**Medi-Cal Universe Record Layout Instructions**

**Revised 6/13/2023**

**Paid, Denied, and Contested Claims**

**Paid Claim:** Any claim paid for non-capitated services within the audit period regardless of the date received, even though one or more line items may have been denied for that claim.

**Denied Claim:** Any claim adjudicated within the audit period in which the total amount paid is zero, regardless of the date received. Examples include but are not limited to duplicate claims, member eligibility and non-authorized services.

**Contested Claim:** Any claim contested for development or in which a determination to pay or deny cannot be made without further information. Examples include claims forwarded for medical review and written requests for additional information sent.

**Table 1:** Requests for Processed Claims, which includes Paid, Partially Paid, Denied and Contested claims.

* Include all requests processed for both contracted and non-contracted providers for paid, denied and contested claims.
* Exclude all requests processed as adjustments to claims and overpayments.
* Note: If a claim has more than one service line item, include all the claim’s service line items in a single row and enter the multiple line items as a single claim.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field**  **Name** | **Field**  **Type** | **Field**  **Length** | **Description** |
| A | Claim # | CHAR Always Required | 40 | The associated claim number assigned by the organization for this request. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| B | Member ID # | CHAR Always Required | 20 | Member identifier assigned by the organization. |
| C | Member Last Name | CHAR Always Required | 50 | Last name of member. |
| D | Member First Name | CHAR Always Required | 50 | First name of member. |
| E | Date of Service | CHAR Always Required | 10 | Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| F | Provider Name | CHAR Always Required | 50 | Name of the provider of service. |
| G | Provider NPI | CHAR Always Required | 10 | The provider of service’s National Provider Identifier (NPI). |
| H | Billing Entity | CHAR Always Required | 100 | Provide the name of the “Pay-To” Billing Provider or Billing Entity. |
| I | Provider Contract Status | CHAR Always Required | 2 | Indicate whether the provider who performed the service is a contracted or non-contracted provider. Valid values:  C for Contracted Provider  NC for Non-Contracted Provider. |
| J | Type of Claim Submission | CHAR Always Required | 1 | Indicate if the claim was submitted in a paper or electronic format. Valid values:  P for Paper Claim  E for Electronic Claim. |
| K | Diagnosis Code(s) | CHAR Always Required | 100 | Provide the member’s ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnosis codes on the claim. |
| L | Place of Service\* (See Appendix A) | CHAR Always Required | 2 | Provide the place of service billed. Valid values include, but are not limited to:  11 for Office visit  12 for Home Health  21 for Inpatient  22 for Outpatient Hospital  23 for Emergency Room  \* For Family Planning services, valid value is FP. Include **only** FP claims with primary diagnosis codes as noted in Appendix A. |
| M | CPT, HCPCS, or Revenue Code (s) | CHAR Always Required | 2,000 | Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim. |
| N | Date Claim Received | CHAR Always Required | 10 | Provide the date the claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| O | Date Claim Acknowledged | CHAR Always Required | 10 | Date claim was acknowledged to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| P | Date Claim  Paid/Denied/Contested | CHAR Always Required | 10 | Date the claim was paid, denied or contested. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| Q | Claim Disposition | CHAR Always Required | 35 | Provide the status of the claim. Valid values:  Paid  Partially Paid  Denied  Contested  If a claim has multiple lines that are Denied and Contested, valid value:  Denied/Contested. |
| R | If Fully Contested or Denied,  Reason for Contesting or Denial | CHAR Always Required | 100 | Reason claim was contested or denied. If paid or partially paid, answer NA. |
| S | Interest Due | CHAR Always Required | 1 | Indicate whether interest was due on the claim. Valid values:  Y for Yes  N for No. |
| T | Date Interest Paid | CHAR Always Required | 10 | Date interest was paid. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA. |
| U | Net Amount Paid  (excluding interest) | CHAR Always Required | 11 | Net amount paid on the claim (excluding interest). Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). If payment was not made, answer NA. |
| V | Interest Amount Paid | CHAR Always Required | 11 | Amount of interest paid. Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). If interest was not paid, answer NA. |
| W | RA/EOB Date | CHAR Always Required | 10 | Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| X | Check Mail Date | CHAR Always Required | 10 | Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020).  If a payment was not made, answer NA. |
| Y | Check # | CHAR Always Required | 10 | Provide the check number or EFT (Electronic Funds Transfer) record number. |
| Z | Date Check Cleared | CHAR Always Required | 10 | Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If not available, answer NA. |

**Medi-Cal Universe Record Layout Instructions**

**Redirected Claims**

**Redirected Claims:** Any claim that is either entered into the claims system or manually logged into another tracking mechanism because the Member cannot be identified, or the claim is determined to be the financial responsibility of another payer and is denied to the provider of service or forwarded to another payer.

**Table 2:** Requests for all claims received by the organization that have been redirected to another party such as IEHP, returned to the provider, forwarded to another IPA or organization (i.e., a carved-out service) that is responsible for the claim.

* Include all redirected claims processed for both contracted and non-contracted providers where all claim lines are forwarded to another payer or denied to the provider of service.
* Exclude all requests processed for paid, overpayments, and adjusted claims.
* Notes:
  + If Redirected claims are not entered into the claims system, the data requested in Table 2 may not be available. If the data is not available, answer NA in these fields.
  + If a misdirected claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field**  **Name** | **Field**  **Type** | **Field**  **Length** | **Description** |
| A | Claim # | CHAR Always Required | 40 | The associated claim number assigned by the organization for this claim. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| B | Provider Name | CHAR Always Required | 50 | Name of the provider of service. |
| C | Billing Entity | CHAR Always Required | 100 | Provide the name of the “Pay-To” Billing Provider or Billing Entity. |
| D | Member Last Name | CHAR Always Required | 50 | Last name of member. |
| E | Member First Name | CHAR Always Required | 50 | First name of member. |
| F | Date Received | CHAR Always Required | 10 | Date redirected claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| G | Date Redirected | CHAR Always Required | 10 | Provide the date the claim was redirected to appropriate entity for payment or returned to provider, which is the date the claim left the organization by US Mail, fax, or electronic communication. Do not enter the date the claim was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| H | Diagnosis Code(s) | CHAR Always Required | 100 | Provide the member’s ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnoses codes on the claim. |
| I | Place of Service\* (See Appendix A) | CHAR Always Required | 2 | Provide the place of service provided. Valid values include but are not limited to:  11 for Office visit  12 for Home Health  22 for Outpatient Hospital  23 for Emergency Room  \* For Family Planning services, valid value is FP. Include **only** FP claims with primary diagnosis as noted in Appendix A. |
| J | CPT, HCPCS, or Revenue Code (s) | CHAR Always Required | 2,000 | Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim. |
| K | Reason Redirected | CHAR Always Required | 100 | Provide the reason for redirecting the claim. |
| L | Where Redirected | CHAR Always Required | 50 | Provide the name of the responsible party or entity that the claim was redirected to. |

**Medi-Cal Universe Record Layout Instructions**

**Provider Dispute Requests (PDR)**

**Provider Dispute:** Any dispute that has been resolved during the audit period regardless of the date it was received.

**Table 3:** Requests for all Provider Disputes Claims, which includes Paid, Partially Paid, Denied, and Contested claims.

* Include all provider disputes processed for both contracted and non-contracted providers claims, including any adjusted claims as a result of a provider dispute.
* Exclude all requests for processed paid, denied, contested claims, unrelated adjustments, overpayments, and misdirected claims.
* Note: If a claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field**  **Name** | **Field**  **Type** | **Field**  **Length** | **Description** |
| A | Original Claim # | CHAR Always Required | 40 | The original claim number associated with this dispute as assigned by the organization. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| B | Date Original Claim Received | CHAR Always Required | 10 | Provide the date the original claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| C | Dispute # | CHAR Always Required | 40 | The associated dispute claim number assigned by the organization for this request. If a dispute claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| D | Member ID # | CHAR Always Required | 20 | Member identifier used to identify the member. This is assigned by the organization. |
| E | Member Last Name | CHAR Always Required | 50 | Last name of member. |
| F | Member First Name | CHAR Always Required | 50 | First name of member. |
| G | Date of Service | CHAR Always Required | 10 | Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| H | Provider Name | CHAR Always Required | 50 | Name of the provider of service. |
| I | Provider NPI | CHAR Always Required | 10 | The provider of service’s National Provider Identifier (NPI) |
| J | Billing Entity | CHAR Always Required | 100 | Provide the name of the “Pay-To” Billing Provider or Billing Entity. |
| K | Provider Contract Status | CHAR Always Required | 2 | Indicate whether the provider who performed the service is a contracted or non-contracted provider. Valid values:  C for Contracted Provider  NC for Non-Contracted Provider. |
| L | Type of PDR Submission | CHAR Always Required | 1 | Indicate if the Provider Dispute Request was submitted in a paper or electronic format. Valid values:  P for Paper Claim  E for Electronic Claim. |
| M | Diagnosis Code(s) | CHAR Always Required | 100 | Provide the member’s ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnoses codes on the claim. |
| N | Place of Service\* (See Appendix A) | CHAR Always Required | 2 | Provide the place of service provided. Valid values include but are not limited to:  11 for Office visit  12 for Home Health  22 for Outpatient Hospital  23 for Emergency Room  \* For Family Planning services, valid value is FP. Include **only** FP claims with primary diagnosis as noted in Appendix A. |
| O | CPT, HCPCS, or Revenue Code (s) | CHAR Always Required | 2,000 | Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim. |
| P | Date Dispute Received | CHAR Always Required | 10 | Provide the date the dispute was received in your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| Q | Date Dispute Acknowledged | CHAR Always Required | 10 | Date acknowledgement letter was issued to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a separate acknowledgment letter was not sent to the provider, enter NA. |
| R | Additional Information  Requested | CHAR Always Required | 1 | Indicate whether additional information was requested for this dispute. Valid values:  Y for Yes  N for No. |
| S | Date Additional Information Received | CHAR Always Required | 10 | Provide the date the additional information was received. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If additional information was not requested or the additional information was not received, answer NA. |
| T | Dispute Upheld Reason | CHAR Always Required | 100 | If the dispute was upheld, provide the reason. If overturned, answer NA. |
| U | Dispute Disposition | CHAR Always Required | 15 | Indicate whether the dispute was overturned or upheld. Valid values:  - Overturned  - Upheld. |
| V | Date Dispute Resolved | CHAR Always Required | 10 | Date resolution letter was issued to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| W | Interest Due | CHAR Always Required | 1 | Indicate whether interest was due on the claim. Valid values:  Y for Yes  N for No. |
| X | Date Interest Paid | CHAR Always Required | 10 | Provide the date interest was paid. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA. |
| Y | Net Amount Paid  (excluding interest) | CHAR Always Required | 11 | Enter net amount paid. Submit in the following format: $xxx,xxx.xx. If payment was not made, answer NA. |
| Z | Interest Amount Paid | CHAR Always Required | 11 | Amount of interest paid. Submit in the following format: $xxx,xxx.xx. If interest was not paid, answer NA. |
| AA | RA / EOB Date | CHAR Always Required | 10 | Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If no RA/EOB was mailed, answer NA. |
| AB | Check Mail Date | CHAR Always Required | 10 | Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not made, answer NA. |
| AC | Check # | CHAR Always Required | 10 | Provide the check number or EFT (Electronic Funds Transfer) record number. |
| AD | Date Check Cleared | CHAR Always Required | 10 | Provide the date the check cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If not available, answer NA. |

**Medi-Cal Universe Record Layout Instructions**

**Claim Adjustments**

**Adjusted Claims:** Any claim that has been re-adjudicated and payment was issued within the audit period regardless of the original date received or original adjudication date.

**Table 4:** Requests for all adjusted claims if payment was issued as a result of the adjustment.

* Include:
  + All adjustments processed for both contracted and non-contracted provider claims.
* Exclude:
  + Adjustments where no additional payment was not due.
  + Adjustments due to a provider dispute.
  + Adjustments due to an overpayment.
* Notes:
  + If an adjusted claim has more than one service line item, include all of the claim’s service line items in a single row and enter the multiple line items as a single claim.
  + Column ID: A through T relates to the adjusted claim.
  + Column ID: U through AD relates to the original claim.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field**  **Name** | **Field**  **Type** | **Field**  **Length** | **Description** |
| A | Adjusted Claim # | CHAR Always Required | 40 | The associated adjusted claim number assigned by the organization for this request. If an adjusted claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| B | Member ID # | CHAR Always Required | 20 | Member identifier used to identify the member. This is assigned by the organization. |
| C | Member Last Name | CHAR Always Required | 50 | Last name of member. |
| D | Member First Name | CHAR Always Required | 50 | First name of member. |
| E | Date of Service | CHAR Always Required | 10 | Date service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2018). |
| F | Provider Name | CHAR Always Required | 50 | Name of the provider of service. |
| G | Provider NPI | CHAR Always Required | 10 | The provider of service’s National Provider Identifier (NPI). |
| H | Billing Entity | CHAR Always Required | 100 | Provide the name of the “Pay-To” Billing Provider or Billing Entity. |
| I | Provider Contract Status | CHAR Always Required | 2 | Indicate whether the provider who performed the service is a contracted or non-contracted provider. Valid values:  C for Contracted Provider  NC for Non-Contracted Provider. |
| J | Diagnosis Code(s) | CHAR Always Required | 100 | Provide the member’s ICD-10 diagnosis/diagnoses codes related to this request. Include all diagnoses codes on the claim. |
| K | Place of Service\* (See Appendix A) | CHAR Always Required | 2 | Provide the place of service provided. Valid values include but are not limited to:  11 for Office visit  12 for Home Health  22 for Outpatient Hospital  23 for Emergency Room  \* For Family Planning services, valid value is FP. Include **only** FP claims with primary diagnosis as noted in Appendix A. |
| L | CPT, HCPCS, or Revenue Code (s) | CHAR Always Required | 2,000 | Provide the applicable CPT, HCPCS, or Revenue Procedure Code(s) as the service description. Include all procedure codes on the claim. |
| M | Date Additional Information was Received to Trigger the Adjustment | CHAR Always Required | 10 | Provide the date additional information was received by your organization to trigger the adjustment (e.g., the date of the telephone call, the date of the internal audit, etc.). Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| N | Interest Due on Adjusted Claim | CHAR Always Required | 1 | Indicate whether interest was due on the adjusted claim: Valid values:  Y for Yes  N for No. |
| O | Date Interest Paid on Adjusted Claim | CHAR Always Required | 10 | Provide the date interest was paid on the adjustment. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA. |
| P | Net Amount Paid on Adjusted Claim  (excluding interest) | CHAR Always Required | 11 | Net amount paid on the adjustment (excluding interest). Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). |
| Q | Interest Amount Paid on Adjusted Claim | CHAR Always Required | 11 | Amount of interest paid on the adjustment. Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). If interest was not paid on the adjustment, answer NA. |
| R | Adjusted RA/EOB Date | CHAR Always Required | 10 | Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| S | Check Mail Date for Adjusted Claim | CHAR Always Required | 10 | Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| T | Check # | CHAR Always Required | 10 | Provide the check number or EFT (Electronic Funds Transfer) record number. |
| U | Date Check Cleared | CHAR Always Required | 10 | Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not issued for the adjustment, answer NA. |
| V | Original Claim # | CHAR Always Required | 40 | The original claim number associated with this claim assigned by your organization. If an original claim number is not available, please provide your internal tracking or case number. Answer NA if there is no original claim or other tracking number available. |
| W | Date Original Claim Received | CHAR Always Required | 10 | Provide the date the original claim was received by your organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020) |
| X | Disposition of Original Claim | CHAR Always Required | 35 | Provide the status of the original claim. Valid values:  Paid  Partially Paid  Denied  Contested  If original claim has multiple lines that are denied and contested, valid value:  Denied/Contested. |
| Y | If fully Contested or Denied,  Reason for Contesting or Denial | CHAR Always Required | 100 | Reason the adjusted claim was contested or denied. If Paid or Partially Paid, answer NA. |
| Z | Interest Due on Original Claim | CHAR Always Required | 1 | Indicate whether interest was due on the original claim. Valid values:  Y for Yes  N for No. |
| AA | Date Interest Paid on Original Claim | CHAR Always Required | 10 | Provide the date interest was paid on the original claim. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If interest was not paid, answer NA. |
| AB | Net Amount Paid on Original Claim  (excluding interest) | CHAR Always Required | 11 | Net amount paid on the original claim (excluding interest). Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). If a payment was not made, answer NA. |
| AC | Interest Amount Paid on Original Claim | CHAR Always Required | 11 | Amount of interest paid on the original claim. Submit in the following format: $xxx,xxx.xx (e.g., $123,456.78). If interest was not paid, answer NA. |
| AD | RA/EOB Date  for Original Claim | CHAR Always Required | 10 | Provide the date the Remittance Advice / Explanation of Benefits (RA/EOB) was mailed to the provider of service, which is the date the RA/EOB left the organization by US Mail, fax, or electronic communication. Do not enter the date the RA/EOB was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| AE | Check Mail Date for Original Claim | CHAR Always Required | 10 | Provide the date the check was mailed to the provider of service, which is the date the check left the organization by US Mail, fax, or electronic communication. Do not enter the date the check was generated or printed within the organization. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a payment was not made, answer NA. |
| AF | Date Check Cleared for Original Claim | CHAR Always Required | 10 | Provide the date the check was cleared/cashed, if available. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If a check was not issued, answer NA. |

**Medi-Cal Universe Record Layout Instructions**

**Overpayments**

**Overpayment Request:** A request for an overpayment from the IPA that was subsequently refunded by the provider, retracted by the IPA, disputed by the provider, or closed due to an administrative decision not to pursue the monies owed.

**Table 5:** Requests for all overpayments made to a provider.

* Include all overpayment requests that were made in writing by the IPA for both contracted and non-contracted provider claims during the audit period.

Exclude all overpayment refunds that were voluntarily returned by a provider.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Column**  **ID** | **Field**  **Name** | **Field**  **Type** | **Field**  **Length** | **Description** |
| A | Claim # | CHAR Always Required | 40 | The associated claim number assigned by the organization for this overpayment. If a claim number is not available, please provide your internal tracking or case number. Answer NA if there is no claim or other tracking number available. |
| B | Member Last Name | CHAR Always Required | 50 | Last name of member. |
| C | Member First Name | CHAR Always Required | 50 | First name of member. |
| D | Member ID # | CHAR Always Required | 20 | Member identifier used to identify the member. This is assigned by the organization. |
| E | Provider Name | CHAR Always Required | 50 | Name of the provider of service. |
| F | Provider NPI | CHAR Always Required | 10 | The provider of service’s National Provider Identifier (NPI). |
| G | Billing Entity | CHAR Always Required | 100 | Provide the name of the “Pay-To” Billing Provider or Billing Entity. |
| H | Provider Contract Status | CHAR Always Required | 2 | Indicate whether the provider who performed the service is a contract or non-contract provider. Valid values are:  C for Contracted Provider  NC for Non-Contracted Provider. |
| I | Date of Service | CHAR Always Required | 10 | Provide the date the service was performed. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| J | Date Originally Paid | CHAR Always Required | 10 | Date overpayment was originally paid. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| K | Date Overpayment  Requested | CHAR Always Required | 10 | Date recovery request/letter was sent to the provider. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). |
| L | Overpayment Reason | CHAR Always Required | 100 | Reason the claim was overpaid or paid in error. |
| M | Overpayment Amount  Recovered | CHAR Always Required | 11 | Amount of overpayment recovered. Submit in the following format: $xxx,xxx.xx. If an overpayment recovery was not received, answer NA. |
| N | Method of Overpayment Recovery | CHAR Always Required | 7 | Provide the method in which the overpayment recovery was made or otherwise resolved. Valid values:  Refund - Refunded by provider  Retract - Retracted through the claims system  Dispute – Disputed by the provider  Closed – Closed due to an administrative decision.  If an overpayment recovery was not received, answer NA. |
| O | Date Overpayment  Recovery Received | CHAR Always Required | 10 | Provide the date the overpayment was received by refund or retraction only. Submit in the following format: MM/DD/YYYY (e.g., 01/01/2020). If an overpayment recovery was not received, answer NA. |

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**Reporting Elements Definitions**

**Appendix A – Crosswalk for Type of Service Field for Family Planning**

The following ICD-10 CM diagnosis codes, when billed as a primary diagnosis code, indicate comprehensive family planning services.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Z30.011** | **Z30.017** | **Z30.41** | **Z30.433** | **Z31.430** | **Z97.5** |
| **Z30.012** | **Z30.018** | **Z30.42** | **Z30.44** | **Z31.438** | **Z98.51** |
| **Z30.013** | **Z30.02** | **Z30.430** | **Z30.45** | **Z31.440** | **Z98.52** |
| **Z30.015** | **Z30.09** | **Z30.431** | **Z30.46** | **Z31.441** |  |
| **Z30.016** | **Z30.2** | **Z30.432** | **Z30.49** | **Z31.5** |  |