

California Department of Health Care Services

County Behavioral Health Managed Care Delivery Systems

Health Care Provider Directory (274)

**Standard Companion Guide Transaction
Information**

**Instructions based on the
X12 274 Implementation Guide V004050X109**

This Companion Guide is applicable to:

- **County Mental Health Plans**
- **County Drug Medi-Cal Organized Delivery Systems**

Document History (Version Control)

Version	Date	Author	Brief Description of Modifications
0.0	07/01/19	Sara Rivera	Initial draft sent to MHPs for comment
1.0	12/13/19	Sara Rivera	Use this version for system modifications. Any subsequent changes will be summarized in this version control table.
1.1	07/24/20	Sara Rivera	<ol style="list-style-type: none"> 1. Section 3.16 Site Detail - LUI segment: Foreign Languages Spoken at this Site — Repetitions increased from 25 to 175. 2. Section 3.16 - Site Detail: 2100DA/ WS Work Schedule at this Site – Usage description updated. 3. Section 3.16 - Site Detail: 2100DA CRC Site Assistive Aid Information – Updated allowable code values. 4. Appendix B – Data Definitions: Facility Type (2100DA N201) – Updated allowed values associated with Satellite Site. 5. Appendix A – A.1 Site Detail and A.2 Provider Detail: Updated allowed values for Telehealth indicator at site level and provider detail level.
1.2	12/21/20	Sara Rivera	<ol style="list-style-type: none"> 1. Updated the file naming conventions in Sections 3.5, 3.6 and 3.7. 2. Section 3.13 – 2100BA NM103: Updated Organization Name code value. 3. Appendix A.2 Provider Detail: Provider Gender values corrected. 4. Appendix A.2 Provider Detail: Mental Health Provider Area of Expertise reference to field length corrected.
1.3	10/04/21	Sara Rivera	<ol style="list-style-type: none"> 1. Clarified use of 2100AB NM103 – Product/Network Name. 2. Clarified multiple field lengths in Appendix A.1 Site Detail and A.2 Provider Detail. 3. Clarified field length for “Distance Provider Travels to Field-Based Services”. 4. Clarified Situational rules for Provider State License Number, Licensure Type and Licensing State.

Version	Date	Author	Brief Description of Modifications
1.4	3/28/22	Sara Rivera	<ol style="list-style-type: none"> 1. Section 3.2 - Available Transaction Response: language clarification. 2. Section 3.15 Provider Group Detail: NPI changed to Situational. 3. Section 3.16 Site Detail: removed reference to "Only Medi-Cal certified sites are to be reported in the 274 file." 4. Section 3.17 Provider Detail – Contract Effective Dates-updated business rule. 5. Appendix A.2 Provider Detail - Business rules updated for Type of Licensure, State License Number and Licensing State. 6. Appendix B.5 Type of Licensure Table updated.
1.5	05/09/2022	Richa Pant	Updated ST\SE segment section
1.6	07/11/2022	Sravan Bojja	Updated value for State License number from ' Not Available ' to ' Unavailable ' when it is not available
1.7	10/14/2022	Sara Rivera	<ol style="list-style-type: none"> 1. Appendix A.2 Provider Detail and Appendix B.5 Type of Licensure (2100EA N202) – Updates for MHP and WAP licensure types/license number reporting. 2. Appendix B.9 – Service Type – Corrected language in example. 3. Site Detail/ Location Effective and Termination Dates 2100DA DTP Contract Dates – Clarified reporting language.

Version	Date	Author	Brief Description of Modifications
2.0 Note: The changes referenced in this version will be implemented with Version 2.1 (see additional updates in the next row)	06/23/23	Sara Rivera	<p>Changed name of CG from County Mental Health Plan CG to Behavioral Health CG. This version includes instructions for both MHP and DMC-ODS plans effective 12/1/23. Plan specific business rules are identified as MHP or DMC-ODS where applicable. Major updates to the CG are highlighted in yellow:</p> <p>1.3-Intended Use 3.1-Transaction Submission 3.5-Submitted Provider Network File Naming Conventions 3.8-ISA/IEA 3.9-GS/GE 3.10-ST/E 3.12-Information Source Detail 3.13-Information Receiver Detail 3.15-Group Detail 3.16-Site Detail 3.17-Provider Detail</p> <p>Data elements added or modified:</p> <ul style="list-style-type: none"> - Site and Provider Modality (New for DMC - ODS only) - Site Age Group Served (DMC-ODS only) - Provider Sees Children Indicator - Site Accepting New Patient - Appendix B.5 – Licensure Types added - Appendix B.11 Modality codes and descriptions - Appendix B.12 HCP Code List
2.1	8/15/23	Sara Rivera	<ul style="list-style-type: none"> - ISA08 and GS03 – Receiver ID changed to DHCS-MCBH-NETWK - Update rule for Site Patience Acceptance Indicator - Provider Detail Service Type length change - Added Site Type of Service (New data element) - Added Appendix B.12 to list Site Type of Service descriptions and code values - Renamed HCP Code List to Appendix B.13 <p>Note: The updates referenced in this version along with the updates made in Version 2.0 will become effective 12/1/23.</p>

Disclosure Statement

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Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by X12's copyrights and Fair Use statement.

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Transaction Instruction (TI)

1 TI Introduction

1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs
- Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.2 Compliance according to X12

X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.3 Intended Use

The Transaction Instruction component of this Companion Guide (CG) must be used in conjunction with an associated X12 Implementation Guide. The instructions in this CG are not intended to be stand-alone requirements documents. This CG conforms to all the requirements of any associated X12 Implementation Guides and is in conformance with X12's Fair Use and Copyright statements. The data files transmitted through the instructions provided in this CG and the associated X12 Implementation Guide are referred to as "Provider Network Files".

This CG provides 274 Provider Network File transmission instructions for County Behavioral Health Managed Care Delivery Systems (referred to as "Plans"). This CG version is applicable to the following plan types:

- Mental Health Plans (MHP)
- Drug Medi-Cal Organized Delivery Systems (DMC-ODS)

Instructions specific to MHP or DMC-ODS plan types are referenced by the associated acronym (MHP or DMC-ODS)

2 Included X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document. The underlying Technical Report – Implementation Guide Type 3 (TR3) document for this transaction is available at [Products | X12](#). Plans are responsible for applicable X12 purchasing and licensing agreements.

Unique ID	Name
004050X109	Health Care Provider Directory (274)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

Only those elements that require specific explanation are included in these tables.

3.1 Transaction Submission

County plans must upload provider network data files to the plan's designated Secure File Transfer Protocol (SFTP) "submission" folder administered by DHCS. File processing will proceed automatically. DHCS processes will identify when the plan submits a file and forwards the submitted file to a secure internal server for file validation. DHCS will delete the file from the submission folder once it has validated the file.

DHCS requires plans to submit provider network information specific to the county or counties covered by the plan in files identified by the plan's Healthcare Plan Code (HCP). The HCP is a three-digit code assigned by DHCS to uniquely identify each plan and is used to track provider network file transmissions for each plan. The full list of HCP codes for MHPs and DMC-ODS plans is included in Appendix B.12.

The Plan's HCP must be included in the submitted file name and the file ISA segment as described in following sections.

A submitted file will be either accepted or rejected.

3.2 Available Transaction Responses

DHCS will post a Validation Response File (VRF) for each submitted file to the Plan's designated SFTP "Response" folder. The VRF is a custom XML error report detailing each error, including identification of each record found to be in error along with the error number value and message.

The TA1 (Interchange Acknowledgement) response file is not available. The sole response file returned is the VRF.

3.3 Transaction Components

Data element separator is "*"

Segment terminator is "~"

3.4 File Contents

Each submitted file must reflect the entire provider network for the Plan, including county-employed and contracted providers, as well as county-operated and contracted facilities (e.g., hospitals, residential treatment facilities).

Files must be comprised of only 274 transactions. Multiple Transaction Set Headers and Transaction Set Trailers (ST-SEs) are allowed to identify subnetworks. See section 3.10 for more information on ST-SEs and subnetworks.

If DHCS finds and reports any fatal errors, the entire file will be rejected and must be resubmitted. BHT02 must equal "27" for all submitted ST-SEs, any other value will cause the entire submission to be rejected.

3.5 Submitted Provider Network File Naming Conventions

Submitted provider network files must use the following naming convention:

XXXXX-XXX_HHH_274B_YYYYMMDD_NNNNN.dat

Where:

XXXXX-XXX is the first node of the file name and is the name of the Plan submitting the file. The second part designates the Plan type: MHP or DMC-ODS. **Enter Plan name in All CAPs.**

HHH is the HCP code for the Plan submitting the provider network information. **Refer to Appendix B.12 for the complete list of HCP codes.**

274B is a constant designating the file as a County Behavioral Health 274 Provider Network File.

YYYYMMDD is the date of the submission.

NNNNN is a unique sequential numeric transaction identifier used to differentiate between network data files submitted on the same day by the same Plan.

The First Node of the file name (county name) must contain no blanks, underscores or other special characters, except for a dash.

Valid examples:

ALAMEDA-MHP_C01_274B_20120930_00001.dat

ALAMEDA-DMC-ODS_D01_274B_20120930_00001.dat

DHCS will reject a file submitted with a duplicate file name or is not in the correct format according to this section.

3.6 Response File Naming Conventions

Response files will mirror the submitted file name with an added designation, as follows:

XXXXX-XXX_HHH_274B_YYYYMMDD_NNNNN_RESP_RPT.XML

Where:

RESP is a constant designating the file as a response file

RPT is a constant.

Examples:

ALAMEDA-MHP_C01_274B_20120930_00001 _RESP_RPT.xml

ALAMEDA-DMC-ODS_D01_274B_20120930_00001 _RESP_RPT.xml

3.7 File Corrections

Counties may submit corrections to previously submitted network files. Any corrections to previously submitted files must include the full provider network with the corrections.

- If DHCS rejects a file, the Plan must make corrections and resubmit the full network file before the monthly processing deadline at the beginning of the month.
- If a file is accepted, but the mental health plan wants to make corrections or additions after the monthly cut-off date, the mental health plan may do so at any time. The MHP must notify DHCS that it will submit a corrected file.

Data from corrected files, accepted prior to the monthly processing deadline at the beginning of the month, will be loaded in the database that month. Data from corrected files, accepted after the monthly processing deadline, will be loaded the following month.

The Plan must follow the standard naming convention when resubmitting a provider network file as described in Section 3.5.

The effective year and month for the resubmitted network data must be included in the ISA02 field.

Examples of resubmitted files:

Scenario	Submission Date	File Name	ISA02 Value (Reporting Year/ Month)	File Acceptance Date	Month data will be loaded into database
Original Submission	10/2/17	COUNTYNAME-MHP_C01_274B_20171002_00001.dat	1709	Rejected	Not loaded
Resubmission because of rejected file	10/4/17	COUNTYNAME-MHP_C01_274B_20171004_00001.dat	1709	Accepted	October
Resubmission to correct data	10/7/17	COUNTYNAME-MHP_C01_274B_20171007_00001.dat	1709	Accepted	October
Resubmission to add records to September file	10/15/17	COUNTYNAME-MHP_C01_274B_20171015_00001.dat	1709	Accepted	November

Scenario	Submission Date	File Name	ISA02 Value (Reporting Year/ Month)	File Acceptance Date	Month data will be loaded into database
Resubmission to correct data to September file	12/20/17	COUNTY-MHP_C01_274B_20171220_00001.dat	1709	Accepted	January

3.8 Interchange Control Header/Trailer (ISA/IEA)

Loop ID	Reference	Name	Codes	Notes/Comments
ISA		Interchange Control Header		
	ISA01	Authorization Information Qualifier	03	
	ISA02	Authorization Information		Enter the Reporting Period (year and month) for which the enclosed provider network data is applicable. Four bytes (YYMM) followed by six blanks Network date should be on or after 1901 (January 2019), and before current calendar month.
	ISA05	Interchange ID Qualifier	ZZ	
	ISA06	Interchange Sender ID		Enter the Plan Federal Tax ID (9 digits - no hyphens) + HCP (3 digits) + 3 spaces. See full list of HCP codes in Appendix B.12.

Loop ID	Reference	Name	Codes	Notes/Comments
	ISA07	Interchange ID Qualifier	ZZ	This ID qualifies the Receiver in ISA08.
	ISA08	Interchange Receiver ID	DHCS- MCBH- NETWK	
	ISA14	Acknowledgement Requested	0	No TA1 response is available at this time.

3.9 Functional Group Header/Trailer (GS/GE)

Loop ID	Reference	Name	Codes	Notes/Comments
GS		Functional Group Header		
	GS02	Application Sender's Code		Sender's Federal Tax ID. Do not include hyphens in the Tax ID.
	GS03	Application Receiver's Code	DHCS- MCBH- NETWK	

3.10 Transaction Set Header/Trailer (ST/SE)

Multiple ST/SEs may be submitted in the same file. This enables the Plan to describe its full provider network in sections delineated by subcontract agreement(s) with organizations that are delegated to manage part or all of the Plan's provider network (referred to as subnetworks). A subnetwork is defined as an entity to which the Plan has delegated administrative responsibilities related to managing the Plan's network providers. Each submitted ST/SE is expected to be a complete provider network within the scope of the subcontract agreement.

For example, a Plan contracted to DHCS manages part of the county's provider network and also subcontracts with an independent organization to manage a subset of the county's provider network. When the Plan submits its 274 provider network file, the file would include two ST/SEs: One ST-SE for the portion of the provider network managed directly by the Plan and the second ST/SE for the portion of the provider network managed by the Plan's subcontracted delegated entity (subnetwork). Each ST/SE must adequately describe the context of each submission in loops 2100AA and 2100AB. Both networks are attributed to the Plan's HCP code specified in the submitted file name.

For Plans that manage the full provider network within the scope of its contract with DHCS, only one ST/SE would be submitted in the 274 file.

A 274 file must have at least one ST/SE. Each ST/SE must have at least one GROUP segment and at least one associated SITE segment. A SITE may be reported without associated PROVIDER segments, depending on the situation.

3.11 Header

The value in BHT02 is very specific and represents that the submitted transaction is a complete network and a full data refresh. Any other value in BHT02 will cause the entire submission to be rejected.

Loop ID	Reference	Name	Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT01	Hierarchical Structure Code	0028	
	BHT02	Transaction Set Purpose Code	27	

3.12 Information Source Detail

Loop ID	Reference	Name	Codes	Notes/Comments
2100AA	NM1	Information Source Name		Only one instance of this segment may be used.
	NM101	Entity Identifier Code	ACV	
	NM103	Organization Name		Enter the name of the Plan submitting the network data as specified in the first node of file name. Refer to Section 3.5 – File Naming Conventions.
	NM108	Identification Code Qualifier	FI	
	NM109	Information Source Primary Identifier		Enter the Plan's Federal Tax ID. Do not include hyphens in the Tax ID.
2100AB	NM1	Network Name		Required. Only one instance of this segment may be used to identify the Plan network or subnetwork (as defined in NM103 below).
	NM101	Entity Identifier Code	NN	

Loop ID	Reference	Name	Codes	Notes/Comments
	NM103	Organization Name		Required. Enter the Plan's network or subnetwork name. A subnetwork is a subcontracted organization to which the Plan has delegated administrative responsibilities for the management of all or part of the Plan's provider network. If no subnetwork, enter the Plan name entered in 2100AA NM103. See Section 3.10 in this section for information about subnetworks.

3.13 Information Receiver Detail

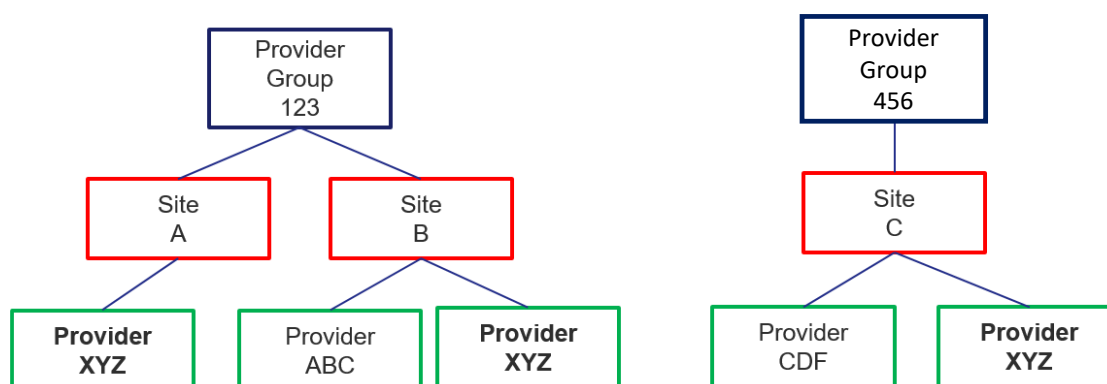
Loop ID	Reference	Name	Codes	Notes/Comments
2100BA	NM1	Information Receiver Name		Only one instance of this segment may be used.
	NM103	Organization Name	DHCS Behavioral Health	Code

3.14 Network Structure

Plans will describe their provider networks using the following three loops within the 274 Transaction structure:

- Loop 2000C – Provider Group Detail
- Loop 2000D – Site Detail
- Loop 2000E – Provider Detail

Since there are no enforced relationships provided within the 274 transaction, the relationship between a Provider Group and a Site will be described by the position of the relevant 2000D Site loop after the “parent” Provider Group 2000C loop. Similarly, a site to provider relationship will be described by the provider loop being positioned after the relevant site. For example, consider a simple network of two Provider Groups. The first Provider Group (123) has two sites, first site (A) has a single provider (XYZ), and the second site (B) has two providers associated (ABC and XYZ). The second Provider Group (456) has only one site (C), and there are two providers associated with this site (CDF and XYZ). The following diagram describes these entities and their relationship.



The following is a list of the 274 loops and their position relative to one another.

Network Description:

- Loop 2000C – Provider Group Detail 123
- Loop 2000D – Site Detail A
- Loop 2000E – Provider Detail XYZ
- Loop 2000D – Site Detail B
- Loop 2000E – Provider Detail ABC
- Loop 2000E – Provider Detail XYZ
- Loop 2000C – Provider Group Detail 456
- Loop 2000D – Site Detail C
- Loop 2000E – Provider Detail CDF
- Loop 2000E – Provider Detail XYZ

Notice that a common provider (XYZ) is included under multiple sites as this accurately describes the working relationship.

Each Provider Group must have at least one Site associated with it. Depending upon the business scenario, each Site may be associated with zero or more providers.

3.15 Provider Group Detail

The Provider Group Detail segment is used to identify the Plan's network provider organizations including county-owned and operated providers and contracted organizations. The term "Organization" refers to the parent organization and/or legal entity designation, including Telehealth organizations.

Loop ID	Reference	Name	Codes	Notes/Comments
2100CA	NM1	Provider Group Name		
	NM101	Entity Identifier Code	QV	
	NM103	Provider Group Name		Required. Enter the name of the Provider Organization contracted or affiliated with the Plan. This may include Sole Proprietorship's contracted directly to the Plan.
	NM108	Identifier Code Qualifier	XX	
	NM109	Identification Code		Requested. Enter the 10-digit National Provider Identification (NPI) number assigned to the provider organization. A warning message will be included in the VRF if NPI is not provided.

Loop ID	Reference	Name	Codes	Notes/Comments
2100CA	N2	Additional Provider Group Name Information		
	N201	Name		Required. Enter the provider group organization's Federal Tax ID Number (no hyphens).
	N202	Name		Required. Enter the Ownership Code associated with the provider organization. See Appendix B.4 for valid values.
2100CA	DTP	Provider Group's Participation Dates		<p>Required. Enter the Contract Effective and Expiration Date. For county-owned and operated providers, enter the effective dates of the plan's contract with DHCS.</p> <p>For contracted provider organizations, enter the effective dates of the Plan's contract with the provider organization.</p> <p>If the contract is terminated, enter the actual termination date.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP01	Date/Time Qualifier	092, 093	Use: “092” for Contract Effective, or “093” for Contract Expiration
	DTP03	Date Time Period		Contract Effective Date, or Contract Expiration Date
2120CA	LQ	Provider Group’s Area of Specialization		Required. Enter the Provider Organization’s Healthcare Taxonomy Code associated with the Organization’s NPI number. Multiple instances may be provided. At least one taxonomy code must be included if the Provider organization has an NPI.
2120CA	TPB	Provider Group’s Network /Product Role		Not requested
2140CA	REF	Provider Group Identification Numbers		

Loop ID	Reference	Name	Codes	Notes/Comments
	REF02	Identification Number		Required for MHPs. Enter the 5-digit Legal Entity Number assigned to the MHP Provider Organization
2100CB	NM1	Affiliated Entity Name		Not requested
2100CB	N2	Affiliated Entity Additional Name Information		Not requested

3.16 Site Detail

The term "site" refers to the physical location (i.e., hospitals, clinics, or satellite sites, etc.) where services are delivered to Medi-Cal beneficiaries. The "site" information must include county-owned and operated facilities and contracted network provider sites.

Loop ID	Reference	Name	Codes	Notes/Comments
2100DA	NM1	Site Name		
	NM101	Entity Identifier Code	77	Service Location
	NM103	Site Name		
	NM108	Identifier Code Qualifier	XX	Use if NM109 is populated with an NPI, otherwise do not send.
	NM109	Identification Code		<p>Requested. Enter the 10-digit National Provider Identification (NPI) number assigned to the site.</p> <p>A warning message will be included in the VRF if NPI is not provided.</p>
2100DA	N2	Site/Location Additional Name Information		

Loop ID	Reference	Name	Codes	Notes/Comments
	N201	Name		<p>See Appendix A.1 for specific mapping information.</p> <ul style="list-style-type: none"> • Site Tax ID Number; • Facility Type; • Institutional Facility Type; • Site County Code; • Licensed Bed Count; • Available Bed Count; • Staffed Bed Count; • Teaching Facility Indicator; • Maximum Number of Medi-Cal Members this Site will Accept; • Current Number of Medi-Cal Members Assigned to this Site; • Telehealth Indicator; • Language Line Available; • Age Groups Served <p>(Each field separated by semi-colon).</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	N202	Name		<p>See Appendix A.1 for specific mapping information and Appendix B.11 for valid values.</p> <ul style="list-style-type: none"> Modality Type (for DMC-ODS only) Type of Service (for MHP reporting only) <p>(Each field separated by semi-colon)</p>
2100DA	PER	Site Contact Information		First Instance.
	PER01	Contact Function Code	AJ	Primary contact
	PER03	Communication Number Qualifier	TE	Telephone

Loop ID	Reference	Name	Codes	Notes/Comments
	PER04	Communication Number		Required. Primary Site contact telephone number. This is the primary phone number used by members to make appointments. For non-appointment sites, use number for customer service. For counties that centralize phone access, use the central phone number.
	PER05	Communication Number Qualifier	EM	Requested. Electronic Mail
	PER06	Communication Number		Requested. Primary Site contact email address. Email address must include an “@” character with at least one character before and after the “@”.
	PER07	Communication Number Qualifier	FX	Facsimile
	PER08	Communication Number		Requested. Primary Site contact facsimile number
2100DA	PER	Site Contact Information		Second Instance

Loop ID	Reference	Name	Codes	Notes/Comments
	PER01	Contact Function Code	AJ	Primary Site Contact
	PER03	Communication Number Qualifier	UR	Uniform Resource Locator (URL)
	PER04	Communication Number		Requested. Enter the URL address of the Site's public website, if applicable.
2100DA	LUI	Site English Speaking Proficiency		Do not send this segment if English is spoken at this site. Plans are required to send this segment only if there are <u>NO</u> English language speakers at this site.
	LUI02	Identification Code	ENG	Upper-case must be used for this data element.
	LUI05	Language Proficiency Indicator		4 – Non-English Speaking

Loop ID	Reference	Name	Codes	Notes/Comments
2100DA	LUI	Foreign Languages Spoken at this Site		<p>Enter when certified bilingual (or multilingual or monolingual in a non-English language) providers or face-to-face interpretation services, other than English, are available at this site and meets the Language Proficiency criteria defined in LUI05.</p> <p>Segment repetitions increased to 175.</p>
	LUI02	Identification Code		<p>Lower case MUST be used for this data element, but the values “eng” or “en” may NOT be used.</p> <p>Language codes from ISO 639-1, 639-2, and ISO 639-3 are accepted.</p> <p>ISO 639 language codes for Medi-Cal threshold languages are included in Appendix B.10.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	LUI05	Language Proficiency Indicator	A or B	<p>A – The site provides certified bilingual providers or certified interpreters who possess certain qualifications or meets standards based on formal testing.</p> <p>B – The site provides oral and/or written proficiency equivalent to that of a native speaker but not a certified interpreter or certified bilingual.</p> <p>Plans should estimate the proficiency as best they can based on these definitions. If the language proficiency level does not meet this criteria, do not enter the foreign language code.</p>
2100DA	DTP	Site Detail/ Location Effective and Termination Dates		Enter the contract effective dates of the site. For Medi-Cal certified sites, enter the contract effective and expiration date. For county operated sites, enter the contract date with DHCS.
	DTP01	Date/Time Qualifier	092, 093	Use: “092” for Effective Date, and “093” for Expiration Date

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP03	Date Time Period		Enter the Effective Date or Expiration Date
2100DA	WS	Work Schedule at this Site		<p>The office hours the site is available to serve Medi-Cal beneficiaries.</p> <p>Include this segment if office hours are other than standard business hours (Monday – Friday, 8am – 5pm) such as evening hours, weekend hours or partial workday hours.</p> <p>Multiple instances may be provided.</p>
	WS01	Office Hours Code		Valid codes are included in the 274 Implementation Guide.
	WS02	Office Hours Start Time		
	WS03	Office Hours End Time		
2100DA	CRC	Patient Acceptance at this Site		Required.
	CRC01	Code Category	C4	Site Conditions

Loop ID	Reference	Name	Codes	Notes/Comments
	CRC03	Patient Acceptance Indicator	P7, P8	<p>Enter value applicable to the site:</p> <p>P7 – Accepting Existing Patients P8 – Accepting New Patients</p> <p>Note: Send P8 if site is accepting new and existing patients. Only one value allowed.</p>
2100DA	CRC	Site Assistive Aid Information		Multiple instances may be provided.
	CRC01	Provider Characteristics and Resources	DJ	

Loop ID	Reference	Name	Codes	Notes/Comments
	CRC03, CRC04, CRC05, CRC06, CRC07	Site or Location Assistive Aid Indicator	1R, 1Y 1S, 1T, 1U, 1V	<p>Use any combination of the following codes applicable to the site:</p> <p>1R – This location is handicapped accessible (ADA Compliant)</p> <p>1Y – This location has Telecommunication Device for the Deaf (TDD) equipment</p> <hr/> <p>Enter only one of the following distance to public transportation codes.</p> <p>1S – This location is less than 1 block from public transportation (less than 0.25 miles)</p> <p>1T – This location is less than 5 block from public transportation (between 0.25 and 0.5 miles)</p> <p>1U – This location is less than 1 mile from public transportation (Between 0.5 and 1.0 miles)</p> <p>1V – This location is 1 or more miles from public transportation</p>
2100DA	PDI	Practice Restrictions at this Site		Not requested.

Loop ID	Reference	Name	Codes	Notes/Comments
2110DA	N3	Site Street Address		Enter the physical address of the site where services are rendered. Do not enter PO Box Numbers.
2110DA	N4	Site Geographic Location		Enter the City, State and Zip Code of the site where services are rendered.
2120DA	LQ	Site Area of Specialization		Multiple instances of the site's Healthcare Taxonomy Code may be provided. If the Site has an NPI, at least one taxonomy code is required.
2120DA	TPB	Network Role at this Site		Not Requested
2140DA	REF	Site Identification Numbers		
	REF02	Reference Identification		<p>See Appendix A.1 for specific mapping information:</p> <ul style="list-style-type: none"> • Site DEA Number; • Facility ID (MHP Site Provider Number or DMC Certification Number) <p>(Each field separated by semi-colon).</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2100DB	NM1	Affiliated Entity Name		At least one site owner is requested for MHP subcontracted sites. A repetition of loop 2100DB and a corresponding NM1 Segment is requested for each co-owner of the business operating at this site
	NM101	Entity Identifier Code	30	
	NM103	Name		Enter the name of the owner described by this instance of the 2100DB loop. Last name or business name, First Name (if applicable) and Middle Name (if known) separated by a semi-colon
	NM108	Identification Code Qualifier	EQ	
	NM109	Identification Code		Federal Tax ID or SSN. Nine numeric digits.

Loop ID	Reference	Name	Codes	Notes/Comments
2100DB	N2	Affiliated Entity Additional Name Information		This segment must be included for each instance of the 2100DB loop if the ownership code and percentage ownership is sent.
	N201	Name		<ul style="list-style-type: none">• The Ownership Code for this owner. See Appendix B.4 for values;• Percentage ownership (three digit numeric, no decimals). If provided, this value must be greater than zero and less than or equal to 100. Include leading zeroes, for example, 15% ownership = "015". (Each field separated by semi-colon).

3.17 Provider Detail

The Provider Detail segment is used to identify the individual practitioner, acting within his or her scope of practice, who is rendering Specialty Mental Health Services (SMHS) directly to the beneficiaries. This includes individuals employed by the Plan, individuals employed by a contracted organization, individual members of a provider group, and individual practitioners rendering services through “fee-for-service” contracts with the Plan, including Telehealth practitioners.

Loop ID	Reference	Name	Codes	Notes/Comments
2100EA	NM1	Provider Name		
	NM108	Identifier Code Qualifier	XX	
	NM109	Identification Code		<p>Requested. Enter the 10-digit National Provider Identification (NPI) number assigned to the provider.</p> <p>A warning message will be included in the VRF if NPI is not provided.</p>
2100EA	N2	Additional Provider Name Information		<p>First Instance. See Appendix A.2 for specific mapping information.</p> <p>Max use of this segment has been modified from the standard. The max use has been changed to greater than one.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	N201	Name		<p>See Appendix A.2 for specific mapping information:</p> <p>“FIRST”</p> <ul style="list-style-type: none">• Provider Gender;• Provider Date of Birth;• Telehealth Indicator;• Provider Profit Status;• Field-Based Services Indicator;• Distance Provider Travels to Field-Based Services;• Accepting New Patients Indicator;• Sees Children Indicator <p>(Each field separated by semi-colon).</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	N202	Name		<p>See Appendix A.2 for specific mapping information:</p> <ul style="list-style-type: none">• State License Number;• Type of Licensure;• Licensing State;• Type of Board Certification;• Mental Health Provider Area of Expertise;• Mental Health Provider Practice Focus;• Service Type;• Cultural Competence Training <p>(Each field separated by semi-colon).</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2100EA	N2	Additional Provider Name Information		Second Instance. See Appendix A.2 for specific mapping information.
	N201	Name		<p>See Appendix A.2 for specific mapping information: “SECOND”</p> <ul style="list-style-type: none"> • Full-Time Equivalent – Serving Children; • Full-Time Equivalent – Serving Adults; • Maximum Number of Medi- Cal Members this Provider will Accept – Children; • Current Medi-Cal Members Assigned to this Provider – Children; • Maximum Number Medi- Cal Members this Provider will Accept – Adults; • Current Medi-Cal Members Assigned to this Provider – Adults <p>(Each field separated by semi- colon).</p>

Loop ID	Reference	Name	Codes	Notes/Comments
2100EA	N2	Additional Provider Name Information		<p>Third Instance. See Appendix A.2 for specific mapping information. Send if an email address is available for the provider.</p> <p>Max use of this segment has been modified from the standard. The max use has been changed to greater than one.</p>
	N201	Name		<p>“EMAIL”</p> <p>Followed by the provider email address. See formatting in Appendix A.2.</p> <p>(Each field separated by semi-colon).</p>
	N202	Name		<p>See Appendix A.2 for specific mapping information and Appendix B.11 for valid values.</p> <ul style="list-style-type: none"> Modality Type (DMC-ODS)

Loop ID	Reference	Name	Codes	Notes/Comments
2100EA	N2	Additional Provider Name Information		See Appendix A.2 for specific mapping information. Max use of this segment has been modified from the standard. The max use has been changed to greater than one.
	N201	Name		Provider Affiliations. See Appendix A.2 for specific mapping information and examples: Choose one, and only one, per data element: "CLNC", "HOSP", "GROUP" or "PROF" Followed by the affiliated NPI. (Each field separated by semi-colon).

Loop ID	Reference	Name	Codes	Notes/Comments
	N202	Name		<p>Provider Affiliations. See Appendix A.2 for specific mapping information and examples:</p> <p>Choose one, and only one per data element:</p> <p>“CLNC”, “HOSP”, GROUP” or “PROF”</p> <p>Followed by the affiliated NPI. (Each field separated by semi-colon).</p>
2100EA	DEG	Providers Degree Information		Not Requested.
2100EA	LUI	English Speaking Proficiency		It is assumed that the provider speaks English. Do not send this segment if the provider speaks English.
	LUI02	Identification Code	ENG	Upper case MUST be used for this data element.
	LUI05	Language Proficiency Indicator	4	4 – Non-English Speaking

Loop ID	Reference	Name	Codes	Notes/Comments
2100EA	LUI	Foreign Languages Spoken by this provider		Enter when languages other than English are spoken by this provider and meets the Language Proficiency criteria defined in LUI05.
	LUI02	Identification Code		<p>Lower case MUST be used for this data element, but the values “eng” or “en” may NOT be used.</p> <p>ISO 639 language codes for Medi-Cal threshold languages are included in Appendix B.10.</p>

Loop ID	Reference	Name	Codes	Notes/Comments
	LUI05	Language Proficiency Indicator	A or B	<p>A – The individual is a certified interpreter or certified bilingual who possesses certain qualifications or meets standards based on formal testing.</p> <p>B – The individual possesses oral and/or written proficiency equivalent to that of a native speaker but is not a certified interpreter or certified bilingual.</p> <p>Plans should estimate the proficiency as best they can based on these definitions. If the language proficiency level does not meet this criteria, do not enter the foreign language code.</p>
2100EA	DTP	Affiliation Participation Dates		Required. For MHP employees, enter the term dates of the MHP contract with DHCS. For MHP network providers, enter the term dates of the MHP's contract with the provider.

Loop ID	Reference	Name	Codes	Notes/Comments
	DTP01	Date/Time Qualifier	092, 093	Use: “092” Contract Effective, or “093” Contract Expiration
	DTP03	Date Time Period		Contract Effective Date, or Contract Expiration Date
2120EA	LQ	Provider Area of Specialization		Multiple instances may be provided. At least one health care taxonomy code must be included for each rendering provider.
2120EA	TPB	Provider’s Network Role		Not Requested
2120EA	YNQ	Provider’s Board Certification		Include if the provider is board certified for specialty in the LQ segment, otherwise do not send this segment.
	YNQ02	Response Code	Y	Provider Board Certification Indicator
2140EA	REF	Provider Identification Numbers		Include if applicable.

Loop ID	Reference	Name	Codes	Notes/Comments
	REF02	Reference Identification		See Appendix A.2 for specific mapping information: <ul style="list-style-type: none">• Provider DEA Number

4 TI Additional Information

None.

Appendix A – Additional Mapping

Note on data types:

Unless a data type is otherwise specified in this appendix, the other sections of the CG or the implementation guide, plans must NOT use any special characters in any submitted data. The sole exception that will be permitted is the use of a dash “-” in a license number.

Unless specifically noted, if a data element is described as situational or requested, the presence of a blank will be edited as an actual submitted value and NOT as a null.

This may result in an error. Submitters are advised to leave a situational/requested data element null when intending not to supply a value. Null value examples:

SEG*XX**~ (Back-to-back asterisks) or REF*XX*valuebeforethenull;;valueafterthenull~ (back-to-back semi-colons).

A.1 Site Detail

Site Loop 2100DA N201 must be redefined as follows:

A maximum of 60 characters is permitted in N201 including all semi-colons. These data elements must be separated by a semi-colon.

Data Element	Length	Description
1. Site Tax ID Number	9	Situational. Enter if the Tax ID is unique to the site and different than the Provider Organization Federal Tax ID entered Provider Group Detail – 2100CA N201. Numeric - no hyphens.
2. Facility Type	2	Required. Enter the two-digit alpha-numeric code that describes the type of site. See valid values in Appendix B.1.
3. Institutional Facility Type	2	Situational. Required when the Facility Type equals 26, 27, 28, 31, 32, or 38. See definition and valid values in Appendix B.2.
4. Site County Code	2	Required. Enter the county in which the site is located. See valid county codes in Appendix B.3.
5. Licensed Bed Count*	Up to 5	Situational. Required when Facility Type equals 27, 28, 31, 32, or 38. Total number of established and licensed beds at an inpatient facility. Definition: The number of licensed beds (excluding beds placed in suspense and nursery bassinets) stated on the hospital license at the end of the reporting period.

Data Element	Length	Description
6. Available Bed Count*	Up to 5	<p>Situational. Required when Facility Type equals 27, 28, 31, 32, or 38. Total number of unoccupied licensed beds.</p> <p>Definition: The average daily complement of beds (excluding nursery bassinets) physically existing and actually available for overnight use, regardless of staffing levels. Excludes beds placed in suspense or in nursing units converted to non-patient care uses which cannot be placed into service within 24 hours.</p>
7. Staffed Bed Count*	Up to 5	<p>Situational. Required when Facility Type equals 27, 28, 31, 32, or 38. Total number of licensed beds that have adequate staffing.</p> <p>Definition: The average daily complement of beds (excluding nursery bassinets) that are set-up, staffed, and equipped, and in all respects, ready for use by patients remaining in the hospital overnight. Staffed beds change daily to reflect the average daily census.</p>
8. Teaching Facility Indicator	1	<p>Required.</p> <p>A Teaching Facility is a hospital or organization that sponsors graduate medical education (GME) programs or participates in GME. Valid values:</p> <p>“0” = No “1” = Yes</p> <p>Source: https://www.acgme.org/Portals/0/PDFs/2010-11.pdf.</p>

Data Element	Length	Description
9. Maximum Number of Medi-Cal Members this Site will Accept	Up to 6	Situational. Enter the maximum number of beneficiaries this site will accept.
10. Current Number of Medi-Cal Members Assigned to this Site	Up to 6	Situational. Enter the actual number of beneficiaries assigned to this site.
11. Telehealth Indicator	1	<p>Required. Indicates if the site provides Telehealth services. Valid values are "O" or "B" or "N".</p> <p>"O" = Services at this site are only provided through telehealth</p> <p>"B" = Services at this site are provided both in-person and through telehealth</p> <p>"N" = No provider uses telehealth at this site</p> <p>California law defines telehealth as "a mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and health care provider is at the distant site." – see Business and Professions Code 2290.5.</p> <p>https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx</p>

Data Element	Length	Description
12. Language Line Available	1	Required. Indicates if the site has the capability to utilize a language line service to screen and/or render services in a non-English language. Valid values are “Y” = Language Line Available “N” = Language Line is not Available
13. Age Groups Served	1	Required. Select one option: “C” = Site Serves only Children “A” = Site Serves only Adults “B” = Site Serves Children and Adults <u>Definitions</u> For MHPs: Child = Age 0-20; Adult = Age 21+ For DMC-ODS: Child = Age 0-17; Adult = Age 18+

These data elements must be separated by a semi-colon.

*Bed Count Definition Source: California’s Office of Statewide Health Planning and Development (OSHPD) Data Dictionary: [https://s3.amazonaws.com/delphi-us-rds-1/file_uploader/files/attacheds/000/076/136/original/OpenGov_Glossary_of_Terms.pdf?1525276357]

Site Loop 2100DA N202 must be redefined as follows:

A maximum of 60 characters is permitted in N202 including all semi-colons. These data elements must be separated by a semi-colon.

Data Element	Field Length	Description
1. Modality Type	Maximum 21 characters	Required for DMC-ODS only. See Appendix B.11 for code values and descriptions.
2. Type of Service	Maximum 36 Characters	Required for MHPs only. See Appendix B.12 for code values and descriptions.

Site Loop 2140DA REF02 must be redefined as follows:

A maximum of 50 characters is permitted in REF02 including all semi-colons. Each data elements must be separated by a semi-colon.

Data Element	Length	Description
1. Site DEA Number	Up to 15	Situational. Enter the site's DEA number, if applicable. (Under the Controlled Substances Act, every person or entity that handles controlled substances must be registered with the Drug Enforcement Agency (DEA) or be exempt by regulation from registration.)
2. Facility ID	Up to 6-digit alphanumeric	Situational. For MHPs, enter the state assigned Site Provider Number. For DMC certified sites, enter the state assigned DMC Certification number.

These data elements must be separated by a semi-colon.

A.2 Provider Detail

The first instance of Provider segment N2, loop 2100EA, data element N201 must be redefined as follows:

A maximum of 60 characters is permitted in N201 including all semi-colons:

Data Element	Field Length	Description
1. Data Element Tag	5	"FIRST"
2. Provider Gender	1, 2 or 3	<p>Required. Valid values are: "M", "F", "MTF", "FTM", "GQ", "AG", or "U".</p> <hr/> <p>F = Female M = Male MTF = Transgender Male To Female FTM = Transgender Female To Male GQ = Genderqueer AG = Another Gender Identity U = Undisclosed</p>
3. Provider Date of Birth	8	Required. Use format CCYYMMDD.

Data Element	Field Length	Description
4. Telehealth Indicator	1	<p>Required. Indicates if the rendering provider delivers services via telehealth services either full or part-time.</p> <p>Valid values are “O” or “B” or “N”.</p> <p>O – Services from this provider are only provided through telehealth</p> <p>B – Services from this provider are provided both in-person and through telehealth</p> <p>N - This provider does not provide telehealth services</p> <p>California law defines telehealth as “a mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and health care provider is at the distant site.” – see Business and Professions Code 2290.5.</p> <p>https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx</p> <p>Note: all telehealth psychiatry service providers should be included in the 274 file.</p>

Data Element	Field Length	Description
5. Provider Profit Status	2	Required. A code denoting the profit status of the provider. Valid values are: 01 = 501(C)(3) Non-profit 02 = For profit – closely held 03 = For profit, publicly traded 04 = Other 88 = Not applicable – the individual only practices as part of a group 99 – Unknown
6. Field-Based Services Indicator	1	Required. Indicates if the rendering provider travels to beneficiaries (e.g., beneficiary's home) and/or community settings to deliver covered services. Valid values are “Y” or “N”.
7. Distance Provider Travels to Field Based Services	Up to 4 numeric	Situational. If Field-Based Services Indicator = “Y”, enter the <u>maximum</u> distance (i.e., actual mileage) the provider is willing to travel to deliver services.
8. Accepting New Patients Indicator	1	Required. Indicates if a provider is accepting new patients (during the reporting month). Valid values are “Y” or “N”.

Data Element	Field Length	Description
9. Sees Children Indicator	1	Required. A code indicating if this provider accepts children. Valid values are: “O” = Only Sees Children “B” = Sees both Children and Adults “N” = Does not see Children <u>Definitions</u> For MHPs: Child is defined as age 0-20; Adult is defined as age 21+ For DMC-ODS: Child is defined as age 0-17; Adult is defined as age 18+

These data elements must be separated by a semi-colon.

The first instance of Provider segment N2, loop 2100EA, data element N202 must be redefined as follows:

A maximum of 60 characters is permitted in N202 including all semi-colons.

Data Element	Length	Description
1. State License Number	Up to 15 alphanumeric	Situational. Enter the provider's California practitioner license or certificate number for all "Type of Licensure" except "OTH", "MHR", "WAP". If the License Number or Certificate Number is not available at the time of reporting, enter "Unavailable".
2. Type of Licensure	3	Required. See Appendix B.5 for code values and descriptions.
3. Licensing State	2	Situational. Enter the state that issued the State License Number for all "Type of Licensure" values except "OTH", "MHR", "WAP".
4. Type of Board Certification	1	Situational. Enter the associated certifying entity. See Appendix B.6 for code values and descriptions. Include if the provider is board certified for the provider's specialty, otherwise leave null.
5. Mental Health Provider Area of Expertise	4	Required for MHPs only. Up to four different areas of expertise can be provided. See Appendix B.7 for code values and descriptions.

Data Element	Length	Description
6. Mental Health Provider Practice Focus	Up to 10	Required for MHPs only. Up to five different values for practice focus can be provided. See Appendix B.8 for code values and descriptions.
7. Service Type	Up to 12	Required for MHPs only. Up to six values for Service Type can be provided. See Appendix B.9 for code values and definitions.
8. Cultural Competence Training	1	Required. Indicates if the rendering provider received cultural competence training within the past 12 months. Valid values are “Y” or “N”.

The second instance of Provider segment N2, loop 2100EA, data element N201 must be redefined as follows:

A maximum of 60 characters is permitted in N201 including all semi-colons:

Data Element	Field Length	Description
1. Data Element Tag	6	"SECOND"
2. Full-Time Equivalent – Serving Children	3 Fixed-numeric	<p>Required MHPs only. The percentage of time this provider is available at this site to deliver specialty mental health services directly to Medi-Cal beneficiaries (ages 0-20). Delivery of specialty mental health services refers to services defined as such in the MHP contract and reimbursable as medical assistance. If the provider serves both children (under 21) and adults (21 and over), separately enter FTE percentage dedicated to serving children and the FTE percentage dedicated to serving adults. For example, if one FTE rendering provider serves children/youth 30% of the time and adults 70% of the time, enter the respective FTE value for that age group (i.e., 030 for 0-20; 070 for 21+).</p> <p>Report as a percentage without any decimals. Enter the percentage as a numeric three digit value that is greater than or equal to "000" and less than or equal to "100". The sum of percentages for one provider located at different sites</p>

Data Element	Field Length	Description
		<p>should not exceed 100. See below for examples:</p> <p>A 100% full-time equivalent provider is available to deliver services (and conduct associated activities) approximately 2,080 hours per year (do not account for paid or unpaid leave time).</p> <p>A 75% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 1,560 hours per year (do not account for paid or unpaid leave time).</p> <p>A 50% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 1,040 hours per year (do not account for paid or unpaid leave time).</p> <p>A 25% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 520 hours per year (do not account for paid or unpaid leave time).</p> <p>A 10% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 208 hours per year (do not account for paid or unpaid leave time).</p>

Data Element	Field Length	Description
3. Full-Time Equivalent – Serving Adults	3 Fixed-numeric	<p>Required for MHPs only. The percentage of time this provider is available at this site to deliver specialty mental health services directly to Medi-Cal beneficiaries ages 21 and over. Delivery of specialty mental health services refers to services defined as such in the MHP contract and reimbursable as medical assistance. If the provider serves both children (under 21) and adults (21 and over), separately enter FTE percentage dedicated to serving children and the FTE percentage dedicated to serving adults. For example, if one FTE rendering provider serves children/youth 30% of the time and adults 70% of the time, enter the respective FTE value for that age group (i.e., 030 for 0-20; 070 for 21+).</p> <p>Report as a percentage without any decimals. Enter the percentage as a numeric three-digit value that is greater than or equal to “000” and less than or equal to “100”. The sum of percentages for one provider located at different sites should not exceed 100. See below for examples:</p> <p>A 100% full-time equivalent provider is available to deliver services (and conduct associated activities) approximately 2,080</p>

Data Element	Field Length	Description
		<p>hours per year (do not account for paid or unpaid leave time).</p> <p>A 75% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 1,560 hours per year (do not account for paid or unpaid leave time).</p> <p>A 50% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 1,040 hours per year (do not account for paid or unpaid leave time).</p> <p>A 25% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 520 hours per year (do not account for paid or unpaid leave time).</p> <p>A 10% full-time equivalent provider available to deliver services (and conduct associated activities) approximately 208 hours per year (do not account for paid or unpaid leave time).</p>

Data Element	Field Length	Description
4. Maximum Number of Medi-Cal Members this Provider will Accept-Children	Up to 4 numeric	Required if the provider has an assigned caseload for children. Enter the maximum caseload. For MHPs, Child is defined as Age 0-20 For DMC-ODS plans, Child is defined as age 0-17
5. Current Medi-Cal Members Assigned to this Provider - Children	Up to 4 numeric	Required if the provider has an assigned caseload for children. Enter the current caseload. For MHPs, Child is defined as Age 0-20 For DMC-ODS plans, Child is defined as age 0-17
6. Maximum Number of Medi-Cal Members this Provider will Accept-Adults	Up to 4 numeric	Required if the provider has an assigned caseload for adults. Enter the maximum caseload. For MHPs, Adult is defined as Age 21+ For DMC-ODS plans, Adult is defined as age 18+
7. Current Medi-Cal Members Assigned to this Provider - Adults	Up to 4 numeric	Required if the provider has an assigned caseload for adults. Enter the current caseload. For MHPs, Adult is defined as Age 21+ For DMC-ODS plans, Adult is defined as age 18+

These data elements must be separated by a semi-colon.

The third instance of Provider segment N2, loop 2100EA, data element N201 must be redefined as follows:

A maximum of 60 characters is permitted in N201 including all semi-colons.

Data Element	Field Length	Description
1. Data Element Tag	5	“EMAIL”
2. Provider email address	Maximum 54 characters	Requested. Enter the full email address of the provider. Email address must include an “@” character with at least one character before and after the “@”.

These data elements must be separated by a semi-colon.

The third instance of Provider segment N2, loop 2100EA, data element N202 must be redefined as follows.

Data Element	Field Length	Description
1. Modality Type	Maximum 21 characters	Required for DMC-ODS reporting only. See Appendix B.11 for code values and descriptions.

The following instances of segment N2, loop 2100EA, data elements N201 and N202 must be redefined as follows:

A maximum of 60 characters is permitted in N201 or N202 including all semi-colons.

Reporting of this Segment is Optional.

Data Element	Field Length	Description
1. Data Element Tag	4 or 5	Enter the type of professional affiliation: "CLNC", "HOSP", "GROUP", or "PROF" _____ CLNC = Clinic HOSP = Hospital GROUP = Provider Organization or Provider Group PROF = Professional such as a Physician, Psychiatrist, Psychologist, etc.
2. Affiliated NPI	10	Enter the Affiliated NPI associated with "CLNC", "HOSP", GROUP "PROF"
3. Additional Affiliated NPI's	10	Enter the Affiliated NPI associated with "CLNC", "HOSP", GROUP "PROF"

These data elements must be separated by a semi-colon.

Given a data element tag of either four or five bytes, this establishes a maximum of 5 Affiliated NPI's per data element. Send as many instances of the N2 segment as is needed to convey all affiliated relationships for the provider.

Only one data element tag may be used per data element.

Example (1): an associate professional clinical counselor has a licensed professional clinical counselor supervising director and is affiliated with two clinics; the corresponding N2 segment would look like this:

```
N2*PROF;1234567890*CLNC;3456789012;4567890123~
```

Example (2): a clinical psychiatrist has admission privileges at two hospitals and works with two Nurse Practitioners, the corresponding N2 segment would look like this:

```
N2*HOSP;1234567890;2345678902*PROF;3456789012;4567890123~
```

The order of the type of affiliations does not matter.

Loop 2140EA REF02 must be redefined as follows:

A maximum of 45 characters is permitted in REF02 including all semi-colons:

Data Element	Length	Description
1. Provider DEA Number	Up to 15	Required. Enter the provider's DEA number, if applicable. Under the Controlled Substances Act, every person or entity that handles controlled substances must be registered with the Drug Enforcement Agency (DEA) or be exempt by regulation from registration.

Appendix B – Data Definitions

B.1 Facility Type (2100DA N201)

Facility Type describes the type of site where health care services are provided. Unless otherwise specified, the code descriptions are derived from the Health Care Provider Taxonomy classification system maintained by the National Uniform Classification System (NUCC). This information is required for CMS Transformed Medicaid Statistical Information System (T-MSIS) reporting. For more information about the code descriptions refer to the NUCC Health Care Provider Taxonomy Code Set PDF at: <http://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53>.

Code	Site Facility Type Description
10	Individuals or Groups (of Individuals) (An individual or group of individuals who render health care or furnish health care to patients. Examples include taxonomy codes for physicians, psychiatrists, psychologists, etc.)
17	Non-Individual - Other Service Providers (Providers, not otherwise classified, who perform or administer services in or related to the delivery or research of health care services, disease, and restoration of health. Examples include taxonomy codes for providers of lodging services or meal delivery services.)

Code	Site Facility Type Description
25	<p>Non-Individual – Agencies</p> <p>(A non-facility provider that renders outpatient outreach services that are not provided at a specific location. The licensure or registration is assigned to the agency rather than to the individual practitioners as would be the case in a group practice. Examples include taxonomy codes for Case Management, Community/Behavior Health, Day Training, Developmentally Disabled Services and Early Intervention Provider Agency.)</p>
26	<p>Non-Individual - Ambulatory Health Care Facilities</p> <p>(A facility or distinct part of one that provides services on an outpatient basis in a fixed location or specifically designed mobile unit, and does not provide overnight accommodations. Examples include taxonomy codes for Clinic/Centers for Adolescent and Children Mental Health, Adult Mental Health, etc.)</p>
27	<p>Non-Individual - Hospital Units</p> <p>(A distinct part of a general acute care hospital determined by characteristics such as the following: the unit has admission and discharge records that are separately identified from those of the hospital; the hospital has policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit, etc. Examples include taxonomy codes for Psychiatric Unit, Rehabilitation Unit, etc.)</p>
28	<p>Non-Individual – Hospitals</p> <p>(A health care organization that has a governing body, an organized medical staff and professional staff and inpatient facilities and provides medical nursing and related services for ill and injured patients 24 hrs. per day, seven days per week. For licensing purposes, each state has its own definition of hospital.)</p>

Code	Site Facility Type Description
29	<p>Non-Individual – Laboratories</p> <p>(A room or building equipped for scientific experimentation, research, testing or clinical studies of materials, fluids or tissues obtained from patients. Examples include taxonomy codes for clinical medical laboratory and physiological laboratory)</p>
31	<p>Non-Individual - Nursing & Custodial Care Facilities</p> <p>(Broad category identifying licensed facilities with inpatient beds specializing in nursing and custodial care. Examples include taxonomy codes for Assisted Living Facility, Custodial Care Facility, etc.)</p>
32	<p>Non-Individual - Residential Treatment Facilities</p> <p>(Live in facilities where patients or clients, who because of their physical, mental, or emotional condition are not able to live independently, and who receive treatment appropriate to their particular needs in a less restrictive environment than an inpatient facility. Examples include taxonomy codes for Community Based Residential Treatment Facility, Mental Illness, Psychiatric Residential Treatment Facility, etc.)</p>
33	<p>Non-Individual – Suppliers</p> <p>(Suppliers, pharmacies, and other health care providers who supply health care related products or medications and associated professional and administrative services.)</p>
34	<p>Non-Individual - Transportation Services</p> <p>(A provider who moves a patient, tissue specimen or equipment from one location to another.)</p>
38	<p>Non-Individual - Respite Care Facility</p> <p>(A facility with dorm rooms where individuals who are unable to care for themselves may stay on a short term basis overnight to allow relief to persons normally providing care to them.)</p>

Code	Site Facility Type Description
SF	<p data-bbox="354 285 639 317">Satellite Site - Fixed</p> <p data-bbox="354 348 1406 709">“Satellite Site - Fixed means a site owned, leased or operated by an organizational provider at which specialty mental health services are delivered to beneficiaries fewer than 20 hours per week, or, if located at a multiagency site at which specialty mental health services are delivered by no more than two employees or contractors of the provider. This includes fixed-location community settings such as a school, community center or other fixed based location with an established address.</p>
SM	<p data-bbox="354 816 862 848">Satellite Site – Mobile Medical Units</p> <p data-bbox="354 879 1406 1241">A “Mobile Medical Unit” is owned, leased or operated by an organizational provider and travels to communities with limited access to care to provide specialty mental health services to beneficiaries fewer than 20 hours per week. The address or closest cross-streets of where the mobile units are located throughout the month should be included at the Site Detail level. Include one Site Detail entry for each location in which the Mobile Medical Unit provided.)</p>

B.2 Institutional Facility Type (2100DA N201)

Institutional Facility Type describes inpatient and outpatient facilities based on codes and descriptions from the National Uniform Billing Committee (NUBC) Type of Bill Code. Required when the Facility Type equals 26, 27, 28, 31, 32, or 38.

Value	Description
11	Hospital Inpatient (Including Medicare Part A)
12	Hospital Inpatient (Medicare Part B only)
13	Hospital Outpatient
14	Hospital Laboratory Services Provided to Non-patients
18	Hospital Swing Beds
21	Skilled Nursing Facility (SNF) Inpatient (Including Medicare Part A)
22	Skilled Nursing Facility (SNF) Inpatient (Medicare Part B only)
23	Skilled Nursing Facility (SNF) Outpatient
28	Skilled Nursing Facility (SNF) Swing Beds
32	Home Health-Inpatient (Plan of treatment under Part B only)
33	Home Health-Outpatient (Plan of treatment under Part A, including DME under Part A)
34	Home Health-Other (for medical and surgical services not under a plan of treatment)
41	Religious Nonmedical Health Care Institutions-Hospital Inpatient
43	Religious Nonmedical Health Care Institutions-Outpatient Services
65	Intermediate Care - Level I
66	Intermediate Care - Level II
70	Clinic - Indian Health Services Facility
71	Clinic - Rural Health
72	Clinic - Hospital Based or Independent
73	Clinic - Free Standing
74	Clinic - Outpatient Rehabilitation Facility
75	Clinic - Comprehensive Outpatient Rehabilitation

Value	Description
76	Clinic - Community Mental Health Center
77	Clinic - Federally Qualified Health Center (FQHC)
78	Licensed Freestanding Emergency Medical Facility
79	Clinic – Other
81	Hospice (non-hospital based)
82	Hospice (hospital based)
83	Ambulatory Surgery Center
84	Free Standing Birthing Center
85	Critical Access Hospital
86	Residential Facility
89	Special Facility – Other

B.3 Site County Code (2100DA N201)

This field identifies the California County where the service site is located.

CODE	COUNTY	CODE	COUNTY
01	Alameda	31	Placer
02	Alpine	32	Plumas
03	Amador	33	Riverside
04	Butte	34	Sacramento
05	Calaveras	35	San Benito
06	Colusa	36	San Bernardino
07	Contra Costa	37	San Diego
08	Del Norte	38	San Francisco
09	El Dorado	39	San Joaquin
10	Fresno	40	San Luis Obispo
11	Glenn	41	San Mateo
12	Humboldt	42	Santa Barbara
13	Imperial	43	Santa Clara
14	Inyo	44	Santa Cruz
15	Kern	45	Shasta
16	Kings	46	Sierra
17	Lake	47	Siskiyou
18	Lassen	48	Solano
19	Los Angeles	49	Sonoma
20	Madera	50	Stanislaus
21	Marin	51	Sutter
22	Mariposa	52	Tehama
23	Mendocino	53	Trinity
24	Merced	54	Tulare
25	Modoc	55	Tuolumne
26	Mono	56	Ventura
27	Monterey	57	Yolo
28	Napa	58	Yuba
29	Nevada	99	Out of State
30	Orange		

B.4 Ownership Code (2100DB N201)

The Ownership Code describes the type of ownership of the Legal Entity.

Code	Description
01	Voluntary – Non-Profit – Religious Organizations
02	Voluntary – Non-Profit – Other
03	Voluntary – multiple owners
04	Proprietary – Individual
05	Proprietary – Corporation
06	Proprietary – Partnership
07	Proprietary – Other
08	Proprietary – multiple owners
09	Government – Federal
10	Government – State
11	Government – City
12	Government – County
13	Government – City-County
14	Government – Hospital District
15	Government – State and City/County
16	Government – other multiple owners
17	Voluntary /Proprietary
18	Proprietary/Government
19	Voluntary/Government
88	N/A – The individual only practices as part of a group, e.g., as an employee

B.5 Type of Licensure (2100EA N202)

This is a three-byte alphanumeric and is defined by the following table:

Type of Licensure	Value	Requires California State License or Practitioner Number*
Marriage and Family Therapist/Licensed Marriage and Family Therapist	MFT	Yes
Master of Social Work/Licensed Clinical Social Worker	CSW	Yes
Nurse - RN, LPN, NA	NRS	Yes
Nurse Practitioner/ Advanced/Masters RN	NPA	Yes
Professional Clinical Counselor (LPCC)	PCC	Yes
Psychologist - PHD-Level	PSY	Yes
Physician	MD	Yes
Board Certified Behavior Analyst (BCBA) or Board-Certified Associate Behavior Analyst (BCaBA)	BCB	Certificate
Licensed Psychiatrists	LPS	Yes
Certified Nurse Specialists	CNS	Yes
Licensed Vocational Nurses	LVN	Yes
Psychiatric Technicians	PTE	Yes
Mental Health Rehabilitation Specialists	MHR	No
Physician Assistants	PAS	Yes
Pharmacists	PHA	Yes
Occupational Therapists	OCT	Yes
Associate Clinical Social Worker	ACS	Yes
Associate Marriage Family Therapist	AMF	Yes
Associate Professional Clinical Counselor	APC	Yes
Waivered Psychologist	WAP	No
Substance Use Disorder Counselors – Registered	SUR	Certificate
Substance Use Disorder Counselors – Certified	SUC	Certificate
Other Qualified Provider	OTH	No

*Enter the provider's California practitioner license or certificate number in State License Number Field. If the state license or certificate number is not available at the time of reporting, enter **"Unavailable"** in State License Number field. Do not enter OTH if there is an applicable Type of Licensure for the provider.

B.6 Type of Board Certification (2100EA N202)

This is a one-byte alphanumeric field that can have one of the following five values, or if no Board Certification is applicable, it can be left as a null value:

Type of Board Certification	Value
State, county, or municipality professional or business license	1
DEA license	2
Professional society accreditation	3
CLIA accreditation	4
Other	5

B.7 Mental Health Provider Area of Expertise (2100EA N202)

This is a four-byte alphanumeric field that is comprised of up to four one-byte characters, and is defined by the following table:

Area of Expertise	Value
Child/Adolescent	C
Adult	A
Geriatric	G
Substance Abuse	S

If a provider's area of expertise included all four of these values, the Mental Health Provider Area of Expertise field would equal "CAGS". The order of the characters is not important ("SGCA" would be equally as valid).

If a provider's areas of expertise included only Adult and Geriatric, then the Mental Health Provider Area of Expertise field would equal either "AG" or "GA". At least one Provider Area of Expertise must be entered.

B.8 Mental Health Provider Practice Focus (2100EA N202)

This is a ten-byte alphanumeric field that is comprised of up to five two-byte characters.

DSM-V Practice Focus	Value
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence	1D
Delirium, Dementia, and Amnestic and other Cognitive Disorders	CD
Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized	GM
Substance-Related Disorders	SR
Schizophrenia and Other Psychotic Disorders	PS
Depressive Disorders	DS
Bi-polar Disorders	BP
Mood Disorders	MD
Anxiety Disorders	AD
Somatoform Disorders	SD
Factitious Disorders	FD
Dissociative Disorders	DD
Sexual and Gender Identity Disorders	SG
Eating Disorders	ED
Sleep Disorders	SL
Impulse-Control Disorders Not Otherwise Elsewhere Categorized	IC
Adjustment Disorders	AJ
Personality Disorders	PD

Select up to five of the provider's primary practice focus areas. For example, if the practice areas to be reported are Mood Disorders, Anxiety Disorders, Eating Disorders and Sleep Disorders, the value for Mental Health Provider Practice Area would equal "MDADED SL".

B.9 Service Type (Rendering Provider 2100EA N202)

This is a two-digit alphanumeric that describes the specialty mental health services delivered by the rendering provider. **Not required for DMC-ODS reporting.**

Service Type	Value
Mental Health Services	MH
Targeted Case Management	TC
Crisis Intervention	CI
Medication Support	MS
Intensive Care Coordination	IC
Intensive Home-Based Services	IH

Select up to **six** of the provider's primary Specialty Mental Health Service types. For example, if the service types to be reported are Targeted Case Management, Crises Intervention and Intensive Care Coordination, the value to be entered in the Service Type field would equal "TCCIIC". At least one service type must be reported.

B.10 ISO 639 Language Codes for Medi-Cal Threshold Languages (2100DA LUI02/2100EA LUI)

The following table provides the ISO 639 language codes for primary Medi-Cal threshold languages. **To report foreign languages other than those listed in this table, refer to the ISO 639 code table available online at [ISO 639-3 | \(sil.org\)](https://iso639-3.sil.org) and select the appropriate language code for the site and/or rendering provider.** On this site, codes may be viewed on-line or downloaded.

Foreign Language Description	ISO 639 Code (enter as lower case)
Arabic	ara
Armenian	hye
Cambodian (Khmer)	khm
Cantonese (Yue Chinese)	yue
Farsi (Persian)	fas
Hmong	hmn
Korean	kor
Mandarin	cmn
Other Chinese	zho
Russian	rus
Spanish	spa
Tagalog	tgl
Vietnamese	vie
American Sign Language (ASL)	ase

B.11 Modality Type (2100DA N202 and 2100EA N202)

This is a three-digit alphanumeric value that describes the Modalities for DMC-ODS sites and providers. "Modality" means those services needed to provide substance use disorder services (as described in Division 10.5 of the Health and Safety Code).

Required for DMC-ODS reporting only. At least one Modality must be entered and up to 7 Modalities may be selected.

The following provides an example of how to report for two separate modalities:

Modalities for Outpatient Treatment, Intensive Outpatient Treatment are reported as: "091105". Do not enter spaces, commas, semicolons or any other character between modality codes.

Code Value	Description	Detail Description
091	Outpatient Treatment	<p>Outpatient Treatment (OT) services (ASAM Level1) consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents. Services are typically provided in regularly scheduled sessions following a defined set of policies and procedures or clinical protocols.</p> <p>Group Counseling: contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.</p> <p>Individual Counseling: contact between a beneficiary and a therapist or counselor.</p>
105	Intensive Outpatient Treatment	<p>Intensive Outpatient Treatment (IOT) ASAM Level 2.1 structured programming services are provided to beneficiaries when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan. Services are provided for a minimum of nine hours with a maximum of nineteen hours a week for adults and for a minimum of six hours with a maximum of nineteen hours a week for adolescents. Services consist primarily of counseling and education about addiction related problems.</p>

Code Value	Description	Detail Description
109	Residential Withdrawal Management 3.2	WM services are provided as part of a continuum of five WM levels in the ASAM Criteria when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements. Each beneficiary shall reside at the facility, if receiving a residential service, and will be monitored during the detoxification process. WM services delivered in a residential setting can be provided in facilities with no bed capacity limit in pilot counties only. Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.
112	Residential 3.1	Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) as medically necessary, and in accordance with the individual treatment plan. Residential treatment services are provided in a continuum as per the five levels of ASAM residential treatment (3.1, 3.3, 3.5, 3.7, and 4). 24-hour structure with available trained personnel, at least 5 hours of clinical service per week, and preparation for outpatient treatment. SABG Criteria: SABG can be used to pay for room and board only for ODS beneficiaries. Refer to codes 58 - Residential Treatment Services, Room & Board Only and 58-1 Residential Treatment Services Perinatal, Room & Board Only to report these expenditures. For beneficiaries not eligible for ODS, SABG funds can be used as the payment of last resort including the room and board.
113	Residential 3.3	24-hour care, with trained counselors, to stabilize multi-dimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment. Note: This level is not designated for adolescents. SABG Criteria: SABG can be used to pay for room and board only for ODS beneficiaries. Refer to codes 58 - Residential Treatment Services, Room & Board Only and 58-1 Residential Treatment Services Perinatal, Room & Board Only to report these expenditures. For beneficiaries not eligible for ODS, SABG funds can be used as the payment of last resort including the room and board.
114	Residential 3.5	24-hour care, with trained counselors, to stabilize multi-dimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community. SABG Criteria: SABG can be used to pay for room and board only for ODS beneficiaries. Refer to codes 58 - Residential Treatment Services, Room & Board Only and 58-1 Residential Treatment Services Perinatal, Room & Board Only to report these expenditures. For beneficiaries not eligible for ODS, SABG funds can be used as the payment of last resort including the room and board.
115	Residential 3.7 (Hospital)	24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability.

Code Value	Description	Detail Description
116	Residential 4.0 (Hospital)	<p>Severe withdrawal needing 24-hour support to complete medically monitored withdrawal management in an inpatient setting and increase likelihood of continuing treatment or recovery.</p> <p>Withdrawal Management (WM) services are provided as part of a continuum of five WM levels in the American Society of Addiction Medicine (ASAM) Criteria when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. WM services delivered in a residential setting can be provided in facilities with no bed capacity limit in pilot counties only.</p>
117	Residential Withdrawal Management 3.7	<p>Severe withdrawal needing 24-hour support to complete medically monitored withdrawal management in an inpatient setting and increase likelihood of continuing treatment or recovery.</p> <p>Withdrawal Management (WM) services are provided as part of a continuum of five WM levels in the American Society of Addiction Medicine (ASAM) Criteria when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. WM services delivered in a residential setting can be provided in facilities with no bed capacity limit in pilot counties only.</p>
118	Residential Withdrawal Management 4.0	<p>Severe, unstable withdrawal needing 24-hour support to complete medically managed withdrawal management in a hospital inpatient setting and unlikely to complete withdrawal management without medical monitoring.</p> <p>Withdrawal Management (WM) services are provided as part of a continuum of five WM levels in the American Society of Addiction Medicine (ASAM) Criteria when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. WM services delivered in a residential setting can be provided in facilities with no bed capacity limit in pilot counties only.</p>

Code Value	Description	Detail Description
120	Opioid Treatment Program	<p>Methadone Dosing: Provision of methadone as prescribed by a physician to alleviate the symptoms of withdrawal from narcotics, and other required/appropriate activities and services provided in compliance with CCR Title 9 beginning with Section 10000. Services include intake, assessment and diagnosis, all medical supervision, urine drug screening, individual and group counseling, admission physical examinations, and laboratory tests. [Title 9, and Title 22, July 2013]</p> <p>Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served.</p> <p>Individual Counseling: Face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits do not qualify as Medi-Cal reimbursable units of service. [Title 22, July 1, 2013]</p>

B.12 Type of Service (Site 2100DA N202)

This is a three-byte alphanumeric that identifies the types of specialty mental health services available at the facility. **Required for MHPs only:**

Types of Service	Value
Adult Residential Treatment Services	ART
Crisis Intervention	CIS
Crisis Residential Treatment Services	CRT
Crisis Stabilization	CSS
Day Rehabilitation	DRF
Day Treatment Intensive	DTI
Intensive Care Coordination	ICC
Intensive Home-Based Services	IHB
Mental Health Services	MHS
Medication Support Services	MSS
Psychiatric Health Facility Services	PHF
Psychiatric Inpatient Hospital Services	PIS
Therapeutic Behavioral Services (Youth)	TBY
Targeted Case Management	TCM
Therapeutic Foster Care (Youth)	TFC

Up to twelve (12) specialty mental health Service Types may be provided in any order. For example, if the site's types of services to be reported are Adult Residential Treatment Services, Crises Intervention and Medication Support: the value entered would equal "ARTCISMSS". At least one service type must be reported for the MHP site. Do not enter any characters (such as commas or semi-colons) in between each Type of Service value.

B.13 Health Care Plan (HCP) Codes

The HCP Code is a three-digit code assigned by DHCS that uniquely identifies a County Behavioral Health Plan. Select the appropriate code for the Plan and enter in the File name and in ISA06 as specified in Section 3.5 File Naming Conventions and Section 3.8-Interchange Control Header/Trailer (ISA/IEA).

County Mental Health Plan HCP Codes

HCP	MHP Plan Name	County Code (fyi only)
C01	Alameda	01
C02	Alpine	02
C03	Amador	03
C04	Butte	04
C05	Calaveras	05
C06	Colusa	06
C07	Contra Costa	07
C08	Del Norte	08
C09	El Dorado	09
C10	Fresno	10
C11	Glenn	11
C12	Humboldt	12
C13	Imperial	13
C14	Inyo	14
C15	Kern	15
C16	Kings	16
C17	Lake	17
C18	Lassen	18
C19	Los Angeles	19
C20	Madera	20
C21	Marin	21
C22	Mariposa	22
C23	Mendocino	23
C24	Merced	24
C25	Modoc	25
C26	Mono	26

HCP	MHP Plan Name	County Code (fyi only)
C27	Monterey	27
C28	Napa	28
C29	Nevada	29
C30	Orange	30
C31	Placer	31
C32	Plumas	32
C33	Riverside	33
C34	Sacramento	34
C35	San Benito	35
C36	San Bernardino	36
C37	San Diego	37
C38	San Francisco	38
C39	San Joaquin	39
C40	San Luis Obispo	40
C41	San Mateo	41
C42	Santa Barbara	42
C43	Santa Clara	43
C44	Santa Cruz	44
C45	Shasta	45
C46	Sierra	46
C47	Siskiyou	47
C48	Solano	48
C49	Sonoma	49
C50	Stanislaus	50
C52	Tehama	52
C53	Trinity	53
C54	Tulare	54
C55	Tuolumne	55
C56	Ventura	56
C57	Yolo	57
C63	Yuba / Sutter	51, 58

Drug Medi-Cal Organized Delivery System HCP Codes

HCP	DMC-ODS Plan Name	County Code (fyi only)
D01	Alameda	01
D07	Contra Costa	07
D09	El Dorado	09
D10	Fresno	10
D13	Imperial	13
D15	Kern	15
D19	Los Angeles	19
D21	Marin	21
D22	Mariposa	22
D24	Merced	24
D27	Monterey	27
D28	Napa	28
D29	Nevada	29
D30	Orange	30
D31	Placer	31
D33	Riverside	33
D34	Sacramento	34
D35	San Benito	35
D36	San Bernardino	36
D37	San Diego	37
D38	San Francisco	38
D39	San Joaquin	39
D40	San Luis Obispo	40
D41	San Mateo	41
D42	Santa Barbara	42
D43	Santa Clara	43
D44	Santa Cruz	44
D50	Stanislaus	50
D54	Tulare	54
D56	Ventura	56
D57	Yolo	57
D60	Partnership Healthcare of California (PHC) 274 file submission includes the following counties in a single file each month: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Solano.	12, 18, 23, 25, 45, 47, 48