Getting Started: Where to Find the Answers

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This section addresses questions most commonly asked about the Medi-Cal billing process. Medi-Cal information is found in Part 1 – *Program and Eligibility* and Part 2 – *Billing and Policy*. The "answers" direct you to the appropriate section found in either the Part 1 or Part 2 manual.

Getting Started guides you to information on the following topics:

Billing Overview	Share of Cost
Recipient Eligibility	Medi-Services
Other Health Coverage	Claim Completion
Covered Services	Remittance Advice Details
Authorization	Claims Follow-up

Sections identified with a slash (/) may contain different information than that listed above based on the policy, claim form type and billing codes. Therefore, locator keys are not listed.

Where Can I Find an Overview of the Billing Process?

Billing Process Table

Manual Section	Topic	Locator Key
See Part 1	*Claim Payment Flowchart*	claim pay

How Do I Determine if a Recipient Is Eligible for Medi-Cal?

Recipient Eligibility Table

Manual Section	Topic	Locator Key
See Part 1	*AEVS: General Instructions* ‹‹This section informs providers about accessing beneficiary eligibility, clear Share of Cost liability and/or reserve a Medi-Service.››	aev gen
See Part 1	*AEVS: Transactions* ‹‹This section describes how to access the Medi-Cal Automated Eligibility Verification System (AEVS) and complete eligibility verifications. This is designed to be photocopied for use in tracking AEVS transactions.››	aev trn

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Recipient Eligibility Table (continued)

Manual Section	Topic	Locator Key
See Part 1	*Eligibility: Recipient Identification* Recipient eligibility information is divided into four areas: Recipient Identification, Recipient Identification, Service Restrictions and Special Groups.	elig rec
See Part 1	*Eligibility: Recipient Identification Cards* The Department of Health Care Services (DHCS) issues a plastic Benefits Identification Card (BIC) to each Medi-Cal recipient.	elig rec crd
See Part 1	*Eligibility: Service Restrictions* When a provider accesses the Medi-Cal eligibility verification system, a message is returned indicating the type of services covered and any limitations or special instructions.	elig rstrict
See Part 1	*Eligibility: Special Groups* This section's guidelines are used to determine Medi-Cal eligibility for individuals identified as members of special groups.	elig special
See Part 1	*Point of Service (POS)* This section has a network/internet agreement. The agreement is required for all providers and non-providers (provider representatives) who intend to use the Medi-Cal POS Network or Medi-Cal website applications at www.medi-cal.ca.gov.	point

See Part 2 for eligibility information for a special program, such as Subacute Care.

How Do I Determine if a Recipient Is Eligible for Other Benefits Before Medi-Cal?

Other Health Care Eligibility Table

Manual Section	Topic	Locator Key
See Part 1	*MCP: An Overview of Managed Care Plans* ‹‹This section is an overview of several manage care plan models.››	mcp an over
See Part 1	*Medicare/Medi-Cal Crossover Claims Overview Other Health Coverage (OHC)* ‹‹This section contains eligibility information and general guidelines about Medicare/Medi-Cal crossover claims.››	medicare
See Part 1	*Guidelines for Billing* ‹‹This section is an overview and billing guideline for all OHC and HMO coverage codes.››	other guide
See Part 2	*Medicare/Medi-Cal Crossover Claims.* ‹‹This section contains billing information, billing tips and Medicare documentation requirements for Medicare/Medi-Cal crossover claims submitted››	medi cr __ * ‹‹medi cr cms *›› ‹‹medi cr cms exm *›› ‹‹medi cr cms prm *›› ‹‹medi cr op *›› ‹‹medi cr op ex *›› ‹‹medi cr op pr *››
See Part 2	*Medicare Non-Covered Services: Charts Introduction* ‹‹This section is an overview of non-covered services with Medicare.››	medi non cha *
See Part 2	*Other Health Coverage (OHC)* ‹‹This section describes the required steps for billing Medi-Cal when a recipient also has Other Health Coverage (OHC) or Medicare.››	oth hlth

How Do I Identify a Covered Service for a Medi-Cal Eligible Recipient?

Covered Services Eligibility Table

Manual Section	Topic	Locator Key
See Part 2	*Medicare Non-Covered Services: Charts Introduction* ‹‹This section is an overview of non-covered services with Medicare.››	medi non cha *
See Part 2	*Other Health Coverage (OHC)* ‹‹This section describes the required steps for billing Medi-Cal when a recipient also has OHC or Medicare.››	oth hlth
See Part 2	*Other Health Coverage (OHC): CPT® and HCPCS Codes* ‹‹Service codes listed in this section may be billed directly to Medi-Cal at the provider's option, even if the recipient has OHC coverage.››	oth hlth cpt *
See Part 2	*TAR and Non-Benefit List: Codes (10000 – 99999)*	tar and non cd__* ‹‹tar and non cd1›› ‹‹tar and non cd2›› ‹‹tar and non cd3›› ‹‹tar and non cd4›› ‹‹tar and non cd5›› ‹‹tar and non cd6›› ‹‹tar and non cd7›› ‹‹tar and non cd8›› ‹‹tar and non cd9››

How Do I Determine if a Service Requires Authorization?

TAR Table

Manual Section	Topic	Locator Key
See FPACT	*TAR Overview* ‹‹This section includes authorization requirements for the Family PACT (Planning, Access, Care and Treatment) Program. Family PACT providers request authorization using a *Treatment Authorization Request* (TAR) form.››	tar
See Part 2	*TAR Completion* ‹‹Physicians, podiatrists, pharmacies, medical supply dealers, outpatient clinics and laboratories use the TAR, 50-1 to request approval from a Medi-Cal consultant for certain procedures/services.››	tar comp *
See Part 2	*TAR Deferral/Denial Policy (Frank v. Kizer)* ‹‹The purpose of this section is to inform providers of the Memorandum of Understanding (MOU) between the Department of Health Care Services (DHCS) and the Legal Aid Society of Alameda County regarding the implementation of the Frank v. Kizer court order.››	tar defer
See Part 2	*TAR Field Office Addresses* ‹‹This section includes the fee-for-service Medi-Cal field office addresses.››	tar field
See Part 2	*TAR and Non-Benefit List: Codes (10000 – 99999)*	tar and non cd__* ‹‹tar and non cd1›› ‹‹tar and non cd2›› ‹‹tar and non cd3›› ‹‹tar and non cd4›› ‹‹tar and non cd5›› ‹‹tar and non cd6›› ‹‹tar and non cd7›› ‹‹tar and non cd8›› ‹‹tar and non cd9››

TAR Table (continued)

Manual Section	Topic	Locator Key
See Part 2	*TAR Submission: Transmittal Form* ‹‹This section informs providers about Transmittal Form items.››	tar submis
See Part 2	*TAR: Submitting Appeals* ‹‹This section includes submission instructions to appeal TAR decisions.››	tar submit

How Do I Clear Share of Cost?

Share of Cost Table

Manual Section	Topic	Locator Key
See Part 1	*Share of Cost (SOC)* ‹‹This section is an overview of the Share of Cost process. Some Medi-Cal subscribers (recipients) must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits.››	share
See Part 2	*Share of Cost (SOC)* ‹‹This section explains how to complete claims for services rendered to recipients who paid a Share of Cost››	‹‹share cms *›› ‹‹share op *››

How Do I Reserve a Medi-Service and Render Services?

Medi-Service Table

Manual Section	Topic	Locator Key
See Part 2	*Acupuncture, audiology, chiropractic, occupational therapy, podiatry, psychology or speech pathology services information*	‹‹acu›› ‹‹audio›› ‹‹chiro›› ‹‹occu›› ‹‹podi›› ‹‹psychol›› ‹‹speech››

How Do I Bill Medi-Cal for Services Rendered?

Claim Completion Table

Manual Section	Topic	Locator Key
See Part 1	*Claim Submission and Timeliness Overview* ‹‹This section includes information about claim forms that providers use to bill services rendered to recipients of the programs listed in this manual. In addition, this section includes basic claim form preparation instructions, claim submission deadline information and a brief description of claims processing procedures.››	claim sub
See Part 1	*Medicare/Medi-Cal Crossover Claims Overview* ‹‹This section contains eligibility information and general guidelines about Medicare/Medi-Cal crossover claims.››	medicare
See Part 2	Code Lists	/ ‹‹Note: Providers should utilize the Search on the website for a specific type of code list.››
See Part 2	Claim Form Completion	‹‹cms comp *›› ‹‹ub comp op *››
‹‹See Part 2››	Special Billing Instructions	‹‹ub spec op *›› ‹‹cms spec *››
See Part 2	Attachments “From-Through” Billing Line-Item Billing Submitting Claims for TAR-Authorized Services	/
See Part 2	Submission and Timeliness	‹‹ub sub *›› ‹‹cms sub *››
See Part 2	Billing Limit Exception Codes Claims Over One Year Old	/

Claim Completion Table (continued)

Manual Section	Topic	Locator Key
See Part 2	Tips for Billing	‹‹cms tips *›› ‹‹ub tips ob *››
See Part 2	*Forms: Legibility and Completion Standards* ‹‹This section explains the basic standards required for processing of the following paper billing forms: claims, TARs, Claims Inquiry Forms (CIFs) and Appeal Forms (90-1).››	forms leg
See Part 2	*Forms Reorder Request: Guidelines* ‹‹This section explains how to order forms and envelopes used to bill and seek authorization for Medi-Cal services.››	forms reo
See Part 1	*Medicare/Medi-Cal Crossover Claims*	‹‹medicare *››
See Part 2	*Modifiers* ‹‹This section provides information about commonly used modifiers.››	modif *
See Part 2	*Modifiers: Approved List* ‹‹This section provides a list of approved modifier codes for use in billing Medi-Cal.››	modif app *
See Part 2	*Modifiers Used with Procedure Codes* ‹‹This section list procedure codes with their corresponding required or allowable modifiers.››	modif used *
See Part 2	*Other Health Coverage (OHC)* ‹‹This chart lists service codes may be billed directly to Medi-Cal at the provider's option, even if the recipient has OHC coverage.››	oth hlth

How Do I Review *Remittance Advice Details* (RAD) And Check Claim Status?

RAD Table

Manual Section	Topic	Locator Key
See Part 1	*Remittance Advice Details (RAD) and Medi-Cal Financial Summary* This section is an overview of RAD and Medi-Cal Financial Summary.	remit
See Part 1	*RAD and Reconciling Medi-Cal Payment* This section is an overview of reconcile claims and Medi-Cal payment. It is important that each claim being reported, or not reported, be accounted for and the necessary follow-up performed and that all the rules governing timeliness be followed.	remit and
See Part 1	*RAD Codes and Messages: 001 – 9999*	RAD_Repository
See Part 2	*RAD* This section is an overview of RAD. RAD is designed for line-by-line reconciliation of transactions.	remit adv
See Part 2	*RAD Examples*	remit ex __ ‹‹remit ex amp›› remit ex op
See Part 2	*RAD: Payments and Claim Status* This section contains information to assist providers in reconciling payment problems.	remit pay

How Do I Follow-Up on Denied or Inappropriately Paid Claims?

How to Follow-Up Table

Manual Section	Topic	Locator Key
See Part 1	*Appeal Process Overview* ‹‹This section contains information to assist providers in the appeal process.››	appeal
See Part 1	*CIF Overview* ‹‹This section is an overview of Claims Inquiry Form. The information is used to help educate providers of the timeframe of each claim.››	cif
See Part 2	*Appeal Form Completion* ‹‹This section describes the instructions for completing an *Appeal Form* (90-1).››	appeal form
See Part 2	*CIF Completion* ‹‹This section contains information to assist providers with completing CIF.››	cif co
See Part 2	*CIF Special Billing Instructions* ‹‹This section explains the unique completion instructions required for *Claims Inquiry Forms* (CIFs) submitted for SOC reimbursement and Medicare/Medi-Cal crossover claims for medical, allied health and pharmacy services.››	‹‹cif_sp››
See Part 2	*CIF Submission and Timeliness Instructions* ‹‹This section explains guidelines and time frames for submitting a CIF.››	cif sub
See Part 2	*Medicare/Medi-Cal Crossover Claims*	‹‹medi cr cms *›› ‹‹medi cr cms exm *›› ‹‹medi cr cms prm *›› ‹‹medi cr op *›› ‹‹medi cr op ex *›› ‹‹medi cr op pr *››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	This section contains provider-specific information and may not appear in all manuals. Refer to the appropriate Part 2 manual.
/	Sections identified with a slash (/) may contain different information than listed above based on the policy, claim form type and billing codes. Therefore, locator keys are not listed.