**STATE OF CALIFORNIA**

**DEPARTMENT OF HEALTH CARE SERVICES**

# MEDI-CAL MANAGEMENT INFORMATION SYSTEM


## SCPI User Manual

(Formerly the ARDS User Manual)

**Revision Date: December 14, 2011**

# Table of Contents

# Section 1 - General Information

## 1.1 Introduction

Through individual agreements, the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) supplies Supplemental Claims Payment Information (SCPI) to Medi-Cal providers and designated agents on computer media. The SCPI information is provided weekly for each Medi-Cal checkwrite. This system was previously known as Automated Remittance Data Services (ARDS) (Reference OIL 264-07). The SCPI information supplied is intended for claim reconciliation purposes only. Dollar values provided on the reconciliation data file may not balance with the dollar value on the check received from DHCS due to adjustment transactions that are not claim-specific. The claim information supplied is current and accurate as of the date the SCPI information was supplied to DHCS.

## 1.2 Contract Information

Each Medi-Cal provider must complete a *SCPI Enrollment* form. If the SCPI data is being delivered to an address other than that specified in the Provider Master File (PMF), or the SCPI data is being delivered to a provider's designated agent, a SCPI Agreement must also be completed. All enrollment forms and service agreements must be returned to the FI prior to electronic SCPI record creation. The FI supplies SCPI information to the provider or designated agent by provider number.

The FI must be informed in writing if there are any additions or deletions to the list of provider numbers for which SCPI data is supplied. All correspondence should be conducted with the SCPI coordinator.

Providers wishing to receive more than one type of media delivered to their address as specified in the PMF must have the Adjudicated Claim Line (ACL) charges deducted from their weekly checkwrite.

Medi-Cal designated agents are invoiced on a monthly basis for SCPI information received. A minimum monthly charge and a one-time implementation fee are applied to all designated agents of Medi-Cal providers. Providers can contact the FI at (916) 373-7705 for current pricing information or to request copies of the SCPI forms.

## 1.3 Available Computer Media

SCPI information is currently available exclusively through Medi-Cal Transaction Services.

### 1.3.1 Medi-Cal Transaction Services

Currently, the Medi-Cal reconciliation data can be retrieved through the Medi-Cal website at www.medi-cal.ca.gov. Users must have access to a browser. The recommended browsers are Microsoft Internet Explorer and Mozilla Firefox, and both can be downloaded from the Medi-Cal Web Tool Box page or the vendor's website, free of charge. Users may find the best results viewing the website with these versions, along with a screen resolution set to at least 800 by 600 pixels.

| Field | Description |
|---|---|
| File Name | On Medi-Cal Transaction Services:<br>SUB_CCYYMMDD.zip where SUB is the registered submitter ID and CCYYMMDD is the checkwrite date.<br>On the PC, unachieved:<br>• RCCYYMMDD contains RAD records<br>• SCCYYMMDD contains Summary Report |
| Encoding Format | All archives are encoded in uppercase "American Standard Code for Information Interchange" (ASCII). |
| Record Length | Maximum of 1573 bytes (refer to Section 4 for specific record layouts). |
| File Format | Fixed record lengths depending on record type. All records on file are padded to the length of the longest record for the particular contract. |
| End of Record | Hex OD/OA<br>Decimal 13/10<br>ASCII CR/LF |
| End of File | Hex 1A<br>Decimal 26<br>ASCII SUB |
| Archiving Software | The SCPI File and Summary File are concatenated and compressed together into a single archive file in Zip format. The file must be downloaded to a PC to be uncompressed using a Zip program. A Zip program called WinZip is available for download free of charge on the Medi-Cal Web Tool Box page. |

## 1.4 Record Layout Specification Form

### 1.4.1 General

Record layouts now include two additional fields – Provider Owner Number and Provider Type – to accommodate the 10-digit National Provider Identifier (NPI) submitted with files created on or after November 19, 2007. Record layouts in this manual reflect the changes that were made to files created on or after June 25, 2010. The record layout specification for Medi-Cal Transaction Services is contained in Section 2 of this document. The claim type determines the following record format(s) computer media:

- Pharmacy (01)
- Long Term Care (02)
- Inpatient (03)
- Outpatient (04)
- Medical/Physician (05)
- Medicare Crossover (06)

An additional C1 record is present for Other Health Coverage (OHC) Carrier Data if the OHC Data Indicator is **Y** on the claim type record.

The information contained in these records corresponds to the Remittance Advice Details (RAD) for providers. The RAD accompanies the checkwrite from DHCS.

### 1.4.2 Field Descriptions

Descriptions of the column headings on the Record Layout Specification Form are as follows:

| Field | Description |
|---|---|
| Record/Format Name | The claim type and, if applicable, whether it is a detail or total record. |
| Record/Format Length | The length of the record excluding any padding done on the record and control bytes on tape or end of record mark on Medi-Cal Transaction Services. |
| D.E. No. | Data Element Number. This number correlates to the field descriptions contained in Appendix 4.1. |
| A/N/P | The format of the field<br>A/N = alphanumeric<br>N = numeric only<br>P = packed |
| No. of Occurs | Number of occurrences for a field or series of fields, if more than once. |
| Length | Length of the field. |
| Picture | Picture description of the field shown in COBOL notation. The number in parentheses indicates the number of bytes in the format preceding the parentheses.<br>X = alphanumeric<br>9 = numeric only<br>V = implied decimal<br>S = signed (positive or negative) |
| Data Position | Inclusive starting and ending bytes of the field. |
| Field Name | Name of the field. Correlates to the field descriptions that are contained in Appendix 4.1. Field names that are indented are subdivisions of the primary field name. |

## 1.5 Description of SCPI Data File

The SCPI data file is sorted by claim type within the provider number category.

The file is designed to simulate the paper Remittance Advice Detail (RAD) received from DHCS. Certain claim types contain total data records along with the detail service line records. These are Outpatient (T4), and Medical/Physician (T5). These records help mirror the paper RAD. It is recommended that reconciliation processing be done against detail services line records only.

The records are defined as four processing categories:

| Claim Type | Adjudication Status | Disposition Code |
|---|---|---|
| 1. Denied Claims | 3 | N/A |
| 2. Approved Claims | 8 | N/A |
| 3. Adjustments | 8 | 2, 3, 5, 6 |
| 4. Suspended Claims | 4, 5, 6 | N/A |

Total Data records for Outpatient, Medical/Physician, and Vision Care are generated for each Claim Control Number (CCN) in a particular processing category.

Adjustments may have two records pertaining to a particular CCN. One record negates the original claim line and the second recreates it.

All suspended claims are included in the reconciliation data file; the paper RAD currently shows only those claims in suspense longer than 30 days.

## 1.6 Generated Reports

The Summary Counts for Computer Media RAD Records report accompanies each reconciliation data file distributed. A sample of this report is shown in the figure below.

The Summary Counts for Computer Media RAD Records report lists summary information by Provider Number, Owner Number, Provider Type and Claim Type for total line counts and dollar figures in each processing category. Providers who participate in the County Medical Services Program (CMSP) show two lines for each processing category – one for Medi-Cal and one for CMSP. Summary information for the tape is shown on the last page of the report.

As of January 2, 1996, the Summary Counts for Computer Media RAD Records report is no longer distributed on paper, but is sent as a second data set on the media requested. The data set holds an 80-column image of the Summary Counts for Computer Media RAD Records report. Header lines are printed every 54 lines, and no carriage control is included in this file.

## Summary Counts for Computer Media RAD Records

```
REPORT NO.  AA-O-PPP     PROVIDER NAME                                  PAGE     1
REPORT DATE 11/12/05  SUMMARY COUNTS FOR COMPUTER MEDIA RAD RECORDS
RUN ON 11/12/04 AT 08:17

PROV:1234567890 OWN:01 PROV TYP:999 CLM TYPE:03 MEDICAL    WARRANT DATE:11/12/05

      TOT LINES  CMC LINES  EPC LINES   TOT CHARGE    NON-COVERED      ALLOWABLE
                       PAID AMOUNT   PATIENT LIAB  3RD PARTY AMT    REIM AMOUNT
ADJ         0          0          0           0.00           0.00           0.00
                               0.00           0.00           0.00           0.00
APPR       11          0          0      47,179.03      15,924.32      31,254.71
                           6,563.49           0.00           0.00       6,563.49
DENY        7          0          0      16,983.45           0.00           0.00
                               0.00           0.00           0.00           0.00
-------------------------------------------------------------------------------
PROV:1234567891 OWN:01 PROV TYP:999 CLM TYPE:03 MEDICAL    WARRANT DATE:11/12/05

      TOT LINES  CMC LINES  EPC LINES   TOT CHARGE    NON-COVERED      ALLOWABLE
                       PAID AMOUNT   PATIENT LIAB  3RD PARTY AMT    REIM AMOUNT
ADJ        10          0          0           0.00     -12,694.04      12,694.04
                           1,362.25           0.00           0.00       1,362.25
APPR       10          0          0           0.00     -12,694.04      12,694.04
                           1,362.25           0.00           0.00       1,362.25
DENY        5          0          0      11,344.04           0.00           0.00
                               0.00           0.00           0.00           0.00
-------------------------------------------------------------------------------
-------------------------------------------------------------------------------
-------------------------------------------------------------------------------
SUMMARY TOTAL COUNTS FOR PROVIDER NAME

      TOT LINES  CMC LINES    CMC PERCENT OF TOTAL   TOTAL CHARGE    REIM AMOUNT
ADJ         10          0              0.0               0.00       1,362.25
APPR        21          0              0.0          47,179.03       7,925.74
DENY        12          0              0.0          28,327.49           0.00
SUSP         0          0              0.0               0.00           0.00
TOTAL       43          0              0.0

------------------------------------ CMSP -------------------------------------
-------------------------------------------------------------------------------
-------------------------------------------------------------------------------
-------------------------------------------------------------------------------
            43          0    TOTAL ADJ, APPR, AND DENY LINES
             0          0    TOTAL SUSP LINES

AFFILIATED CMPTR SRVCS
CMC OPERATIONS
820 STILLWATER ROAD
WEST SACRAMENTO CA 95605
```

## 1.7 Test Supplemental Claims Payment Information Files

A test file may be created upon request for use in program testing, delaying the start date for receiving actual payment data. The implementation fee is required prior to creating a test file. The regular contract invoicing begins when actual payment data is received.

To request a test file, users should contact the FI SCPI Operations at (916) 373-7705. The SCPI Coordinator can assist the user in setting up the correct specifications for receiving the SCPI file on computer media.

**IBM 3490E Cartridge (EBCDIC only) Record Layout Specifications**

Effective June 25, 2010, DHCS no longer supports the delivery of Medi-Cal reconciliation data on IBM 3490E tape cartridges.

As a result, the “IBM 3490E Cartridge (EBCDIC only) Record Layout Specifications” section was deleted as of February 2010.

# Section 2 - Medi-Cal Transaction Services Record Layout Specifications

The following section contains layouts for files created on or after June 25, 2010.

Changes/additions are highlighted in bold.

**Note:** Vision Care Claims were made obsolete with SDN 02014, HIPAA: Conversion of Vision Qualifier Code Set, (July 1, 2006) and are no longer included in the SCPI system.

### 2.1.1 Pharmacy

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: PHARMACY (01)
RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |

## Pharmacy (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: PHARMACY (01)

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |
| ---- | A/N | | 4 | X(4) | 263-266 | Filler |
| 0501 | A/N | | 11 | X(11) | 267-277 | Drug Code |
| 0386 | A/N | | 8 | X(08) | 278-285 | Prescription Number |
| 0327 | N | | 5 | 9(05) | 286-290 | Units of Service |
| 0321 | P | | 5 | S9(07)V99 | 291-300 | Claim Submitted Amount |
| ---- | A/N | | 5 | X(05) | 301-310 | Filler |
| 0380 | P | | 5 | S9(07)V99 | 311-320 | Allowable Payment Amount |
| ---- | A/N | | 15 | X(15) | 321-335 | Filler |
| 0904 | A/N | | 4 | X(04) | 336-339 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 340-340 | Filler |
| 0904 | A/N | | 4 | X(04) | 341-344 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 345-345 | Filler |
| 0904 | A/N | | 4 | X(04) | 346-349 | Explanation Code 3 |
| 0901 | P | | 10 | S9(07)V99 | 350-359 | Share of Cost / Patient Liability |
| ---- | A/N | | 10 | X(10) | 360-369 | Filler |
| 0349 | N | | 10 | S9(07)V99 | 370-379 | Amount Payable |
| 1335 | A/N | | 4 | X(04) | 380-383 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 384-392 | OHC Policy Holder SSN |
| 0327 | N | | 10 | 9(07V999 | 393-402 | Units of Service (Metric Decimal Quantity |
| | N | | 6 | +9(03)V99 | 403-408 | Co-pay Amount |
| | A/N | | 1 | X(01) | 409-409 | Co-pay Indicator |
| ---- | A/N | | 7 | X(07) | 410-480 | Filler |

## 2.1.2 Long Term Care

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: LONG TERM CARE (01) — RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | 96 | | | 031-126 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date – From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |

## Long Term Care (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: LONG TERM CARE (01)

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 18 | X(18) | 263-280 | Filler |
| 0348 | N | | 3 | 9(03) | 281-283 | Claim Covered Accomm |
| 0240 | A/N | | 2 | X(02) | 284-285 | Accommodation Code |
| 0334 | A/N | | 1 | X(01) | 286-286 | Medicare Status |
| 0316 | A/N | | 2 | X(02) | 287-288 | Patient Status |
| ---- | A/N | | 2 | X(02) | 289-290 | Filler |
| 0914 | N | | 10 | S9(07)V99 | 291-300 | Claim Submitted Amount |
| 0815 | N | | 10 | S9(07)V99 | 301-310 | Non-Covered Charges |
| 0380 | N | | 10 | S9(07)V99 | 311-320 | Allowable Payment Amount |
| 0382 | N | | 5 | S9V999 | 321-325 | Reimbursement Rate |
| RC10 | N | | 10 | S9(07)V99 | 326-335 | Paid Amount |
| 0904 | A/N | | 4 | X(04) | 336-339 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 340-340 | Filler |
| 0904 | A/N | | 4 | X(04) | 341-344 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 345-345 | Filler |
| 0904 | A/N | | 4 | X(04) | 346-349 | Explanation Code 3 |
| 0901 | N | | 10 | S9(07)V99 | 350-359 | Share of Cost / Patient Liability |
| 0329 | N | | 10 | S9(07)V99 | 360-369 | Other Coverage |
| 0349 | N | | 10 | S9(07)V99 | 370-379 | Amount Payable |
| 1335 | A/N | | 4 | X(04) | 380-383 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 384-392 | OHC Policy Holder SSN |
| ---- | A/N | | 88 | X(88) | 393-480 | Filler |

### 2.1.3 Inpatient

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: INPATIENT (03) — RECORD/FORMAT LENGTH: FIXED @ 1573

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |

## Inpatient (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: INPATIENT (03)
RECORD/FORMAT LENGTH: FIXED @ 1573

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 6 | X( 6) | 263-268 | Filler |
| RC80 | A/N | | 2 | X(02) | 269-270 | Line Count |
| | | 22 | 54 | | 271-1458 | Detail Service Lines |
| RC60 | N | | 2 | 9(02) | 271-272 | Line Number |
| 0925 | N | | 3 | 9(03) | 273-275 | Days/Revenue Units |
| RC65 | A/N | | 1 | X(01) | 276-276 | Hours Indicator |
| 0923 | A/N | | 4 | X(04) | 277-280 | Accommodation Code/Cost Center Code |
| 0914 | N | | 10 | S9(07)V99 | 281-290 | Claim Submitted Amount |
| 0815 | N | | 10 | S9(07)V99 | 291-300 | Non-Covered Charges |
| 0380 | N | | 10 | S9(07)V99 | 301-310 | Allowable Payment Amount |
| 0904 | A/N | | 4 | X(04) | 311-314 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 315-315 | Filler |
| 0904 | A/N | | 4 | X(04) | 316-319 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 320-320 | Filler |
| 0904 | A/N | | 4 | X(04) | 321-324 | Explanation Code 3 |
| RC15 | N | | 3 | 9(03) | 1459-1461 | Total of Days/ Revenue Units |
| 0321 | N | | 10 | S9(07)V99 | 1462-1471 | Total Claim Charge |
| RC20 | N | | 10 | S9(07)V99 | 1472-1481 | Total of Line Non-Covered Charges |
| RC25 | N | | 10 | S9(07)V99 | 1482-1491 | Total of Line Payable Charges |

## Inpatient (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: INPATIENT (03)

RECORD/FORMAT LENGTH: FIXED @ 1573

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| 0382 | N | | 5 | S9V999 | 1492-1496 | Reimbursement Rate |
| RC30 | N | | 10 | S9(07)V99 | 1497-1506 | Total of Line Paid Amounts |
| 0904 | A/N | | 4 | X(04) | 1507-1510 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 1511-1511 | Filler |
| 0904 | A/N | | 4 | X(04) | 1512-1515 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 1516-1516 | Filler |
| 0904 | A/N | | 4 | X(04) | 1517-1520 | Explanation Code 3 |
| 0901 | N | | 10 | S9(07)V99 | 1521-1530 | Share of Cost / Patient Liability |
| 0329 | N | | 10 | S9(07)V99 | 1531-1540 | Other Coverage |
| 0349 | N | | 10 | S9(07)V99 | 1541-1550 | Amount Payable |
| 1335 | A/N | | 4 | X(04) | 1551-1554 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 1555-1563 | OHC Policy Holder SSN |
| ---- | A/N | | 10 | X(10) | 1564-1573 | Filler |

### 2.1.4 Outpatient

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: OUPATIENT (04) DETAIL SERVICE LINES — RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From 0313 |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date – To |

## Outpatient (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: OUPATIENT (04) DETAIL SERVICE LINES

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 18 | X(18) | 263-280 | Filler |
| 0327 | N | | 3 | 9(03) | 281-283 | Units of Service |
| 0500 | A/N | | 5 | X(05) | 284-288 | HCPCS Code |
| 0384 | A/N | | 2 | X(02) | 289-290 | HCPCS Code Modifier |
| 1343 | A/N | | 4 | X(04) | 291-294 | NUBC Revenue Code |
| 0091 | A/N | | 2 | X(02) | 295-296 | HCPCS Code Modifier 2 |
| 0092 | A/N | | 2 | X(02) | 297-298 | HCPCS Code Modifier 3 |
| 0093 | A/N | | 2 | X(02) | 299-300 | HCPCS Code Modifier 4 |
| 0914 | N | | 10 | S9(07)V99 | 301-310 | Claim Submitted Amount |
| 0815 | N | | 10 | S9(07)V99 | 311-320 | Non-Covered Charges |
| 0380 | N | | 10 | S9(07)V99 | 321-330 | Allowable Payment Amount |
| 0382 | N | | 5 | S9V999 | 331-335 | Reimbursement Rate |
| RC10 | N | | 10 | S9(07)V99 | 336-345 | Paid Amount |
| 0904 | A/N | | 4 | X(04) | 346-349 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 350-350 | Filler |
| 0904 | A/N | | 4 | X(04) | 351-354 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 355-355 | Filler |
| 0904 | A/N | | 4 | X(04) | 356-359 | Explanation Code 3 |
| 0901 | N | | 10 | S9(07)V99 | 360-369 | Share of Cost / Patient Liability |
| 0329 | N | | 10 | S9(07)V99 | 370-379 | Other Coverage |
| 0349 | N | | 10 | S9(07)V99 | 380-389 | Amount Payable |
| 1335 | A/N | | 4 | X(04) | 390-393 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 394-402 | OHC Policy Holder SSN |
| ---- | A/N | | 10 | X(10) | 403-412 | Filler |
| | N | | 6 | +9(03)V99 | 413-418 | Co-pay Amount |
| | A/N | | 1 | X(01) | 419-419 | Co-pay Indicator |
| ---- | A/N | | 71 | X(71) | 420-490 | Filler |

## Outpatient (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: OUPATIENT (T4) TOTAL DATA

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From 0313 |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date – To |

## Outpatient (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: OUPATIENT (T4) TOTAL DATA — RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 28 | X(28) | 263-290 | Filler |
| 0321 | N | | 11 | S9(08)V99 | 291-301 | Total Claim Charge |
| RC20 | N | | 10 | S9(07)V99 | 302-311 | Total of Line Non-Covered Charges |
| RC25 | N | | 11 | S9(08)V99 | 312-322 | Total of Line Payable Charge |
| 0382 | N | | 5 | S9V999 | 323-327 | Reimbursement Rate |
| RC30 | N | | 10 | S9(07)V99 | 328-337 | Total of Line Paid Amounts |
| 0904 | A/N | | 4 | X(04) | 338-341 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 342-342 | Filler |
| 0904 | A/N | | 4 | X(04) | 343-346 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 347-347 | Filler |
| 0904 | A/N | | 4 | X(04) | 348-351 | Explanation Code 3 |
| RC35 | N | | 10 | S9(07)V99 | 352-361 | Total of Line Share of Cost |
| RC40 | N | | 10 | S9(07)V99 | 362-371 | Total of Line Other Coverage Am |
| RC45 | N | | 11 | S9(08)V99 | 372-382 | Total of Line Amounts Payable |
| ---- | A/N | | 98 | X(98) | 383-480 | Filler |

### 2.1.5 Medical/Physician

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICAL/PHYSICIAN (05) DETAIL SERVICE LINES
RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |

## Medical/Physician (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICAL/PHYSICIAN (05) DETAIL SERVICE LINES — RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 18 | X(18) | 263-280 | Filler |
| 9315 | N | | 3 | 9(03) | 281-283 | Quantity |
| 0500 | A/N | | 5 | X(05) | 284-288 | HCPCS Code |
| 0384 | A/N | | 2 | X(02) | 289-290 | HCPCS Code Modifier |
| 0914 | N | | 10 | S9(07)V99 | 291-300 | Claim Submitted Amount |
| ---- | A/N | | 10 | X(10) | 301-310 | Filler |
| 0380 | N | | 10 | S9(07)V99 | 311-320 | Allowable Payment Amount |
| ---- | A/N | | 15 | X(15) | 321-335 | Filler |
| 0904 | A/N | | 4 | X(04) | 336-339 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 340-340 | Filler |
| 0904 | A/N | | 4 | X(04) | 341-344 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 345-345 | Filler |
| 0904 | A/N | | 4 | X(04) | 346-349 | Explanation Code 3 |
| 0901 | N | | 10 | S((07)V99 | 350-359 | Share of Cost/Patient Liability |
| 0329 | N | | 10 | S9(07)V99 | 360-369 | Other Coverage |
| 0349 | N | | 10 | S9(07)V99 | 370-379 | Amount Payable |
| 1335 | A/N | | 4 | X(04) | 380-383 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 384-392 | OHC Policy Holder SSN |
| ---- | A/N | | 10 | X(10) | 393-402 | Filler |
| | N | | 6 | +9(03)V99 | 403-408 | Co-pay Amount |
| | A/N | | 1 | X(01) | 409-409 | Co-pay Indicator |
| ---- | A/N | | 71 | X(71) | 410-480 | Filler |

## Medical/Physician (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICAL/PHYSICIAN (T5) TOTAL DATA

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | 100 | | | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | **X(20)** | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | **233-233** | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |

## Medical/Physician (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICAL/PHYSICIAN (T5) TOTAL DATA
RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 28 | X(28) | 263-290 | Filler |
| 0321 | N | | 11 | S9(08)V99 | 291-301 | Total Claim Charge |
| ---- | A/N | | 10 | X(10) | 302-311 | Filler |
| RC25 | N | | 11 | S9(08)V99 | 312-322 | Total of Line Payable Charges |
| ---- | A/N | | 15 | X(15) | 323-337 | Filler |
| 0904 | A/N | | 4 | X(04) | 338-341 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 342-342 | Filler |
| 0904 | A/N | | 4 | X(04) | 343-346 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 347-347 | Filler |
| 0904 | A/N | | 4 | X(04) | 348-351 | Explanation Code 3 |
| RC35 | N | | 10 | S9(07)V99 | 352-361 | Total of Line Share of Cost |
| RC40 | N | | 10 | S9(07)V99 | 362-371 | Total of Line Other Coverage Am |
| RC45 | N | | 11 | S9(08)V99 | 372-382 | Total of Line Amounts Payable |
| ---- | A/N | | 98 | X(98) | 383-480 | Filler |

## 2.1.6 Medicare Crossover

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICARE CROSSOVER (06) — RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC05 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 0202 | A/N | | 28 | X(28) | 003-030 | Provider Name |
| 0203 | | | 100 | | 031-130 | Provider Address |
| | A/N | | 24 | X(24) | 031-054 | Attention Line |
| | A/N | | 24 | X(24) | 055-078 | Address Line 1 |
| | A/N | | 24 | X(24) | 079-102 | Address Line 2 |
| | A/N | | 17 | X(17) | 103-119 | City |
| | A/N | | 2 | X(02) | 120-121 | State |
| | N | | 9 | 9(09) | 122-130 | Zip Code |
| 0201 | A/N | | 10 | X(10) | 131-140 | Provider Number |
| 2002 | N | | 2 | 9(02) | 141-142 | Owner Number |
| 0205 | N | | 3 | 9(03) | 143-145 | Provider Type |
| 0800 | N | | 2 | 9(02) | 146-147 | Claim Type |
| 0943 | N | | 9 | 9(09) | 148-156 | Sequence Number |
| 0376 | N | | 6 | 9(06) | 157-162 | Warrant Date |
| 0101 | A/N | | 14 | X(14) | 163-176 | Recipient ID Number |
| 0103 | A/N | | 23 | X(23) | 177-199 | Recipient Name |
| 0320 | A/N | | 20 | X(20) | 200-219 | Medical Record Number |
| 0300 | A/N | | 13 | X(13) | 220-232 | Claim Control Number |
| 0351 | A/N | | 1 | X(01) | 233-233 | Adjudication Status |
| 0816 | A/N | | 1 | X(01) | 234-234 | Claim Disposition |
| 0817 | A/N | | 13 | X(13) | 235-247 | Prior CCN |
| 0911 | A/N | | 3 | X(03) | 248-250 | Adjustment Reason Code |
| 0312 | N | | 6 | 9(06) | 251-256 | Service Date - From |
| 0313 | N | | 6 | 9(06) | 257-262 | Service Date - To |

## Medicare Crossover (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICARE CROSSOVER (06)

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| ---- | A/N | | 23 | X(23) | 263-285 | Filler |
| 0334 | A/N | | 1 | X(01) | 286-286 | Medicare Status |
| ---- | A/N | | 4 | X(04) | 287-290 | Filler |
| 0914 | N | | 10 | S9(07)V99 | 291-300 | Claim Submitted Amount |
| 0815 | N | | 10 | S9(07)V99 | 301-310 | Non-Covered Charges |
| 0380 | N | | 10 | S9(07)V99 | 311-320 | Allowable Payment Amount |
| 0382 | N | | 5 | S9V999 | 321-325 | Reimbursement Rate |
| RC10 | N | | 10 | S9(07)V99 | 326-335 | Paid Amount |
| 0904 | A/N | | 4 | X(04) | 336-339 | Explanation Code 1 |
| ---- | A/N | | 1 | X(01) | 340-340 | Filler |
| 0904 | A/N | | 4 | X(04) | 341-344 | Explanation Code 2 |
| ---- | A/N | | 1 | X(01) | 345-345 | Filler |
| 0904 | A/N | | 4 | X(04) | 346-349 | Explanation Code 3 |
| 0901 | N | | 10 | S9(07)V99 | 350-359 | Share of Cost / Patient Liability |
| 0329 | N | | 10 | S9(07)V99 | 360-369 | Other Coverage |
| 0349 | N | | 10 | S9(07)V99 | 370-379 | Amount Payable |
| 0331 | N | | 8 | S9(05)V99 | 380-387 | Blood Deductible Amount |
| 0330 | N | | 8 | S9(05)V99 | 388-395 | Medicare Cash Deductible |
| 0332 | N | | 10 | S9(07)V99 | 396-405 | Medicare Coinsurance Amount |
| RC70 | N | | 10 | S9(07)V99 | 406-415 | Medicare Billed |

## Medicare Crossover (continued)

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: MEDICARE CROSSOVER (06)

RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| RC75 | N | | 10 | S9(07)V99 | 416-425 | Medicare Share of Cost / Other Coverage |
| 0897 | N | | 10 | S9(07)V99 | 426-435 | Medicare Allowed |
| 0898 | N | | 10 | S9(07)V99 | 436-445 | Medicare Paid |
| 0117 | A/N | | 2 | X(02) | 446-447 | Medicare Claim Type |
| 1335 | A/N | | 4 | X(04) | 448-451 | OHC Carrier Code |
| 1340 | N | | 9 | 9(09) | 452-460 | OHC Policy Holder SSN |
| ---- | A/N | | 20 | X(20) | 461-480 | Filler |

### 2.1.7 OHC Carrier Data

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION (SCPI) MANUAL

MEDI-CAL TRANSACTION SERVICES RECORD LAYOUT SPECIFICATIONS

RECORD/FORMAT NAME: OHC CARRIER DATA (C1)
RECORD/FORMAT LENGTH: FIXED @ 480

| DE No. | A/N/P | No. of OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
|---|---|---|---|---|---|---|
| 1332 | A/N | | 2 | X(02) | 001-002 | Record Type |
| 1335 | A/N | | 4 | X(04) | 003-006 | OHC Carrier Code |
| 3356 | A/N | | 30 | X(30) | 007-036 | OHC Carrier Name |
| 3358 | A/N | | 50 | X(50) | 037-086 | OHC Carrier Address Li |
| 3359 | A/N | | 50 | X(50) | 087-136 | OHC Carrier Address Li |
| 3361 | A/N | | 20 | X(20) | 137-156 | OHC Carrier City |
| 3362 | A/N | | 2 | X(02) | 157-158 | OHC Carrier State |
| 3363 | A/N | | 9 | X(09) | 159-167 | OHC Carrier Zip |
| ---- | A/N | | 313 | X(313) | 168-480 | Filler |

# Section 3 - Summary File Record Layout Specifications

## 3.1.1 Summary Report File Layout

ALL FORMATS – CARTRIDGE TAPE AND MEDI-CAL TRANSACTION SERVICES

| RECORD/FORMAT NAME<br>SUMMARY REPORT FILE | | | | RECORD/FORMAT LENGTH<br>FIXED @ 80 | |
|---|---|---|---|---|---|
| DE No. | No. of A/N/P | OCCURS | LENGTH | PICTURE | DATA POSITION | FIELD NAME |
| --- | A/N | | 80 | X(80) | 001-080 | Report Line |

# Section 4 - Appendix

## 4.1 Data Element Dictionary

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0091 | | | | X | | | | HCPCS CODE MODIFIER 2<br>A code used in conjunction with a Procedure Code (D.E. 0500) to indicate the method used for calculating payment. |
| 0092 | | | | X | | | | HCPCS CODE MODIFIER 3<br>A code used in conjunction with a Procedure Code (D.E. 0500) to indicate the method used for calculating payment. |
| 0093 | | | | X | | | | HCPCS CODE MODIFIER 4<br>A code used in conjunction with a Procedure Code (D.E. 0500) to indicate the method used for Calculating payment. |
| 0101 | X | X | X | X | X | X | X | RECIPIENT ID NUMBER<br>Recipient identification number assigned by the counties. |
| 0103 | X | X | X | X | X | X | X | RECIPIENT NAME<br>Name of the individual for whom services were performed. |
| 0117 | | | X | | | | | MEDICARE CLAIM TYPE<br>The original claim type of the Medicare claim. |
| 0201 | X | X | X | X | X | X | X | PROVIDER NUMBER<br>Provider number registered with the California Department of Health Care Services. |
| 0202 | X | X | X | X | X | X | X | PROVIDER NAME<br>Legal name as used on official records. |
| 0203 | X | X | X | X | X | X | X | PROVIDER ADDRESS<br>Current business address. |
| 0205 | X | X | X | X | X | X | X | PROVIDER TYPE<br>A code assigned based upon the type of service provided by the provider (inpatient, pharmacy, etc.) |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0240 | X | | | | | | | ACCOMMODATION CODE<br>A code indicating the type of accommodation available for hospital categories of service. Refer to the Provider Manual for a complete list of codes and explanations |
| 0300 | X | X | X | X | X | X | X | CLAIM CONTROL NUMBER (CCN)<br>A unique number assigned by ACS to identify each claim received. Format is YDDDBBBBSSSLL, where:<br><br>Y = last digit of the year. DDD= Julian day of the year (001-365).<br>BBBB= assigned by type of activity<br>SSS= claim sequence number<br>LL = claim service line item<br><br>If BBBB starts with either 63, 64, or 65, this indicates that the claim was received electronically through the CMC Program. |
| 0312 | X | X | X | X | X | X | X | SERVICE DATE - FROM<br>The date upon which the first service covered by a claim was rendered. MMDDYY format. |
| 0313 | X | X | X | X | X | X | X | SERVICE DATE - TO<br>The date upon which the last service covered by a claim was rendered. MMDDYY format. |
| 0316 | X | | | | | | | PATIENT STATUS<br>A code explaining recipient's status as of the "to" service date (DE 0313). Refer to the Provider Manual for a complete list of codes and explanations. |
| 0320 | X | X | X | X | X | X | X | MEDICAL RECORD NUMBER<br>A number assigned (optionally) by the provider to a recipient's claim for reference purposes. |
| 0321 | | X | X | X | X | | | TOTAL CLAIM CHARGE<br>The sum of all Claim Submitted Amounts (DE 0914) associated with an individual claim. |
| 0327 | X | | X | | | | | UNITS of SERVICE<br>The number of units rendered to a recipient (i.e., days, procedures, visits, miles, or number dispensed). |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0329 | X | X | X | X | X | | | OTHER COVERAGE<br>The amount of payment rendered toward a claim by third party sources. |
| 0330 | | | X | | | | | MEDICARE CASH DEDUCTIBLE<br>The unmet Medicare deductible which is to be paid by Medi-Cal. Applies to Part A and Part B. |
| 0331 | | | X | | | | | BLOOD DEDUCTIBLE AMOUNT<br>The unmet Medicare deductible for blood which is to be paid by Medi-Cal. |
| 0332 | | | X | | | | | MEDICARE COINSURANCE AMOUNT<br>The Medicare coinsurance amount to be paid by Medi-Cal. Applies to Part A and Part B. |
| 0334 | X | | | | | | | MEDICARE STATUS<br>A code indicating the recipient's Medicare status. Refer to the Provider Manual for complete list of codes and explanations. |
| 0348 | X | | | | | | | CLAIM COVERED ACCOMMODATION DAYS<br>Number of claim covered accommodation days. |
| 0349 | X | X | X | X | X | X | X | AMOUNT PAYABLE<br>Non-Institutional: The payment amount due to a provider for a claim after deductions have been made from the Allowable Payment (DE 0380) for Share of Cost/Patient Liability (DE 0901) and Other Coverage (DE 0329). Claim Types 01, 05, 07.<br><br>Institutional: The payment amount due a provider for a claim after deductions have been made from the Paid Amount (DE RC10) for Share of Cost/Patient Liability (DE 0901) and Other Coverage (DE 0329). Claim Types 02, 03, 04, 06. |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0351 | X | X | X | X | X | X | X | ADJUDICATION STATUS<br>A code to indicate the current status of a claim.<br><br>3 - denied<br>4 - returned to provider via RTD<br>5 - error suspend<br>6 - review suspend<br>8 - paid |
| 0376 | X | X | X | X | X | X | X | WARRANT DATE<br>The date a warrant authorization was generated. MMDDYY format. |
| 0380 | X | X | X | X | X | X | X | ALLOWABLE PAYMENT AMOUNT<br>The calculated maximum allowable payment amount for a particular service as determined by Title 22. Share of Cost/Patient Liability (DE 0901) and Other Cover (DE 0329) have not been applied. |
| 0382 | X | X | X | X | X | | | REIMBURSEMENT RATE<br>The percent of the Allowable Payment Amount (DE 0380) which is applied to determine the Paid Amount (DE. RC10). |
| 0384 | | X | X | X | | | | HCPCS CODE MODIFIER<br>A code used in conjunction with a Procedure Code (DE 0500) to indicate the method used for calculating payment. |
| 0386 | X | | | | | | | PRESCRIPTION NUMBER<br>The number assigned by a Pharmacist when he fills a prescription. |
| 0500 | | X | X | X | | | | HCPCS CODE<br>The California Relative Values Studies (CRVS), the Schedule of Maximum Allowances HCPCS code that identifies a procedure. |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0501 | X | | | | | | | DRUG CODE<br>The Medi-Cal drug code used to describe a particular drug or supply.<br><br>FORMAT 1:<br>Medi-Cal Drug Code<br>LLLLMMDDDDQ<br><br>L = Low Values<br>M = Manufacturer Code<br>D = Generic Drug Code<br>Q = Alpha Strength Code<br>FORMAT 2:<br>National Drug Code (NDC)<br>MMMMMPPPPSS<br><br>M = NDC Labeler<br>P = Product Code<br>S = Package Size |
| 0800 | | | | | | | | CLAIM TYPE<br>A code indicating the type of claim received from the provider. |
| | X | | | | | | | 01 = Drug |
| | X | | | | | | | 02 = LTC |
| | | X | | | | | | 03 = Inpatient |
| | | X | | | | | | 04 = Outpatient |
| | | | X | | | | | 05 = Medical |
| | | | X | | | | | 06 = Medicare Crossover |
| | | | | X | | | | 07 = Vision |
| 0815 | X | X | X | X | | | | NON-COVERED CHARGES<br>The non-allowed charges for the claim line. The difference between the Claim Submitted Amount (DE 0914) and the Allowable Payment Amount (DE 0380)<br><br>Crossover = The non-covered charges is determined by Change Order 20 pricing |
| 0816 | X | X | X | X | X | X | X | CLAIM DISPOSITION<br>0 = Original claim<br>1 = CMC claim<br>2 = Debit adjustment<br>3 = Retroactive debit adjustment<br>5 = Credit adjustment<br>6 = Void |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 0817 | X | X | X | X | X | X | X | PRIOR CCN<br>The Claim Control Number (DE 0300) of the previously paid claim being adjusted. |
| 0897 | | | X | | | | | MEDICARE ALLOWED<br>The amount approved for Medicare. |
| 0898 | | | X | | | | | MEDICARE PAID<br>The amount paid by Medicare. |
| 0901 | X | X | X | X | X | X | X | SHARE of COST/ PATIENT LIABILITY<br>Amount owed by the recipient for the services being billed by the provider. |
| 0904 | X | X | X | X | X | X | X | EXPLANATION CODE<br>A code used to notify the provider of any unusual conditions; i.e. 401 = payment adjusted to maximum allowable. Refer to the appropriate Provider Manual for a complete list of codes and explanations. |
| 0911 | X | X | X | X | X | X | X | ADJUSTMENT REASON CODE |
| 0914 | X | X | X | X | X | X | X | CLAIM SUBMITTED AMOUNT<br>The charge associated with an individual line item as submitted by the Provider. |
| 0923 | | X | | | | | | ACCOMMODATION CODE/COST CENTER CODE<br>The codes identifying accommodations and ancillary services billed on an inpatient claim. Refer to the Provider Manual for a complete list of codes and explanations. |
| 0925 | | X | | | | | | DAYS/REVENUE UNITS<br>The number of days associated with an Accommodation Code / Cost Center (DE 0923) on an inpatient claim. |
| 0943 | X | X | X | X | X | X | X | SEQUENCE NUMBER<br>An ACS assigned number which is also printed on the hardcopy RAD. |
| 1332 | X | X | X | X | X | X | X | RECORD TYPE<br>C1 OHC Carrier Data |
| 1333 | X | X | X | X | X | X | X | OHC DATA PRESENT INDICATOR<br>"Y" indicates OHC carrier data is present in the C1 record.<br>"N" indicates no OHC data. |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| 1335 | X | X | X | X | X | X | X | OHC CARRIER CODE<br>A Medi-Cal assigned number, which identifies unique OHC insurance companies (carriers). |
| 1340 | X | X | X | X | X | X | X | OHC POLICY HOLDER SSN<br>The SSN of the person holding the policy related to this claim. |
| 1343 | | | | X | | | | NUBC REVENUE CODE<br>Codes that identify specific Accommodations, Ancillary service, or Unique billing calculations or Arrangements. |
| 2002 | X | X | X | X | X | X | X | PROVIDER OWNER NUMBER<br>A number assigned to owner(s) of the provider number due to ownership changes, etc. |
| 3356 | X | X | X | X | X | X | X | OHC CARRIER NAME |
| 3358 | X | X | X | X | X | X | X | OHC CARRIER ADDRESS LINE 1 |
| 3359 | X | X | X | X | X | X | X | OHC CARRIER ADDRESS LINE 2 |
| 3361 | X | X | X | X | X | X | X | OHC CARRIER CITY |
| 3362 | X | X | X | X | X | X | X | OHC CARRIER STATE |
| 3363 | X | X | X | X | X | X | X | OHC CARRIER ZIP |
| 9315 | | | X | X | | | | QUANTITY<br>The number of times a procedure was rendered. |
| RC05 | | | | | | | | RECORD TYPE |
| | X | | | | | | | 01 - Detail record for claim type 01 |
| | X | | | | | | | 02 - Detail record for claim type 02 |
| | | X | | | | | | 03 - Detail record for claim type 03 |
| | | X | | | | | | 04 - Detail record for claim type 04 |
| | | X | | | | | | T4 - Total record for claim type 04 |
| | | | X | | | | | 05 - Detail record for claim type 05 |
| | | | X | | | | | T5 - Total record for claim type 05 |
| | | | X | | | | | 06 - Detail record for claim type 06 |
| | | | | X | | | | 07 - Detail record for claim type 07 |
| | | | | X | | | | T7 - Total record for claim type 07 |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| RC10 | X | X | X | X | | | | PAID AMOUNT<br>The amount payable by Medi-Cal for the claim or claim line after the Reimbursement Rate (DE 0382) has been applied to the Allowable Payment Amount (DE 0380), but prior to deductions for Share of Cost/Patient Liability (DE 0901) and Other Coverage (DE 0329) amounts. |
| RC15 | | X | | | | | | TOTAL of DAYS/REVENUE UNITS<br>The sum of all Days/Revenue Units (DE 0925) associated with an individual claim. |
| RC20 | | X | X | | X | | | TOTAL of LINE NON-COVERED CHARGES<br>The sum of all Non-Covered Charges (DE 0815) associated with an individual claim. |
| RC25 | | X | X | X | X | | | TOTAL of LINE PAYABLE CHARGES<br>The sum of all Allowable Payment Amounts (DE 0380) associated with an individual claim. |
| RC30 | | X | X | | X | | | TOTAL of LINE PAID AMOUNTS<br>The sum of all Paid Amounts (DE RC10) associated with an individual claim. |
| RC35 | | X | X | X | | | | TOTAL of LINE SHARE of COST<br>The sum of all Share of Cost/Patient Liability (DE 0901) associated with an individual claim. |
| RC40 | | X | X | X | | | | TOTAL of LINE OTHER COVERAGE AMOUNTS<br>The sum of all Other Coverage (DE 0329) associated with an individual claim. |
| RC45 | | X | X | X | | | | TOTAL of LINE AMOUNTS PAYABLE<br>The sum of all Amount Payable (DE 0349) associated with an individual claim. |

FI SUPPLEMENTAL CLAIMS PAYMENT INFORMATION MANUAL

DATA ELEMENT (D.E.) DESCRIPTIONS

| D.E. No. | CLAIM TYPE 01 | 02 | 03 | 04 | 05 | 06 | 07 | D. E. NAME / DESCRIPTION |
|---|---|---|---|---|---|---|---|---|
| RC60 | | X | | | | | | LINE NUMBER<br>Number of a detail service line on the original claim. |
| RC65 | | X | | | | | | HOUR INDICATOR<br>Indicates units are in hours instead of days. |
| RC70 | | | X | | | | | MEDICARE BILLED<br>The amount billed to Medicare as reflected on the Medicare EOMB. |
| RC75 | | | X | | | | | MEDICARE SHARE of COST/ OTHER COVERAGE<br>Amount owed by the recipient for the services being billed by the provider. |
| RC80 | | X | | | | | | LINE COUNT<br>Number of Detail Service Lines on the record. |

## 4.2 Forms: SCPI Enrollment Form and SCPI Services Agreement

The following section includes the forms required for provider and vendor enrollment in the SCPI program. These forms include the enrollment form and the release authorization form to be filled out by vendor or provider for enrollment in the SCPI program.

## MEDI-CAL

**Supplemental Claims Payment Information (SCPI) ENROLLMENT**

(PROVIDER)

**FI USE ONLY** Start Date: _____/_____/_____ Receiver ID: _____

### I. PROVIDER/CONTACT INFORMATION:

**Address listed below is the "Pay-To" address on DHCS Provider Enrollment records? ☐**
**(✓ = Yes)**

**Address as specified on DHCS Provider Enrollment records:**

Contact Person _____

Phone Number _____

Provider Name _____

Provider Address _____

City _____ State_____ Zip_____

### II. TESTING:

_____REQUIRED (FI provides a test file in the format requested)
_____NOT REQUIRED (FI provides production data on the Medi-Cal Transaction Services)

### III. DISTRIBUTION METHOD:

**MEDI-CAL Transaction Services**

Do you have a Windows-compatible system with a current version of a Web browser such as Microsoft Internet Explorer or Mozilla Firefox, or do you have Internet access through an Internet Service Provider (ISP) in order to download SCPI files from Medi-Cal Transaction Services?

_____ YES
_____ NO (I do not have access to one or more of these resources noted above.)

### IV. FEES:

1. During the term of this agreement, Provider agrees to pay the FI, through a separate invoice, for services as follows:
   a) A recreation fee of $125.00 for each SCPI file that is past the five-week availability on the Medi-Cal Transaction Services.
   b) An administration fee of $15.00 to add, change, or delete each provider number. Up to ten provider numbers may be added during enrollment at no charge.
2. The Provider agrees to pay DHCS through the regular Medi-Cal claims payment system as follows:
   a) A fee of $0.02 (2 cents) per Adjudicated Claim Line (ACL) shall be charged to the provider for the provider's hardcopy paper Remittance Advice Details (RAD) when the provider requests for a copy to be delivered to the provider's business address.

### V. PROVIDER RELEASE AUTHORIZATION:

Please fill in the complete nine or 10-digit provider number along with the last four digits of their Federal Tax ID Number (TIN) for each provider that you are requesting to receive SCPI records for the receiver listed in section I.

***Note:*** *If "'YES" is not marked, "No" will be the default value for receiving Paper RAD and Medicare "No-Pay" crossover data records.*

| **Provider number and Last four digits of TIN** | **Provider Name** | **Receive Paper Rad?** | **Receive Medicare "No-Pay" Records?** |
|---|---|---|---|
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) __YES |

I certify by signing this release that I am authorized to sign on behalf of the provider specified and to the best of my knowledge and belief the information furnished is correct. I also certify by signing this release that I permit the Department of Health Care Services (DHCS) to collect from the provider's regular Medi-Cal claims payment, $0.02 (two-cents) for every Adjudicated Claim Line (ACL) processed when the provider requests for a hardcopy paper RAD. Furthermore, I agree to notify the FI, in writing, should any change to the information provided above occur. Other charges shall be assessed as set forth in section IV (Fees).

Authorized Signature:_____

Print Name:_____

Title:_____

Date:_____

**Return Agreement To**:
ACS
Attn: SCPI Operations
820 Stillwater Road
Sacramento, CA 95605

# Supplemental Claims Payment Information (SCPI)
# SERVICES AGREEMENT

Between

ACS
820 Stillwater Road
Sacramento, CA 95605

And

_____
Customer
_____
Address
_____
City State Zip

To provide Medi-Cal Supplemental Claims Payment Information (SCPI) in accordance with the terms and conditions set forth below.

**Scope of Service**: The DHCS Fiscal Intermediary (FI) agrees to supply to the customer SCPI data for FI adjudicated and suspended Medi-Cal claims for providers who have authorized the customer to receive such information. The FI will:

a) Provide such data in accordance with FI's then-current format described in the Supplemental Claims Payment Information User Manual (or similar documentation). The parties recognize that the FI data format may change from time to time as a result of state or FI requirements.

b) Provide such data on the computer media specified on the Supplemental Claim Payment Information Enrollment form.

c) Begin providing service at such time is mutually agreed upon by both parties, but no earlier than 10 business days after the effective date of this Agreement.

d) Customer will pay a fee of $125.00 for each re-creation of a SCPI file that is past the five-week availability on the Medi-Cal Transaction Services.

**Customer Obligations**: The Customer will:

a) Prior to submission by the FI hereunder of SCPI data on any Medi-Cal provider, obtain from each such provider a completed *Supplemental Claims Payment Information Enrollment* form (provider release authorization) and forward, or have forwarded, the *Supplemental Claims Payment Information Enrollment* form (provider release authorization) to the FI. The FI will not furnish SCPI data for any provider unless and until a current *Supplemental Claims Payment Information Enrollment* form is on file at the FI.

b) Complete and submit to the FI a *Supplemental Claims Payment Information Enrollment* form indicating that they would like to download their SCPI files from Medi-Cal Transaction Services. Services will not commence until after such information has been received by the FI.

c) Not provide the data supplied under this agreement to any third-party except the applicable providers for whom the customer is providing billing collection and/or reconciliation services. The customer acknowledges that SCPI data is the confidential information of the state, the FI, and/or applicable providers. This provision shall survive the expiration of this agreement.

d) Inspect and review all SCPI data provided by the FI and reject all unreadable data within 28 business days after receipt thereof. Failure to reject any such data shall constitute acceptance thereof.

**Term:** This agreement shall begin on the date (the "effective date") this agreement is last signed by an authorized representative of each party and shall continue in effect for a period of one year unless otherwise terminated as provided herein. Upon expiration of the initial term, this agreement will automatically renew on a month-to-month basis. Notwithstanding the foregoing, either party may terminate this agreement upon 30 days written notice to the other party.

**Fees**: During the term of this Agreement, Customer shall pay the FI as follows:

a) A one-time development and implementation fee of $100.00 will be charged to new SCPI customers. A monthly operations charge of $0.04 (four cents) for each Medi-Cal adjudicated claim line. The FI will give the customer a credit against the monthly charge set forth above in this paragraph 4a in the amount of $0.02 (two cents) for each Medi-Cal adjudicated claim line submitted using computer media input criteria specified by the FI. Notwithstanding anything to the contrary however, the customer shall pay a minimum monthly operation charge of $500.00.

b) A one-time administrative fee of: $15.00 to add, change, or delete a provider number. Up to ten provider numbers may be added during enrollment at no charge.

c) A late payment fee in the amount of $10.00. If the late payment fee exceeds the interest rate allowed by law, such fee shall be reduced to the highest monthly amount allowed by applicable law.

d) A return of check for insufficient funds fee in the amount of $25.00.

e) A recreation fee of $125.00 per paragraph 1 (d) above.

f) Any other charges set forth in this Agreement.

g) After the expiration of the initial term, the FI may change the prices for the services provided herein upon thirty-(30) days written notice to Customer.

**Payment:** Customer shall pay the FI for services invoiced hereunder within thirty (30) days following the date of the FI invoice. If Customers account is past due, SCPI Medi-Cal Transaction Services will be held until full-payment is posted by the FI.

**Taxes:** Federal, State and local taxes are not included in the fees set forth above. The FI shall add to the charges set forth herein, and Customer shall pay, all taxes, however designated, which are levied on this Agreement, or the products or services, excluding taxes based upon the FI's income.

**Warranty**: FI agrees to furnish Customer with provider SCPI data then-currently recorded and available in the FI Medi-Cal production system. The FI makes no representations as to the accuracy such recorded and available data; and, except as otherwise provided in this paragraph (7), ACS HEREBY DISCLAIMS ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, and INCLUDING ANY WARRANTY of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

**Limitation of Liability**: The FI shall not be liable to customer or any third party directly or through Customer for any claim of, or damage or injury suffered by the customer or third-party caused by the FI's delay in furnishing the data supplied hereunder.

Moreover, neither party shall be liable for any damage amounts representing indirect, consequential (such as loss of business or loss of profits), or punitive damages. Furthermore, in no event will the FI's liability to the customer for all events, acts or omissions hereunder exceed, in the aggregate during the term of this agreement, the monthly amount invoiced to the customer hereunder during the four months preceding the event(s) giving rise to such claim or loss. The FI shall not be liable to the customer for any actions or inactions under this contract, including erroneous data provided by the FI hereunder.

## Miscellaneous Provision:

a) Each party shall be excused from performance under this Agreement. For any period and to the extent that it is prevented from performing; in whole or in part, as a result of delays caused by the other party, the State, or an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control.

b) Whenever under this Agreement one party is required or permitted to given notice to the other. Such notice shall be deemed given when delivered in hand when mailed by United States Mail, registered or certified, return receipt requested, postage prepaid, and addressed to the parties as set forth above in the identification of the contracting parties.

c) This Agreement including any Exhibits referred herein and attached hereto. Each of which is incorporated into this Agreement represents an entire Agreement between the parties with respect to the provision or Supplemental Claim Payment Information (SCPI). And there are no representations, understandings, or agreements relative to this Agreement that are not signed in writing by an authorized representative of the party against which such change, waiver or discharge is sought to be enforced.

ACCEPTED AND AGREED TO:

| Customer | ACS |
|---|---|
| _____ | _____ |
| Authorized Signature | Authorized Signature |
| _____ | _____ |
| Printed Name | Printed Name |
| _____ | _____ |
| Title | Title |
| _____ | _____ |
| Date | Date |

**Return Agreement To**: ACS
Attn: SCPI Operations
820 Stillwater Road
Sacramento, CA 95605

**MEDI-CAL**
**Supplemental Claims Payment Information (SCPI) ENROLLMENT**
(VENDOR)

| **FI USE ONLY** | Start Date: _____/_____/_____ | Receiver ID: _____ |
|---|---|---|

**I. VENDOR CONTACT INFORMATION:**

Contact Person _____

Phone Number _____

Company Name _____

Company Address _____

City _____ State_____ Zip_____

**II. TESTING** _____ REQUIRED
_____ NOT REQUIRED

**III. DISTRIBUTION METHOD:**

**a. MEDI-CAL Transaction Services (DOS ASCII format only)**

Do you have a Windows-compatible system with a current version of a Web browser such as Microsoft Internet Explorer or Mozilla Firefox? Do you have Internet access through an Internet Service Provider (ISP) in order to download SCPI files from Medi-Cal Transaction Services?

_____ YES
_____ NO (I do not have access to one or more of these resources noted above.)

**IV. FEES:**

During the term of this Agreement, Customer agrees to pay the FI as follows:

a) A re-creation fee of $125.00 for each SCPI file that is past the 5 week availability on the Medi-Cal website.

b) An administration fee of $15.00 to: add, change, or delete each provider number. Up to 10 provider numbers may be added during enrollment at no charge.

c) A monthly operations charge of $0.04 (4 cents) for each Medi-Cal adjudicated claim line. A credit will be given to the Customer in the amount of $0.02 (2 cents) for each Medi-Cal adjudicated claim line using CMC. Customer shall pay a minimum monthly operation charge of $500.00.

d) All other fees as specified within the Supplemental Claims Payment Information Agreement, paragraph 4.

## Exhibit B

## PROVIDER RELEASE AUTHORIZATION

This release is submitted to ACS as authorization to forward Medi-Cal Supplemental Claims Payment Information (SCPI) on computer media directly to the designated agent listed below and/or in Section I of the Medi-Cal Supplemental Claims Payment Information (SCPI) Enrollment, for the purposes of Medi-Cal billing, collection, and/or reconciliation services.

SCPI Receiver Number _____

Contact Person _____

Phone Number _____

Provider Name _____

Provider Address _____

City _____ State_____ Zip_____

Please enter the complete nine or 10 digit alpha-numeric Provider Number along with the last four digits of their Federal Tax ID Number (TIN) for each provider that you are requesting to receive SCPI records for the receiver listed above.

*Note: "NO" is the default value for receiving paper RAD and Medicare "no-pay" crossover data records. By selecting "NO" for paper RAD, the provider will not receive paper RAD from the State Controller's Office. If the provider wishes to continue to receive their paper RAD data, select option "YES" below.*

| **Provider number and Last four digits in TIN** | **Provider Name** | **Receive Paper RAD?** | **Receive Medicare "No-Pay" Records?** |
|---|---|---|---|
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |
| _____ | _____ | ___(NO) ___YES | ___(NO) ___YES |

I certify by signing this release that I am authorized to sign on behalf of the Provider specified, and to the best of my knowledge and belief the information furnished is correct. Furthermore, I agree to notify ACS, in writing, should any change to the information provided above occur.

Authorized Signature: _____ Title: _____

Print Name:_____

Date:_____

**Return Agreement To**: ACS
Attn: SCPI Operations
820 Stillwater Road
Sacramento, CA 95605