Private Hospital Directed Payment Program
SFY 2017-18 & SFY 2018-19
Encounter Detail File Review Toolkit
Version: March 15, 2019

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Summary

The Department of Health Care Services (DHCS) is implementing the state fiscal year (SFY) 2017-18 and 2018-19 Private Hospital Directed Payment Program (PHDP), applicable to qualifying services during each service period. The federal Centers for Medicare & Medicaid Services (CMS) approved the PHDP for SFY 2017-18 on March 6, 2018, and for SFY 2018-19 on December 17, 2018. The PHDP provides supplemental reimbursement to participating hospitals based on the actual utilization of qualifying services, as reflected in Medi-Cal managed care encounter data reported to DHCS.

To assist the ongoing PHDP implementation efforts, DHCS will periodically provide encounter detail files (tab-delimited data files) to participating hospitals and Medi-Cal managed care plans (Plans) for Medi-Cal managed care utilization associated with the National Provider Identifiers

(NPIs) reported by hospitals. The encounter detail files are intended to facilitate discussions between hospitals and Plans to ensure the accuracy and completeness of the encounter data.

Purpose

The purpose of this document is to provide the information needed to interpret and evaluate the encounter detail file, such as data definitions and logic, as well as guidance related to reviewing encounter data, contracting relationships and information about the PHDP policy overall. The toolkit will be periodically updated as necessary, and updates will be recorded in a change log (see Appendix E). This toolkit will be posted on DHCS's public website: http://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx.

Additional resources, including a statewide directory of hospital and Plan contacts, are also posted on DHCS's public website at the same location and will be updated periodically.

Encounter Detail Files

DHCS will save your organization's encounter detail file(s) on a Secure File Transfer Protocol (SFTP) site accessible through this link: https://etransfer.dhcs.ca.gov/.

Follow the steps below to retrieve your organization's encounter detail file(s):

1. Have your organization's designated SFTP Contact(s) log in to the SFTP site using their assigned user login and selected password.

2. If accessing the SFTP site for the first time using the temporary password provided by DHCS, immediately change the temporary password to a unique password.

3. In the upper left corner of the front page, click "Folders".

4. Click to open the "DHCS-CRDD-HospitalFinancing" folder.

5. Click to open either the "Private Hospitals" folder (for hospitals only) or the "Health Plans" folder (for Plans only).

6. Click to open the folder(s) corresponding to your organization.

7. Transfer the file(s) to your organization's servers. The files are:
    a. A raw data file (encounter-level detail including Protected Health Information) in tab delimited format (see Appendix B).
        i. This file includes all Medi-Cal managed care utilization for the applicable service period associated with your organization based on the NPIs reported by hospitals, including utilization associated with excluded services (see PHDP: Structure and Policy).

DHCS anticipates providing encounter detail files on multiple occasions; the current encounter detail file release schedule is outlined in Appendix A.

Review Steps for Hospitals

If you identify material differences between the service counts reflected on your encounter detail file and your anticipated service counts, follow these steps:

1. Are the differences related to Plans (see Appendix D) with which you were contracted (either directly or indirectly through a delegated arrangement) to provide qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for PHDP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter detail file?
    a. If no, align to the service period covered by the encounter detail file.
    b. If yes, proceed to step 3.

3. Is your service logic aligned with the encounter detail file logic (see Appendix C)?
    a. If no, align to DHCS' encounter detail file logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter detail file?
    a. If no, proceed to step 6.
    b. If yes, verify the NPI is not related to an excluded provider type (i.e. CBRC, FQHC, IHCP, or RHC).
        i. If there is still a variance, notify DHCS at PrivateDP@dhcs.ca.gov in order to report the missing NPI(s) and troubleshoot the issue.
        ii. Once you have notified DHCS, proceed to step 6 for NPIs that are included in the encounter detail file.

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter detail file?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your affected Plan partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected Plan partner(s) able to identify and resolve the data deficiencies?
    a. If no, proceed to step 8
    b. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PrivateDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Review Steps for Plans

If you identify material differences between the service counts reflected on your encounter detail file and your anticipated service counts, follow these steps:

1. Are the differences related to hospitals with which you were contracted (either directly or indirectly through a delegated arrangement) for qualifying services during the applicable service period?
    a. If no, do not proceed, as these services are not eligible for PHDP payments.
    b. If yes, proceed to step 2.

2. Are you comparing utilization for the same service period covered by the encounter detail file?
    a. If no, align to the service period covered by the encounter detail file.
    b. If yes, proceed to step 3.

3. Is your service logic aligned with DHCS's encounter detail file logic (see Appendix C)?
    a. If no, align to DHCS' encounter detail file logic in order to perform an equivalent comparison.
    b. If yes, proceed to step 4.

    Note: The encounter detail file logic is not the same as the RDT logic.

4. Are you applying the appropriate exclusions (see PHDP: Structure and Policy)?
    a. If no, apply the appropriate exclusions to mirror DHCS's counting logic.
    b. If yes, proceed to step 5.

5. Are the differences related to NPIs that are missing from the encounter detail file?
    a. If no, proceed to step 6.
    b. If yes, notify the hospital that the NPI is not included in the encounter detail file, and then proceed to step 6 for NPIs that are included.

6. Are your anticipated service counts still materially different from the service counts reflected on your encounter detail file?
    a. If no, no further action is needed.
    b. If yes, proceed to step 7.

7. Work with your hospital partner(s) to resolve identified data deficiencies and ensure the accuracy and completeness of the encounter data. Are you and your affected hospital partner(s) able to identify and resolve the data deficiencies?
    c. If no, proceed to step 8
    d. If yes, no further action is needed.

    Note: Discrepancies may be due to multiple factors such as: (i) the Plan did not receive encounters (or required data was missing); (ii) the Plan did not submit encounters to DHCS; and (iii) encounters were rejected by DHCS's system edits.

8. Contact DHCS at PlanDP@dhcs.ca.gov and outline the nature and materiality of the differences, the steps you have taken to resolve them, and any additional information that would help DHCS to research the issue.

Background

Prior to SFY 2017-18, historical financing mechanisms for private hospitals included the Hospital Quality Assurance Fee (HQAF) program, which increased capitation payments made to Plans to reimburse for hospital services provided to Medi-Cal enrollees.

On May 6, 2016, CMS issued the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, which at the time was the first major update to federal managed care regulations concerning Medicaid and CHIP in more than a decade.[1] Among other changes, the final rule prohibited states from directing payments to providers through managed care contracts except under specified circumstances. Broadly, the final rule limited allowable direction of managed care payments to instances of:

- Value-based purchasing models (e.g. pay-for-performance, bundled payments);
- Delivery system reform or performance improvement initiatives; and
- Minimum/maximum fee schedules, or uniform dollar/percentage increases.

Existing hospital pass-through payments, which the final rule defined in a manner that included the HQAF program, were deemed unallowable direction of payment and required to be phased out over a period of no more than 10 years. Additionally, on January 18, 2017, CMS issued another final rule which capped existing hospital pass-through payments at levels in effect as of July 5, 2016.[2]

In response to the new federal regulations, and to continue support for private hospitals in order to maintain access and improve quality of care for Medi-Cal beneficiaries, DHCS is implementing two statewide private hospital financing programs for SFY 2017-18 and SFY 2018-19:

- The pre-existing HQAF program, which is deemed a pass-through payment under the final rule, will continue and be subject to the 10-year phasedown. For the SFY 2017-18 service period, this program is expected to result in supplemental payments to private hospitals totaling approximately $1.8 billion, subject to final approval by CMS.
- The new directed payment program, PHDP, implements a uniform dollar increase to reimbursements to private hospitals for contract services. For the SFY 2017-18 and SFY 2018-19 service periods, the PHDP is expected to result in supplemental payments to private hospitals totaling $2.1 billion and $2.33 billion, respectively, subject to final approval by CMS.

This toolkit, and the associated encounter detail file(s), apply only to the PHDP.

PHDP: Structure and Policy

Final PHDP payments will be implemented using a statewide pool approach, with separate sub-pools for:

- Inpatient services
- Hospital Outpatient (OP) and Emergency Room (ER) services

[1] See Federal Register Document Number 2016-09581, available at https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
[2] See Federal Register Document Number 2017-00916, available at https://www.federalregister.gov/documents/2017/01/18/2017-00916/medicaid-program-the-use-of-new-or-increased-pass-through-payments-in-medicaid-managed-care-delivery.

Due to implementation considerations, each SFY 2017-18 and SFY 2018-19 pool is subdivided into two equal halves:

- SFY 2017-18 pools:
  - Phase I, for the service period of July 1, 2017 through December 31, 2017.
  - Phase II, for the service period of January 1, 2018 through June 30, 2018.
- SFY 2018-19 pools:
  - Phase I, for the service period of July 1, 2018 through December 31, 2018.
  - Phase II, for the service period of January 1, 2019 through June 30, 2019.

Additionally, final PHDP payments will be based on the actual utilization of contract services as reflected in the Medi-Cal managed care encounter data received by DHCS. Therefore, while DHCS will initially develop proxy per-member-per-month (PMPM) rate add-on amounts for the PHDP based on projected expenditures in SFY 2017-18 and in SFY 2018-19, pursuant to the PHDP proposals approved by CMS, these proxy PMPMs will not be paid. For the final PHDP payments, DHCS will adjust (recalculate) the rate add-on amounts based on the actual distribution of Inpatient and OP/ER utilization.

Note: Only contract services are eligible for PHDP payments. (see Contract Services for details).

Exclusions

The following services are excluded from the PHDP:

- Inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.
- Services provided to enrollees with Other Health Coverage.
- Services provided by the following:
  1. Cost-Based Reimbursement Clinics (CBRCs)
  2. Indian Health Care Providers (IHCPs)
  3. Federally Qualified Health Centers (FQHCs)
  4. Rural Health Clinics (RHCs)
- State-only abortion services.[3]

Where a hospital and CBRC, FQHC, IHCP, or RHC share the same NPI, Inpatient and ER encounters are not zeroed out because of the NPI. OP encounters, however, are excluded.

Contract Services

For purposes of the PHDP, a contract service is a Medi-Cal covered service rendered to a beneficiary actively enrolled in a Plan by an eligible hospital pursuant to a contractual arrangement that meets the minimum criteria outlined in the following notice for the applicable date(s) of service:
https://www.dhcs.ca.gov/services/Documents/DirectedPymts/DHCS_MEMO_Hospital_DP_Definition_20181005.pdf

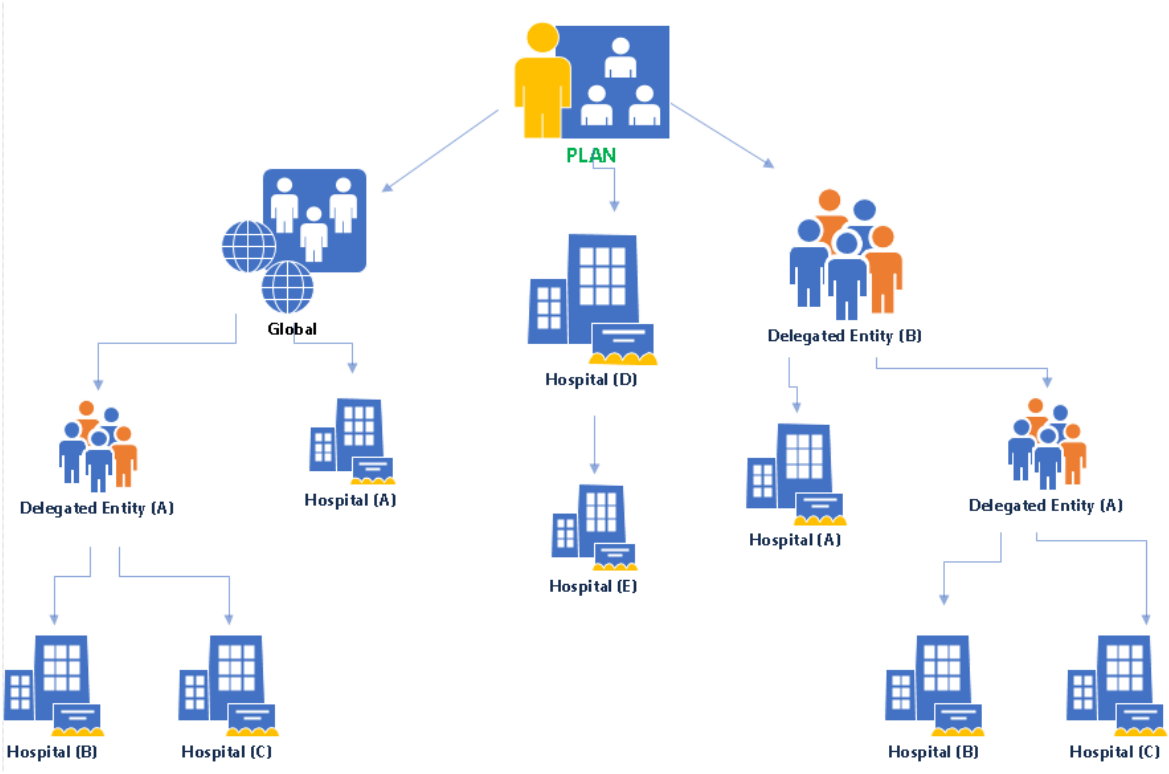
[3] State-only abortion services are identified by one of the following procedure codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866, X7724, X7726, Z0336, 01964, or 01966.

For SFY 2017-18 and SFY 2018-19, a contractual agreement must meet the following criteria:

Agreement MUST	Agreement MUST NOT
Cover one or more defined non-excluded populations of Medi-Cal beneficiaries	Be limited to a single patient only
Cover a defined set of one or more non-excluded hospital services	Be limited to treatment of a single case or instance only
Specify rates of payment or include a defined methodology for calculating specific rates of payment	Permit payment to be negotiated on a per patient or single instance of service basis
Be for a term of at least 120 days, be signed and date, and be effective for the date(s) of service	Expressly permit the provider to select on a case-by-case basis whether to provide services covered in the agreement to a patient covered by the agreement

Furthermore, for a delegated arrangement, there must be a demonstrable "unbroken contracting path" between the Plan and the provider for the service rendered and the member receiving the service, as well as the applicable date(s) of service. An "unbroken contracting path" means a sequence of contracts (as defined above) linking a health plan and a direct subcontractor or a series of subcontractors to the provider.

Note: Additional guidance and requirements, as outlined in All Plan Letter 19-001 (see https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx), apply to services provided on or after July 1, 2019. At this time, DHCS has not yet obtained approval from CMS to continue the PHDP in SFY 2019-20.



Contracting Examples

- ***Example 1:***
  Hospital A has a full-risk capitation agreement with a Plan to care for a specific population. Hospital A also has a contract with Hospital B to provide quaternary care to that population when the service is not available at Hospital A. Hospital B receive payment directly from Hospital A for treating this population.
  A) If Hospital B is not contracted with the Plan, are they considered a network provider when providing quaternary services for this population?
  Yes, for the specific population and for quaternary services.
  B) If Hospital B is contracted with the Plan, but for a different population, are they considered a network provider when providing quaternary services for this population?
  Yes, for the specific population and for quaternary services.

- ***Example 2:***
  Hospital A has a contract with an Independent Physicians Association (IPA) to provide ancillary services. If a patient from the IPA presents to the hospital's emergency room and is ultimately admitted as an inpatient for treatment, is Hospital A considered a network provider?
  No for inpatient services; **Yes** for ancillary services.

- ***Example 3:***
  Hospital A has a contract with IPA A to treat their patient population with a Plan. Hospital A does not have a contract with IPA B to treat their population with the Plan. Is Hospital A considered a network provider when they treat members of IPA B?
  No. Hospital A is contracted for IPA A's population only.

- ***Example 4***:
  Hospital A has a one-year contract (as defined above) with a Plan to care for a specific population. Hospital A terminates the contract after 90 days. Does this contract meet the requirements under the contracting definition?
  Yes. The term of the agreement was for a period of at least 120 days. However, only services provided during the 90 days under contract would be counted.

- **Example 5:**
  Hospital A has a direct contract with a Plan. A beneficiary of the Plan assigned to IPA B for professional services was seen by a specialist at Hospital A. IPA B is financially responsible for the beneficiary's professional services. IPA B does not have a contract with Hospital A. Does this qualify as an unbroken contracting chain?
  No, this would not qualify. For professional services, there must be a contract between IPA B and Hospital A that meets the contracting definition.

PHDP: Implementation Timeline

In order to meet federal timely claim filing deadlines, DHCS must make PHDP payments for SFY 2017-18 to Plans no later than September 30, 2019 for Phase I and no later than March 31, 2020 for Phase II. Therefore, and considering both encounter system lags and the time needed to perform calculations, any additional or revised encounter data must be received by DHCS **no later than December 31, 2018 for Phase I**, and **no later than June 30, 2019 for Phase II**, to be considered during the calculation of final PHDP payments. Encounter data must

be submitted through existing, established processes, and DHCS is unable to accept data submitted through a supplemental process.

For SFY 2018-19, DHCS must make PHDP payments to Plans no later than September 30, 2020 for Phase I and no later than March 31, 2021 for Phase II. Therefore, encounter data must be received by DHCS **no later than December 31, 2019 for Phase I**, and **no later than June 30, 2020 for Phase II**, to be considered during the calculations of final PHDP payments.

Note: DHCS anticipates Plans will communicate specific encounter data submission deadlines that are earlier than the due dates noted above. Hospitals and Plans are expected to work together to determine these specific deadlines.

See the graphic below for an overview of the full PHDP implementation timeline.

SFY 2017-18:

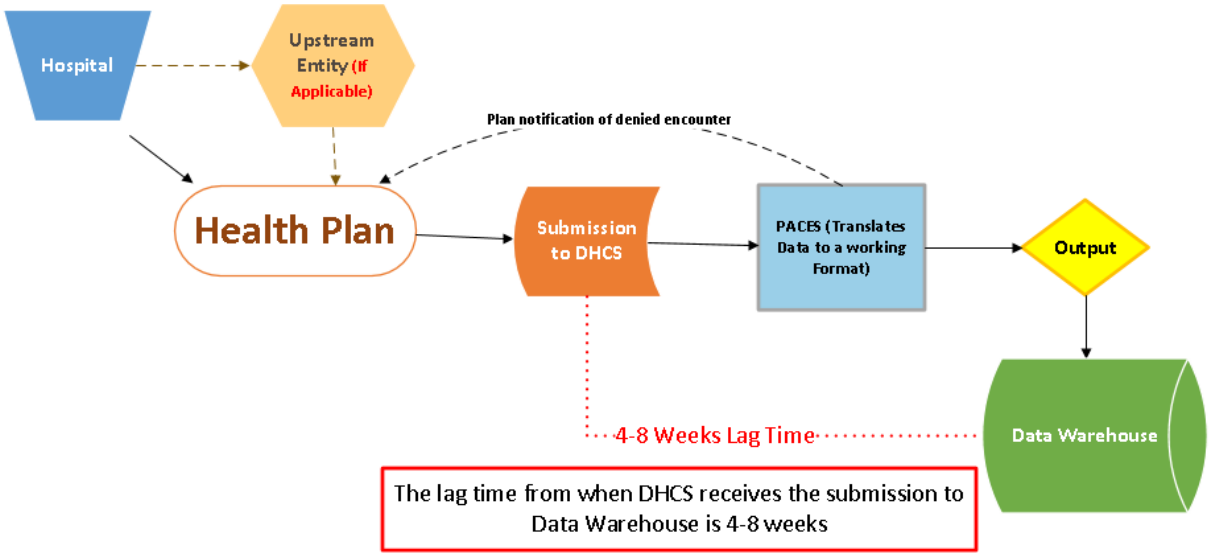
	ACTIVITY	Q4 CY2018	Q1 CY2019	Q2 CY2019	Q3 CY2019	Q4 CY2019	Q1 CY2020
Phase I	Deadline for Encounter Data Submission to Health Plans	Exact Due Dates are Plan Specific					
	Deadline for Encounter Data Submission to DHCS	December 31, 2018					
	Final Encounter Data Pull for Payment Calculation		March 2019				
	Development of Rate Adjustments			Q2 CY2019			
	Finalization of Rate Adjustments				July 1, 2009		
	Notice of Draft Payment Amounts				August 2019		
	Projected Payment to Plans				September 2019		
Phase II	Deadline for Encounter Data Submission to Health Plans			Exact Due Dates are Plan Specific			
	Deadline for Encounter Data Submission to DHCS			June 30, 2019			
	Final Encounter Data Pull for Payment Calculation				September 2019		
	Development of Rate Adjustments					Q4 CY2019	
	Finalization of Rate Adjustments						January 1, 2020
	Notice of Draft Payment Amounts						February 2020
	Projected Payment to Plans						March 2020

SFY 2018-19:

A detailed timeline for SFY 2018-19 will be added in future versions of this toolkit.

Encounter Data Flow

Encounters are generated by the provider of the service and transmitted, either directly or indirectly through an upstream entity, to the Plan. Once encounters are received, the Plan applies appropriate system edits and submits accepted encounters to DHCS, where the encounter system translates the incoming encounters into a working format that can be queried and used for statistical analysis and reporting. See the chart below for a visual representation of encounter data flow.



There is a 4–8-week lag (approximately) between the time Plans submit encounter data to DHCS and the time DHCS is able to query the encounter data for inclusion in encounter detail file. As a result, encounter data submitted to DHCS within approximately 8 weeks of the date of the encounter detail file likely will not be represented.

For further background information, please see the Standard Companion Guide Transaction Information released by DHCS, which details how encounter data is transacted once received in DHCS' systems:
https://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Documents/2.02%20834%205010%20Documents/2.02_WEDI_X12_5010_834_CG_TIv3_1v2.pdf

Also, below is a link to DHCS' managed care contract boilerplates:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

Counting Logic

Services are counted in accordance with the logic described in Appendix C subject to the caveats indicated below.

As of the December 2018 encounter data release, DHCS applied a technical update to the logic to map services more appropriately to particular service categories. DHCS added sorting logic that placed the detail lines of encounters in the same order as the service category mapping hierarchy outlined in Appendix C. Previously, service counts were applied to the first detail line of an encounter record, which did not appropriately account for encounter records that have detail lines corresponding to multiple service categories.

Inpatient Hospital days are equal to the Discharge Date (INPAT_DISCHARGE_DT) minus the Service From Date (SVC_FROM_DT). If the two fields contain the same date, the day count is set equal to "1". If INPAT_DISCHARGE_DT is blank, the Service To Date (SVC_TO_DT) is used instead.

For inpatient stays that span the beginning or end of a six-month phase, only the portion of "earned days" occurring during the service period are counted. For example, for SFY 2017-18 Phase I:

Service From Date	Discharge Date	Day Difference	Service Count
07/01/2017	07/01/2017	0	1
07/01/2017	07/02/2017	1	1
07/01/2017	07/03/2017	2	2
06/30/2017	07/01/2017	1	0
06/29/2017	07/02/2017	3	1
12/31/2017	01/01/2018	1	2
12/30/2017	01/02/2018	3	3

For **delivery-related inpatient stays**, the service count is equal to the lesser of:

- The value of the INPAT_DAYS_STAY field; or
- Twice the difference of INPAT_DISCHARGE_DT minus SVC_FROM_DT.
    - If the two fields contain the same date, the day count is set equal to "2".
    - If INPAT_DISCHARGE_DT is blank, SVC_TO_DT is used instead.

Delivery-related inpatient stays are identified as follows:

- PROC_CD is equal to one of the following: 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59610, 59612, 59614, 59510, 59514, 59515, 59525, 59618, 59620, 59622
  OR
- REVENUE_CD is equal to one of the following: 720, 721, 722, 724, 729
  OR
- PRIMARY_DIAG_CD_ICD10 is equal to one of the following: 0TQDXZZ, 0DQP0ZZ, 0DQP3ZZ, 0DQP4ZZ, 0DQP7ZZ, 0DQP8ZZ, 0DQR0ZZ, 0DQR3ZZ, 0DQR4ZZ, 0UQG0ZZ, 0UQG3ZZ, 0UQG4ZZ, 0UQG7ZZ, 0UQG8ZZ, 0UQGXZZ, 0UQM0ZZ, 0UQMXZZ, 0WQNXZZ, 0UJD7ZZ, 0W3R0ZZ, 0W3R3ZZ, 0W3R4ZZ, 0W3R7ZZ, 0W3R8ZZ, 2Y44X5Z, 0JCB0ZZ, 0JCB3ZZ, 0UCG0ZZ, 0UCG3ZZ, 0UCG4ZZ, 0UCM0ZZ, 0US90ZZ, 0US94ZZ, 0US9XZZ, 10H003Z, 10H00YZ, 10P003Z, 10P00YZ, 10P073Z, 10P07YZ, O6010X0, O6010X1, O6010X2, O6010X3, O6010X4, O6010X5, O6010X9, O6012X0, O6012X1, O6012X2, O6012X3, O6012X4, O6012X5, O6012X9, O6013X0, O6013X1, O6013X2, O6013X3, O6013X4, O6013X5, O6013X9, O6014X0, O6014X1, O6014X2, O6014X3, O6014X4, O6014X5, O6014X9, O6020X0, O6020X1, O6020X2, O6020X3, O6020X4, O6020X5, O6020X9, O6022X0, O6022X1, O6022X2, O6022X3, O6022X4, O6022X5, O6022X9, O6023X0, O6023X1, O6023X2, O6023X3, O6023X4, O6023X5, O6023X9, O670, O678, O679, O68, O690XX0, O690XX1, O690XX2, O690XX3, O690XX4, O690XX5, O690XX9, O691XX0, O691XX1, O691XX2, O691XX3, O691XX4, O691XX5, O691XX9, O692XX0, O692XX1, O692XX2, O692XX3, O692XX4, O692XX5, O692XX9, O693XX0, O693XX1, O693XX2, O693XX3, O693XX4, O693XX5, O693XX9, O694XX0, O694XX1, O694XX2, O694XX3, O694XX4, O694XX5, O694XX9, O695XX0, O695XX1, O695XX2, O695XX3, O695XX4, O695XX5, O695XX9, O6981X0, O6981X1, O6981X2, O6981X3, O6981X4, O6981X5, O6981X9, O6982X0, O6982X1, O6982X2, O6982X3, O6982X4, O6982X5, O6982X9, O6989X0, O6989X1,

O6989X2, O6989X3, O6989X4, O6989X5, O6989X9, O699XX0, O699XX1, O699XX2, O699XX3, O699XX4, O699XX5, O699XX9, O700, O701, O702, O703, O704, O709, O720, O721, O722, O723, O730, O731, O740, O741, O742, O743, O744, O745, O746, O747, O748, O749, O750, O751, O752, O753, O754, O755, O7581, O7582, O7589, O759, O76, O770, O771, O778, O779, O778, O779

For non-Inpatient visits, a visit is counted for each unique combination of patient (AKA_CIN), provider (NPI), and date of service (Service From Date).

- For ER services, the header-level date of service on the encounter record is used.
- For OP services, the detail-level date of service on the encounter record is used. This is intended to account for recurring visits where multiple visits are reported on one claim or encounter, such as for a series of physical therapy visits.

Questions

For questions, please contact:

- Private Hospitals – PrivateDP@dhcs.ca.gov
- Plans – PlanDP@dhcs.ca.gov

This toolkit and the statewide directory of private hospital and Plan contacts will be posted on DHCS's public website in the near future. Links will be provided at a later date.

Appendix A: Encounter Detail File Release Schedule

Date	SFY 17/18 Phase 1	SFY 17/18 Phase 2	SFY 18/19 Phase 1	SFY 18/19 Phase 2
June 29, 2018	✓			
August 17, 2018	✓	✓ (partial)		
October 12, 2018	✓	✓ (partial)		
November 9, 2018	✓	✓		
December 14, 2018	©			
March 1, 2019	©			
March 15, 2019		✓	✓	
April 12, 2019		✓	✓	
June 14, 2019		©	✓	✓
August 16, 2019			✓	✓
September 13, 2019		©		
October 11, 2019			✓	✓
December 13, 2019			©	✓

© indicates a data release for the purpose of contract status reporting. Future dates are tentative and subject to change.

Appendix B: Encounter Detail File Data Elements

Note: The following fields were populated with an “X” if they were left blank in the Summary Files.

OC_CD
CLAIM_FORM_IND
FI_CLAIM_TYPE_CD
FI_PROV_TYPE_CD
PROV_SPEC_CD
PROV_TAXON
POS_CD
REVENUE_CD
VENDOR_CD

Organized data elements alphabetically and added new elements and descriptions as appropriate.

ADJ_IND -

Code	Description
	Not an adjustment
1	Positive Supplemental
2	Negative Supplemental (negative only)
3	Refund to Medi-Cal (negative only)
4	Positive side of void and reissue
5	Negative side of void and reissue
6	Cash disposition (obsolete)

ADMIT_FAC_NPI - Admitting Facility NPI (from Claims)

AGE - Age of Beneficiary

AKA_CIN - Actual non-masked CIN Number

BENE_FIRST_NAME - Beneficiary First Name

BENE_LAST_NAME - Beneficiary Last Name

BENE_BIRTH_DT - Beneficiary Birth Date

BILL_TYPE_CD - A four-digit numeric code which identifies the specific type of bill (inpatient, outpatient, adjustments, voids, etc.). The first digit represents Type of Facility, the second digit the Bill Classification, and the third digit the Frequency. The first and second positions are separated from the third by the qualifier.

See accompanying attachment "Bill Type Code Defs.pdf".

BIRTH_DT - Birth Date

CCN - CMS' Certification Number (CCN), is the hospital's identification number and is linked to its Medicare provider agreement.

CHECK_DT - Check Issue Date

CLAIM_FORM_IND - Identifies if the claim form used is a UB-92 or a HCFA-1500 form

CLINIC_TYPE - Generated field based on a specified list of NPIs

FQ – Federally Qualified Health Centers
RH – Rural Health Clinic
IH – Indian Health Service
CB – Cost Based Reimbursement Clinics
NA – None of the Above

DTL_SVC_FROM_DT - Detail Service From Date

DTL_SVC_TO_DT - Detail Service To Date

ENCRYPTED_AKA_CIN - Encrypted CIN

FI_CLAIM_TYPE_CD -

Code	Description
	Unknown
01	Pharmacy
02	Long Term Care
03	Hospital Inpatient
04	Outpatient
05	Medical/Allied
06	Code not used at DHCS
07	Vision
09	Code not used at DHCS
5	Unknown
55	Unknown
AP	Advanced Payment (No Provider) (IHSS)
CC	Contract County Provider (IHSS)
IP	Individual Provider (IHSS)
RM	Restaurant & Meals (No Provider) (IHSS)

FI_PROV_TYPE_CD -

Code	Description
	UNKNOWN
000	UNKNOWN
001	ADULT DAY HEALTH CARE CENTERS
002	ASSISTIVE DEVICE AND SICK ROOM SUPPLY DEALERS

003	AUDIOLOGISTS
004	BLOOD BANKS
005	CERTIFIED NURSE MIDWIFE
006	CHIROPRACTORS
007	CERTIFIED NURSE PRACTIONER
008	CHRISTIAN SCIENCE PRACTIONER
009	CLINICAL LABORATORIES
010	GROUP CERTIFIED NURSE PRACTITIONER
011	FABRICATING OPTICAL LABORATORY
012	DISPENSING OPTICIANS
013	HEARING AID DISPENSERS
014	HOME HEALTH AGENCIES
015	COMMUNITY OUTPATIENT HOSPITAL
016	COMMUNITY INPATIENT HOSPITAL
017	LONG TERM CARE FACILITY
018	NURSE ANESTHETISTS
019	OCCUPATIONAL THERAPISTS
020	OPTOMETRISTS
021	ORTHOTISTS
022	PHYSICIANS GROUP
023	GROUP OPTOMETRISTS
024	PHARMACIES/PHARMACISTS
025	PHYSICAL THERAPISTS
026	PHYSICIANS
027	PODIATRISTS
028	PORTABLE X-RAY
029	PROSTHETISTS
030	GROUND MEDICAL TRANSPORTATION
031	PSYCHOLOGISTS
032	CERTIFIED ACUPUNTURIST
033	GENETIC DISEASE TESTING
034	MEDICARE CROSSOVER PROVIDER ONLY
035	RURAL HEALTH CLINICS/FEDERALLY QUALIFIED HEALTH CENTER
036	UNKNOWN
037	SPEECH THERAPISTS
038	AIR AMBULANCE TRANSPORTATION SERVICES
039	CERTIFIED HOSPICE
040	FREE CLINIC
041	COMMUNITY CLINIC
042	CHRONIC DIALYSIS CLINIC
043	MULTISPECIALTY CLINIC
044	SURGICAL CLINIC
045	CLINIC EXEMP FROM LICENSURE

046	REHABILITATION CLINIC
047	UNKNOWN
048	COUNTY CLINICS NOT ASSOCIATED WITH HOSPITAL
049	BIRTHING CENTER SERVICES
050	OTHERWISE UNDESIGNATED CLINIC
051	OUTPATIENT HEROIN DETOX CENTER
052	ALTERNATIVE BIRTH CENTERS - SPECIALTY CLINIC
053	EVERY WOMAN COUNTS
054	EXPANDED ACCESS TO PRIMARY CARE
055	LOCAL EDUCATION AGENCY
056	RESPIRATORY CARE PRACTITIONER
057	EPSDT SUPPLEMENTAL SERVICES PROVIDER
058	HEALTH ACCESS PROGRAM
059	HOME AND COMMUNITY BASED SERVICES NURSING FACILITY
060	COUNTY HOSPITAL INPATIENT
061	COUNTY HOSPITAL OUTPATIENT
062	GROUP RESPIRATORY CARE PRACTITIONERS
063	LICENCED BUILDING CONTRACTORS
064	EMPLOYMENT AGENCY
065	PEDIATRIC SUBACUTE CARE/LTC
066	PERSONAL CARE AGENCY
067	RVNS INDIVIDUAL NURSE PROVIDERS
068	HCBC BENEFIT PROVIDER
069	PROFESSIONAL CORPORATION
070	LICENSED CLINICAL SOCIAL WORKER INDIVIDUAL
071	LICENSED CLINICAL SOCIAL WORKER GROUP
072	MENTAL HEALTH INPATIENT SERVICES
073	AIDS WAIVER SERVICES
074	MULTIPURPOSE SENIOR SERVICES PROGRAM
075	INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT
076	DRUG MEDI-CAL
077	MARRIAGE AND FAMILY THERAPIST INDIVIDUAL
078	MARRIAGE AND FAMILY THERAPIST GROUP
080	CCS/GHPP NON-INSTITUTIONAL
081	CCS/GHPP INSTITUTIONAL
082	LICENSED MIDWIVES
084	INDEPENDENT DIAGNOSTIC TESTING FACILITY XOVER PROV ONLY
085	CLINICAL NURSE SPECIALIST X-OVER PROVIDER ONLY
086	MEDICAL DIRECTORS
087	LICENSED PROFESSIONALS
089	ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM
090	OUT OF STATE
092	RESIDENTIAL CARE FACILITIES FOR THE ELDERLY (RCFE)

093	CARE COORDINATOR (CCA).
095	PRIVATE NON-PROFIT PROPRIETARY AGENCY
098	UNKNOWN
099	UNKNOWN

HOSPITAL_NAME - Name of Hospital

HOSPITAL_SYSTEM - The names of the Hospitals derived based on NPIs

INPAT_ADMISSION_DT - Admission Date identifies the date the patient was admitted to the hospital (Inpatient and LTC claims only).

INPAT_DAYS_STAY - Inpatient Days Stay is only populated for inpatient and Long Term Care claims.

INPAT_DISCHARGE_DT - Discharge Date identifies the date the patient was discharged (Inpatient and LTC claims only).

INPAT_DISCHARGE_DT_FLAG - If =1, the blank INPAT_DISCHARGE_DT was populated with SVC_TO_DT

MAIN_SGMNT_ID_NO - Claim Line Number

MC_HDR_MEDI_CAL_PAID_AMT - Header Paid Amount

MC_STAT_A OR MC_STAT_B -

Code	Description
	No coverage
0	No coverage
1	Paid for by beneficiary
2	Paid for by State Buy-In
3	Free (Part A only)
4	Paid by state other than California
5	Paid for by Pension Fund
6	UNKNOWN
7	Presumed eligible
8	UNKNOWN
9	Aged alien ineligible for Medicare

Full Duals must meet both criteria:

- Medicare Indicator A – 1, 2, 3, 4, or 5
- Medicare Indicator B – 1, 2, 4 or 5

MC_STAT_D - Indicates an enrollee's Medicare Part D status

MEDICARE_STATUS -

Full Dual – Both Medicare Part A and Part B

MC_Part_A – Medicare Part A
MC_Part_B – Medicare Part B
MCal_only – No Medicare

MEDI_CAL_REIMB_AMT - Detail Paid Amount

NPI - National Provider Number (from Claims Header)

OC_CD - Identifies the Other Health Coverage (OC) circumstances for each service rendered

Value	Description
	No Coverage
2	Provident Life and Accident (no longer in use)
3	Principal Financial Group (no longer in use)
4	Pacific Mutual Life Insurance (no longer in use)
6	AARP (no longer in use)
9	Healthy Families
A	Any Carrier (includes multiple coverage), pay and chase
B	Blue Cross (no longer in use)
C	CHAMPUS Prime HMO
D	Medicare Part D
E	Plans Limited to Vision Coverage
F	Medicare Risk HMO (formerly First Farwest)
G	CDCR Medical Parolee Plan (formerly American General)
H	Multiple Plans Comprehensive
I	Public Institution Coverage (formerly Metropolitan Life)
K	Kaiser
L	Dental only policies
M	Two or more carriers (no longer in use)
N	No Coverage
O	Override - Used to remove cost avoidance OHC codes posted by DHS Recovery or data matches (OHC Source is H, R, or T). Changes OHC to A.
P	PHP/HMOs and EPO (Exclusive Provider Option) not otherwise specified
Q	Pharmacy Plans Only(Non-Medicare)
R	Ross Loos (no longer in use)
S	Blue Shield (no longer in use)
T	Travelers (no longer in use)
U	Connecticut General (no longer in use)
V	Any carrier other than above, includes multiple coverage (formerly Variable)
W	Multiple Plans Non-Comprehensive
X	Blue Shield (no longer in use)
Y	Blue Cross North (no longer in use)
Z	Blue Cross South (no longer in use)

PAT_CTL_NBR – Patient Control Number. Identifies the client or the client's episode of service within the provider's system to facilitate retrieval of individual financial and clinical records and posting of payment.

PLAN_CD - Plan Code from Eligibility Table

PLAN_CAP_AID_CD - Aid Codes based on capitation payments

PLAN_NAME - Health Plan Name

POS_CD - Point of Service Code

POS_CD	***Description***
0	Emergency Room
1	Inpatient Hospital
2	Outpatient Hospital
3	Nursing Facility, Level A/B
4	Home
5	Office, Lab, Clinic
6	ICF-DD
7	Other

PRIMARY_DIAG_CD - Primary Diagnosis Code

PRIMARY_DIAG_CD_ICD10 - Primary Diagnosis Coded for ICD-10.

PROC_CD - Procedure Code

PROC_IND -

Code	Description
	EDS Inpatient long-term care (LTC) Note: the procedure code field is a space, so the accommodation code is used.
0	DELTA Dental Table of Dental Procedures (prior to 7/1/93 when HCPCS [Health Care Financing Administration Common Procedure coding system] replaced them)
1	UB-92s ([Uniform Billing - 1992] Uniform Billing codes began on January 1, 1992.)
2	SMA [Scheduled Maximum Allowance] (replaced by HCPCS Levels II and III except for special rural health clinic/federally qualified health center codes) Note: EPSDT (Early Periodic Screening, Diagnosis and Treatment) claims always use this indicator.
3	UPC (Universal Product Code), PIN (Product Identification Number), HRI (Health Related Item), NDC (National Drug Code) codes for drugs, NDC medical supply codes and state drug code IDs for Medical Supplies. SEE F35B-MEDICAL-SUPPLY-INDICATOR and F35B-PROCE
4	CPT-4 (as of 11/1/87 -- Current Procedure Terms: A systematic listing and coding of healthcare procedures and services performed by clinicians. The American Medical Associations CPT-4 refers to procedures delivered by physicians.)
5	Unknown
6	California Health Facilities Commission (CHFC)
7	Los Angeles Waiver/L. A. Waiver
8	Short-Doyle/Medi-Cal (only on Plan Code 8)
9	HCPCS Levels II and III (effective on October 1, 1992)

PROV_SPEC_CD – Provider Specific Code

Code	Description
	Unknown
	Unknown
0	Unknown
1	Unknown
2	Unknown
3	Unknown
4	Unknown
5	Unknown
6	Unknown
7	Unknown
8	Unknown
#N	Unknown
*G	Unknown
*N	Unknown
00	General Practioner (Dentists Only)
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease (M.D. only)
07	Dermatology
08	Family Practice
09	Gynecology (D.O. only)
0X	UNKNOWN
1	Unknown
10	Gastroenterology (M.D. only), Oral Surgeon (Dentists Only)
11	Aviation (M.D. only)
12	Manipulative Therapy (D.O. only)
13	Neurology (M.D. only)
14	Neurological Surgery
15	Obstetrics (D.O. only), Endodontist (Dentists Only)
16	Obstetrics-Gynecology (M.D. Only) Neonatal
17	Ophthalmology, Otolaryngology, Rhinology (D.O. only)
18	Ophthalmology
19	Dentists (DMD)
1A	Unknown
1B	Unknown
1C	Unknown
1G	Unknown

1Y	Unknown
2	Nurse Practitioner (non-physician medical practitioner)
20	Orthopedic Surgery, Orthodontist (Dentists Only)
21	Pathologic Anatomy: Clinical Pathology (D.O. only)
22	Pathology (M.D. only)
23	Peripheral Vascular Disease or Surgery (D.O. only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation, Certified Orthodontist (Dentists Only)
26	Psychiatry (child)
27	Psychiatry Neurology (D.O. only)
28	Proctology (colon and rectal)
29	Pulmonary Diseases (M.D. only)
2X	Unknown
3	Physician Assistant (non-physician medical practitioner)
30	Radiology, Pedodontist (Dentists Only)
31	Roentgenology, Radiology (M.D. only)
32	Radiation Therapy (D.O. only)
33	Thoracic Surgery
34	Urology and Urological Surgery
35	Pediatric Cardiology (M.D. only)
36	Psychiatry
37	Unknown
38	Geriatrics
39	Preventive (M.D. only)
4	Nurse Midwife (non-physician medical practitioner)
40	Pediatrics, Periodontist (Dentists Only)
41	Internal Medicine
42	Nuclear Medicine
43	Pediatric Allergy
44	Public Health
45	Nephrology (Renal-Kidney)
46	Hand Surgery
47	Miscellaneous
48	Unknown
49	Unknown
5	Unknown
50	Prosthodontist (Dentists Only)
51	Unknown
52	Unknown
53	Unknown
54	Unknown
55	Unknown
56	Unknown

57	Unknown
58	Unknown
59	Unknown
6	Unknown
60	Oral Pathologist (Dentists Only)
61	Unknown
62	Unknown
63	Unknown
64	Unknown
65	Unknown
66	Emergency Medicine (Urgent Care)
67	Endocrinology
68	Hematology
69	Unknown
6Y	Unknown
7	Unknown
70	Clinic (mixed specialty), Public Health (Dentists Only)
71	Unknown
72	Unknown
73	Unknown
74	Unknown
75	Unknown
76	Unknown
77	Infectious Disease
78	Neoplastic Diseases/Oncology
79	Neurology-Child
7A	Unknown
8	Unknown
80	Full-Time Facility (Dentists Only)
81	Unknown
82	Unknown
83	Rheumatology
84	Surgery-Head and Neck
85	Surgery-Pediatric
86	Unknown
87	Unknown
88	Unknown
89	Surgery-Traumatic
9	Unknown
90	Pathology-Forensic
91	Pharmacology-Clinical
92	Unknown
93	Marriage, family and child counselor

94	Licensed clinical social worker
95	Registered nurse
96	Unknown
97	Unknown
98	Unknown
99	Unknown (on EDS claims)

PROV_TAXON - Billing Provider taxonomy identifies the provider type, classification, and specialization for the billing provider (Claims Header Information).

RECORD_ID - Record Identification Number provides a unique number for each claim header record.

- The first four digits of RECORD_ID indicate the year and month the Plan submitted the encounter record to DHCS. For example, if a Plan submitted the encounter record on August 19, 2018, the first four digits would be listed as 1808.

REF_PRESC_NPI - Referring Prescribing NPI (from Claims Detail)

REMOVE_NOTE - The reason a service count was removed i.e. (Full Duals, Part A or B, Other Coverage, NA)

REMOVE_SVC_CNT - A DHCS derived field that indicates how many units of service have been subtracted. This subtraction removes services performed at a CBRC, FQHC, IHCP, or RHC. It also removes services provided to enrollees with other health coverage as well as inpatient services provided to enrollees with Medicare Part A, and Non-Inpatient services provided to enrollees with Medicare Part B.

REND_OPERATING_NPI - Rendering Operating NPI (from Claims Detail)

REVENUE_CD - Revenue Code

SEC_DIAG_CD - Secondary Diagnosis Code

SEC_DIAG_CD_ICD10 - Secondary Diagnosis Code for ICD-10 identifies a patient's secondary diagnosis, which requires supplementary medical treatment.

SVC_CAT - Category of Service (COS) groups

SVC_CAT	Description
S01_IP	Inpatient Hospital
S02_ER	Emergency Room
S03_OP	Outpatient Facility
S04_LTC	Long-Term Care
S05_SP	Physician Specialty
S06_PCP	Physician Primary Care
S07_MHOP	Mental Health - Outpatient
S08_NPP	Other Medical Professional
S09_FQHC	FQHC
S10_OTH	All Other

COS is based on the COS grouping logic and hierarchy. For example, inpatient (S01) has a higher hierarchy than outpatient (S02). If a record meets both the criteria for inpatient and outpatient, that record will be classified as inpatient. See Appendix C for more details.

SVC_CNT - Service unit count (see Appendix C)

SVC_FROM_DT - Header Service From Date

SVC_TO_DT - Header Service To Date

SVC_UNITS_NBR - Service Units

VENDOR_CD -

Code	Description
	Unknown
M	INVALID
0	Unknown
00	INVALID
01	Adult Day Health Care Centers
02	Medicare Crossover Provider Only
03	CCS / GHPP
04	Genetic Disease Testing
05	Certified Nurse Midwife
06	Certified Hospice Service
07	Certified Pediatric NP
08	Certified Family NP
09	Respiratory Care Practitioner
1	UNKNOWN
10	Licensed Midwife Program
11	Fabricating Optical Labs
12	Optometric Group
13	Nurse Anesthetist
14	Expanded Access to Primary Care
16	INVALID
19	Portable X-ray Lab
2	INVALID
20	Physicians (MD or DO)
21	Ophthalmologist (San Joaquin Foundation only)
22	Physicians Group
23	Lay Owned Lab Services(RHF)
24	Clinical Lab
25	INVALID
26	Pharmacies
27	Dentist

28	Optometrist
29	Dispensing Optician
30	Chiropractor
31	Psychologist
32	Podiatrist
33	Acupuncturist
34	Physical Therapist
35	Occupational Therapist
36	Speech Therapist
37	Audiologist
38	Prosthetist
39	Orthotist
40	Other Provider (non-prof. prov svcs)
41	Blood Bank
42	Medically Required Trans
44	Home Health Agency
45	Hearing Aid Dispenser
47	Intermediate Care Facility-Developmentally Disabled
49	Birthing Center
5	INVALID
50	County Hosp - Acute Inpatient
51	County Hosp - Extended Care
52	County Hosp - Outpatient
53	Breast Cancer Early Detection Program
55	Local Education Agency
56	State Developmental Centers
57	State Hosp - Mentally Disabled
58	County Hosp - Hemodialysis Center
59	County Hosp - Rehab Facility
6	UNKNOWN
60	Comm Hosp - Acute Inpatient
61	Comm Hosp - Extended Care
62	Comm Hosp - Outpatient
63	Mental Health Inpatient Consolidation
64	Short Doyle Comm MH - Hosp Svcs
68	Comm Hosp - Renal Dialysis Center
69	Comm Hosp - Rehab Facility
70	Acute Psychiatric Hosp
71	Home/Comm Based Service Waivers
72	Surgicenter
73	AIDS Waiver Services
74	Short Doyle Comm MH Clinic Svcs
75	Organized Outpatient Clinic

76	DDS Waiver Services
77	Rural Health Clinics/FQHCs/Indian Health Clinics
78	Comm Hemodialysis Center
79	Independent Rehabilitation Facility
8	Unknown
80	Nursing Facility (SNF)
81	MSSP Waiver Services
82	EPSDT Supplemental Services
83	Pediatric Subacute Rehab/Weaning
84	Assist. Living Waiver Pilot Project (ALWPP)
87	INVALID
88	Self-Directed Services(SDS) Waiver Services
89	Personal Care Services Program (IHSS)
9	Unknown
90	Others and Out-of-State
91	Outpat Heroin Detox
92	Medi-Cal Targeted Case Management
93	DDS Targeted Case Management
94	CHDP Provider
95	Short Doyle Comm MH - Rehab Treatment
99	INVALID
A1	INVALID
B1	INVALID
CQ	Unknown
DN	Unknown
NF	Unknown
OD	INVALID
OE	INVALID
OG	INVALID
OH	INVALID
OL	INVALID
OM	INVALID
OO	INVALID
OS	INVALID
OT	INVALID
PA	Unknown
PC	Unknown
PS	Unknown
XX	INVALID

Appendix C: Category of Service Groupings - Mapping Logic

Notes for COS Mapping Logic:

1. DHCS groups data into different Categories of Service (COS). Below is a description of the hierarchy used to identify each of the COS.
2. Logic Format Notes: 1) All bullet points under each criteria must be met to satisfy that criteria. 2) For COS where there are multiple criteria, there is a line that reads: "Criteria Combinations". This line explains which criteria need to be met in order to satisfy the requirement for assignment to the COS. For example, if the line reads "Criteria Combinations - (1,2) or (1,3) or (1,4)", then if criteria 1 AND 2, or 1 AND 3, or 1 AND 4 are met, then the claim should be assigned to the COS.
3. The categories of service are listed in hierarchical order and should be followed when claims meet criteria for more than one COS. For example, if a claim meets criteria for both Inpatient and Emergency Room, the claim would be assigned to Inpatient because Inpatient is listed higher on the hierarchy than Emergency Room.
4. Any one claim/encounter is classified into only one COS. Therefore, if a claim has multiple detail lines with varying COS assignments, use the hierarchy to decide the COS to which the entire claim will be assigned.
5. Crossover claims should be reported in their corresponding COS.

Inpatient Hospital

Unit Type	Unit type special instructions
Days	One inpatient stay per calendar day per member for "earned days" occuring during the service period (Day Count = INPAT_DISCHARGE_DT − SVC_FROM_DT; when SVC_FROM_DT = INPAT_DISCHARGE_DT, then Day Count = 1)

Description: Facility-related expenses for hospital inpatient services, including room, board, and ancillary charges.
- **Includes** any Emergency Room facility charges for individuals who are admitted to the hospital on an inpatient basis.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- **Excludes** outpatient and Emergency Room (that does not result in an inpatient admission)
- **Excludes** LTC

Criteria #1
- **CLAIM_FORM_IND** = "U"
- **FI_CLAIM_TYPE_CD** = "03" (Inpatient Hospital)

Criteria #2
- **INPAT_DISCHARGE_DT** or **SVC_TO_DT** > **SVC_FROM_DT**

Criteria #3
- **Provider Type Codes**

60 - County Hospital Inpatient	72 - Mental Health Inpatient
16 - Community Hospital Inpatient	

Criteria #4
- **INPAT_DAYS_STAY** ≥ 1

Criteria Combinations - (1,2) or (1,3) or (1,4)

Community-Based Adult Services (CBAS)

Unit Type	Unit type special instructions
Days	Do not count more than one day as a unit per calendar day per member

Description: All expenses related to services provided by a CBAS center. CBAS replaced the former Adult Day Health Care program effective April 1, 2012.
- **Includes** both the per day CBAS costs as well as CBAS assessment costs.
- **Excludes** LTC facility costs as they are reported in the LTC facility COS line.

Criteria #1

Vendor Codes
01 - Adult Day Health Care Centers

Criteria #2

Procedure Codes	
H2000 - Comp multidisipln evaluation	S5102 - Adult day care per diem
T1023 - Program intake assessment	S5100 - day care services, adult per 15 minutes
S5101 - day care services, adult per half day	

Criteria Combinations - (1) or (2)

Emergency Room

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (SVC_FROM_DT), and facility (NPI)

Description: All facility-related expenses of an Emergency Room visit that did not result in an inpatient admission.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).
- After applying all COS logic, look for any OP facility claims occurring on the same day a member had an ER professional claim and reclassify these from OP Facility COS to ER COS

Criteria #1
- Claims with **FI_CLAIM_TYPE_CD** = 04 (Outpatient)

Criteria #2
- **POS_CD** = 0 (Emergency Room)

Criteria #3
- PROC_CD of Z7502, 99281, 99282, 99283, 99284, or 99285

Criteria #4
- Revenue Code of 450, 451, 452, 453, 454, 455, 456, 457, 458, or 459

Criteria Combinations - (1,2) or (1,3) or (1,4)

Outpatient Facility

Unit Type	Unit type special instructions
Visits	One visit = unique person (AKA_CIN), date of service (DTL_SVC_FROM_DT), and provider (NPI)

Description: All facility-related expenses incurred for outpatient services.
- **Excludes** Emergency Room
- **Includes** all facility-related costs for non-inpatient services from a hospital or other outpatient facilities such as an ambulatory surgery center.
- **Excludes** any physician, non-physician professional, and/or ancillary components billed separately on a CMS 1500 claim form (or other Non-UB form).

Criteria #1
- **Provider Type Codes**

61 - County Hospital Outpatient	15 - Community Hospital Outpatient Departments
49 - Birthing Centers-Primary Care Clinics	52 - Alternative Birth Centers- Specialty Clinics
44 - Surgical Clinics	42 - Chronic Dialysis Clinics

Criteria #2
- **FI_CLAIM_TYPE_CD** = 04 (Outpatient)
- **Provider Type Codes**

60 - County Hospital Inpatient	16 - Community Hospital Inpatient
72 - Mental Health Inpatient	

Criteria #3
- **FI_CLAIM_TYPE_CD** = 02 (Long Term Care) or 03 (Hospital Inpatient)
- **POS_CD** = 2 (Outpatient Hospital) or 5 (Office, Lab, Clinic)

Criteria #4
- **FI_PROV_TYPE_CD** = 50 (Clinic-otherwise undesignated)
- **Provider Taxonomy Codes**

261QX0200X	261QP3300X

Criteria Combinations - (1) or (2) or (3) or (4)

Appendix D: Crosswalk of Plan Names to Health Care Plan Codes

Plan Name	County	Plan Code	Region
Aetna	Sacramento	15	GMC
	San Diego	16	GMC
United	Sacramento	17	GMC
	San Diego	18	GMC
Alameda Alliance for Health	Alameda	300	Two-Plan
Anthem	Alpine	100	Regional
	Amador	101	Regional
	Butte	102	Regional
	Calaveras	103	Regional
	Colusa	104	Regional
	El Dorado	105	Regional
	Glenn	106	Regional
	Inyo	107	Regional
	Mariposa	108	Regional
	Mono	109	Regional
	Nevada	110	Regional
	Placer	111	Regional
	Plumas	112	Regional
	Sierra	113	Regional
	Sutter	114	Regional
	Tehama	115	Regional
	Tuolumne	116	Regional
	Yuba	117	Regional
	Fresno	362	Two-Plan
	Tulare	311	Two-Plan
	Alameda	340	Two-Plan
	San Francisco	343	Two-Plan
	Contra Costa	344	Two-Plan
	Kings	363	Two-Plan
	Madera	364	Two-Plan
	San Benito	144	Regional
	Sacramento	190	GMC
	Santa Clara	345	Two-Plan
CalOptima	Orange	506	COHS
CalViva Health	Fresno	315	Two-Plan
	Kings	316	Two-Plan
	Madera	317	Two-Plan

Plan Name	County	Plan Code	Region
CA Health & Wellness	Imperial	143	Regional
	Tehama	139	Regional
	Tuolumne	141	Regional
	Alpine	118	Regional
	Amador	119	Regional
	Butte	120	Regional
	Calaveras	121	Regional
	Colusa	122	Regional
	El Dorado	123	Regional
	Glenn	124	Regional
	Inyo	128	Regional
	Mariposa	129	Regional
	Mono	133	Regional
	Nevada	134	Regional
	Placer	135	Regional
	Plumas	136	Regional
	Sierra	137	Regional
	Sutter	138	Regional
	Yuba	142	Regional
Care 1st	San Diego	167	GMC
CenCal	San Luis Obispo	501	COHS
	Santa Barbara	502	COHS
Central CA Alliance for Health	Merced	514	COHS
	Santa Cruz	505	COHS
	Monterey	508	COHS
Community Health Group	San Diego	29	GMC
Contra Costa HP	Contra Costa	301	Two-Plan
Gold Coast HP	Ventura	515	COHS
Health Net	Los Angeles	352	Two-Plan
	Tulare	353	Two-Plan
	San Joaquin	354	Two-Plan
	Kern	360	Two-Plan
	Sacramento	150	GMC
	San Diego	68	GMC
	Stanislaus	361	Two-Plan

Plan Name	County	Plan Code	Region
HP of San Joaquin	San Joaquin	308	Two-Plan
	Stanislaus	312	Two-Plan
HP of San Mateo	San Mateo	503	COHS
Inland Empire HP	Riverside	305	Two-Plan
	San Bernardino	306	Two-Plan
Kaiser	Sacramento	170	GMC
	San Diego	79	GMC
	Amador	177	Regional
	Placer	179	Regional
	El Dorado	178	Regional
Kern Health Systems	Kern	303	Two-Plan
LA Care HP	Los Angeles	304	Two-Plan
Molina	Sacramento	130	GMC
	Imperial	145	Regional
	San Diego	131	GMC
	Riverside	355	Two-Plan
	San Bernardino	356	Two-Plan
Partnership Health Plan	Marin	510	COHS
	Napa	507	COHS
	Solano	504	COHS
	Yolo	509	COHS
	Sonoma	513	COHS
	Mendocino	512	COHS
	Lake	511	COHS
	Humboldt	517	COHS
	Lassen	518	COHS
	Modoc	519	COHS
	Shasta	520	COHS
	Siskiyou	521	COHS
	Trinity	522	COHS
	Del Norte	523	COHS
San Francisco Health Plan	San Francisco	307	Two-Plan
Santa Clara Family HP	Santa Clara	309	Two-Plan

Appendix E: Change Log

Changes from Previous Versions			
ID	**Change Description**	**Toolkit Section**	**Version Date**
1	Updated SFTP access link	Encounter Detail Files	08/2018
2	Added encounter detail file release details	Encounter Detail Files	08/2018
3	Added phased implementation	PHDP: Structure and Policy	08/2018
4	Added NPI & LTC update	Exclusions	08/2018
5	Updated implementation schedule	PHDP: Implementation Timeline	08/2018
6	Updated data release schedule	Appendix A	08/2018
7	Added more fields and descriptions	Appendix B	08/2018
8	Added Appendix E: Change Log	Appendix E	08/2018
9	Added Appendix F: Sample Encounter Volume Chart	Appendix F	08/2018
10	Identified State-only abortion services as an excluded service category	Exclusions	10/2018
11	Added new contracting service definition guidance	Contract Services	10/2018
12	Added links to Companion Guide and Managed Care contract boilerplates	Encounter Data	10/2018
13	Added new Counting Logic section	Counting Logic	10/2018
14	Added new data elements and descriptions as appropriate; various organizational changes	Appendix B	10/2018
15	Clarified unit type special instructions	Appendix C	10/2018
16	Removed procedure code Z7500, in combination with FI_CLAIM_TYPE_CD '04' (Outpatient), as an indicator of ER	Appendix C	10/2018
17	Inserted "Bill Type Code" list in Field Definitions	Appendix C	11/2018
18	Additional Contracting Scenario Added	Contract Services	11/2018
19	Added to the Contract Services definition	Contract Services	12/2018
20	December 2018 release logic update	Counting Logic	12/2018
21	Updated with information related to SFY 2018-19	Multiple sections	03/2019
22	Added reference to All Plan Letter 19-001	Contract Services	03/2019
23	Updated encounter detail file release schedule	Appendix A	03/2019
24	Removed Appendix F	Appendix F	03/2019