablets), 7 (Buprenorphine-Naloxone Combo Product aka Suboxone), or 10 (Naltrexone: Long-Acting Injection aka Vivitrol).

Buprenorphine-Naloxone can be billed to Medicare using G2068 per the Medicare FAQs, however Brand Name Suboxone may not be covered so the requirement for OHC has been removed from SDMC. If Medicare has reimbursed the provider for Buprenorphine-Naloxone Combo Product and the county wishes to also submit to SDMC OHC should still be included on the claim.

All SDMC Drug Type Numbers are listed later in this document.

3. **Question: Do trading partners have to submit claims to Drug Medi-Cal for Medi/Medi NTP/OTP claims if they are satisfied with the payment from**

Medicare? Does the county need to include these claims as part of their program or track units for cost settlement if they are not billed to Medi-Cal?"

Answer: There is no requirement to claim to Drug Medi-Cal. These units of service would not need to be reported on the cost settlement since they are not Medi-Cal claims.

4. Question: Will the state's cost report reconciliation report reflect the approved and denied units by claim level or service level?

Answer: The cost report reconciliation report will reflect approved and denied units, but the report does not separate the units by claim or service level detail.

5. Question: Should the units of service on the 837P be reported on the claim level or service level? Will the units of service on the 835 Remittance Advice (RA) be returned on the claim or service level?

Answer: The units of service should be reported on the 837P on the service level. The 835 RA will return the units of service on the service level.

6. Question: Does the 7-day calendar period mean 7 consecutive days including weekends and holidays?

Answer: Yes, the 7-day calendar period is 7 consecutive days including weekends and holidays. Services do not need to occur on all 7 days. If a service doesn't occur on a day within the 7 days, do not report that day on the 837P.

7. Question: In some counties, OTP providers use their own system to submit claims directly to Medicare. Consequently, Medicare explanation of benefits (EOB) are sent by the OTP providers to the county. How will the county ensure that Medicare payment or denials are applied correctly in the 7-days of service covered by Medicare and will crosswalk to the right HCPCS codes? County does a manual data entry in posting the Medicare EOB.

Answer: Counties should do their best to work with their OTP providers to provide the Medicare payment and correctly apply it to Medi-Cal.

8. Question: What services can be included in the 7-day weekly bundle?

Answer: NTP dosing, NTP group or individual counseling, and Additional MAT dosing.

Medi/Medi NTP/OTP Claiming Examples

Note: *The segment names and data elements have been modified for the below billing examples. Due to the copyright protection of the ASC X12N v5010 Implementation Guides, DHCS will not publish any data elements found in the Implementation Guides.*

Medicare NTP/OTP Billing Example: Medicare Part B or Medicare Part C
A beneficiary that has Medicare Part B or C and the total amount billed to Medicare was $115. The Medicare Payment Amount equals $50 and is entered correctly at the claim line level. Service lines are for dates of service not greater than 7 from the first start date and all services are in the same month.

<u>Claim Level</u>

Total Amount Billed to Medicare	CLM*12345*115*
Claim Filing Indicator	SBR*P*18*******MB or 16
Claim Level Adjustments	CAS*CO*45*65
COB Medicare Paid Amount	AMT*D*50
Remaining Patient Liability	AMT*EAF*65
Other Insurance Coverage Information	OI***Y***I

<u>Service Level</u>

NTP Service 1	SV1*HC:H0004:UA:HG*35*UN*2***1:2
Date	DTP*20210117
NTP Service 2	SV1*HC:H0020:UA:HG*15*UN*1***1:2
Date	DTP*20210118
NTP Service 3	SV1*HC:H0004:UA:HG*35*UN*2***1:2
Date	DTP*20210120
NTP Service 4	SV1*HC:H0005:UA:HG*15*UN*4***1:2
Date	DTP*20210121
NTP Service 5	SV1*HC:H0004:UA:HG*15*UN*4***1:2
Date	DTP*20210123

Below is a chart to illustrate how SDMC will apply the COB amount by service line from the first date of service until the entire Medicare payment is expended. Then Medi-Cal will pay the remaining amount up to the State Maximum Allowed (SMA). Notice that no services were rendered on dates of service 1/19/21 or 1/22/21, however, the days are still counted as part of the 7-calendar day bundle.

Claim Service Line	DOS	Billed Amount $115 Total	Medi-Cal Paid Amount
1	01/17/21	$35	$0 payment CO45 Adjusted amount over SMA =$3.52 CO23 Adjusted amount for Medicare payment =$31.48
2	01/18/21	$15	$0 payment CO45 Adjusted amount over SMA =$1.46 CO23 Adjusted amount for Medicare payment =$13.54
3	01/20/21	$35	$26.50 payment CO45 Adjusted amount over SMA =$3.52 CO23 Adjusted amount for Medicare payment =$4.98
4	01/21/21	$15	$8.46 payment CO45 Adjusted amount over SMA =$1.46
5	01/23/21	$15	$13.54 payment CO45 Adjusted amount over SMA =$1.46

Using the same example as above but shown with MAT services instead.

Claim Level

Total Amount Billed to Medicare	CLM*12345*150*
SBR Claim Filing Indicator	SBR*P*18*******MB or 16
CAS Claim Level Adjustments	CAS*CO*45*70
COB Payer Paid Amount	AMT*D*80
Remaining Patient Liability	AMT*EAF*70
Other Insurance Coverage Information	OI***Y***I

Service Level

NTP Service 1	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*20210117
NTP Service 2	SV1*HC:S5000:UA:HG*25*UN*.08***1:2
Date	DTP*20210118
NDC Code	LIN***123456789
Quantity	CTP****.08*UN

NTP Service 3	SV1*HC:S5000:UA:HG*25*UN*.02***1:2
Date	DTP*20210118
NDC Code	LIN***567890123
Quantity	CTP****.02*UN
NTP Service 4	SV1*HC:H0005:UA:HG*50*UN*4***1:2
Date	DTP*20210121
NTP Service 5	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*20210123

Denial Type 1: CO/95
COB amount is required to be entered at the claim line level only. Claim will be denied with **CO/95** if the coordination of benefits is entered at the service line level, or a combination of the claim line and service line level. The SVD, CAS, and Remittance Date DTP segments must be removed from the service line on the 837P. The 837P service level should look similar to the example below.

Claim Level

Total Amount Billed to Medicare	CLM*12345*105*
SBR Claim Filing Indicator	SBR*P*18*******MB or 16
CAS Claim Level Adjustments	CAS*CO*45*105
COB Payer Paid Amount	AMT*D*0
Remaining Patient Liability	AMT*EAF*105
Other Insurance Coverage Information	OI***Y***I

Service Line Level

NTP Service 1	SV1*HC:H0004:UA:HG*35*UN*2***1:2
Date	DTP*472*D8*20210117
NTP Service 2	SV1*HC:H0020:UA:HG*35*UN*1***1:2
Date	DTP*472*D8*20210118
NTP Service 3	SV1*HC:H0004:UA:HG*35*UN*2***1:2
Date	DTP*472*D8*20210120

Denial Type 2: CO/267/N74

When 7-day period spans two calendar months, counties should submit services on two claims; one for each month of service. The Medicare paid amount can be allocated between the two claims or applied to one claim and the second claim will be allowed as long as COB segments are present, even if Medicare payment is $0.00. The following is an example of the payment allocated between the two claims: Medicare was billed $270 and paid $50. Two claims are required to bill for 7 dates of service; claim 1 has two service lines and a COB amount of $14.29; claim 2 has five service lines and a COB amount of $35.71.

Claim Level (1)

Total Amount Billed to Medicare	CLM*12345*60***
SBR Claim Filing Indicator	SBR*P*18*******MB or 16
CAS Claim Level Adjustments	CAS*CO*45*45.71
COB Payer Paid Amount	AMT*D*14.29
Remaining Patient Liability	AMT*EAF*60
Other Insurance Coverage Information	OI***Y***I

Service Level

NTP Service 1	SV1*HC:H0004:UA:HG*35*UN*2***1:2
Date	DTP*472*D8*20210330
NTP Service2	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210331

Claim Level (2)

Total amount billed to Medicare	CLM*12345*210***
SBR Claim Filing Indicator	SBR*P*18*******MB or 16
CAS Claim Level Adjustments	CAS*CO*45*174.29
COB Payer Paid Amount	AMT*D*35.71
Remaining Patient Liability	AMT*EAF*210
Other Insurance Coverage Information	OI***Y***I

Service Level (2)

NTP Service 1	SV1*HC:H0005:HG*35*UN*2***1:2
Date	DTP*472*D8*20210401
NTP Service 2	SV1*HC:H0020:HG*50*UN*1***1:2
Date	DTP*472*D8*20210402

NTP Service 3	SV1*HC:H0005:HG*25*UN*4***1:2
Date	DTP*472*D8*20210403
NTP Service 4	SV1*HC:H0005:HG*50*UN*4***1:2
Date	DTP*472*D8*20210404
NTP Service 5	SV1*HC:H0005:HG*50*UN*4***1:2
Date	DTP*472*D8*20210405

Below is a chart to illustrate how SDMC will apply the COB amount by service line from the first date of service until the entire Medicare payment is expended. Then Medi-Cal will pay the remaining amount up to the SMA. The Medicare payment breakdown amount is not reported on the 837P.

CLAIM 1

Claim Service Line	DOS	Billed Amount $60	Medi-Cal Paid Amount
1	03/30/21	$35	$17.19 payment CO45 Adjusted amount over SMA =$3.52 CO23 Adjusted amount for Medicare payment =$14.29
2	03/31/21	$25	$15.74 payment CO45 Adjusted amount over SMA =$9.26

CLAIM 2

Claim Service Line	DOS	Billed Amount $210	Medi-Cal Paid Amount
1	04/01/21	$35	$0 payment CO45 Adjusted amount over SMA =$3.52 CO23 Adjusted amount for Medicare payment =$31.48
2	04/02/21	$50	$9.21 payment CO45 Adjusted amount over SMA =$36.56 CO23 Adjusted amount for Medicare payment =$4.23
3	04/03/21	$25	$15.74 payment CO45 Adjusted amount over SMA =$9.26
4	04/04/21	$50	$13.44 payment CO45 Adjusted amount over SMA =$36.56
5	04/05/21	$50	$13.44 payment CO45 Adjusted amount over SMA =$36.56

If the entire COB payment amount is reported on the first claim, the second claim must still report the COB with a zero-payment amount or the services on claim 2 will be denied with **CO/22/N479** (Medicare must be billed prior to the submission of this claim (Medi-Medi)).

Report zero-dollar payment amount if Medicare denied the claim, the claim filing indicator must be MB for Medicare Part B, or 16 for Medicare Part C.

Denial Type 3: CO/16/M53
A beneficiary has Medicare Part B or C and the total Medicare payment amount is reported correctly on the claim line, however, NTP service lines that exceed the 7-day calendar period starting on the first date of service are **denied with CO/16/M53**.

Claim Level

Total amount billed to Medicare	CLM*12345*200***
SBR Claim Filing Indicator	SBR*P*18*******MB or 16
CAS Claim Level Adjustments	CAS*CO*45*120
COB Payer Paid Amount	AMT*D*80
Remaining Patient Liability	AMT*EAF*120
Other Insurance Coverage Information	OI***Y***I

Service Level

NTP Service 1	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210117
NTP Service 2	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210118
NTP Service 3	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210120
NTP Service 4	SV1*HC:H0005:UA:HG*50*UN*4***1:2
Date	DTP*472*D8*20210121
NTP Service 5	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210123
NTP Service 6	SV1*HC:H0005:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210124
NTP Service 7	SV1*HC:H0004:UA:HG*25*UN*2***1:2
Date	DTP*472*D8*20210125

The chart below shows dates of service from 1/17/2021 – 1/25/2021. Services were not administered on 1/19/2021 or 1/22/2021, however, those days count as part of the 7-day bundle. Dates of service 1/24/2021 and 1/25/2021 exceed the 7 days and are denied. Those dates of service are available to replace.

Claim Service Line	DOS	Claim Status
1	01/17/21	Approved
2	01/18/21	Approved
3	01/20/21	Approved
4	01/21/21	Approved
5	01/23/21	Approved
6	01/24/21	Denied with CO/16/M53
7	01/25/21	Denied with CO/16/M53

Drug Medi-Cal Short Doyle Drug Types

Drug Type	Drug Name and Delivery Method
1	Methadone – **No NDC Required**
2	Buprenorphine – “mono” product tablets
3	Disulfiram – aka Antabuse
4	Naloxone aka Narcan
5	Naltrexone (Not Vivitrol)
6	Acamprosate Tablets
7	Buprenorphine-Naloxone aka Suboxone
8	Buprenorphine-Naloxone: Sublingual film
9	Buprenorphine: Long-Acting Injection
10	Naltrexone: Long-Acting Injection – Vivitrol

Note: effective 7/1/23, all services are required to be submitted with only one level of care modifier, even for non-ODS DMC claims. Meaning, claims for NTP services must be submitted with both HG and UA modifiers to be valid. Refer to the DMC State Plan billing manual posted on the MedCCC Library for more information.