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# Electronic Methods for Eligibility Transactions and Claim Submissions

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Medi-Cal offers a variety of electronic methods that allow providers to establish and verify recipient eligibility, perform batch eligibility transactions, clear Share of Cost (SOC), reserve Medi-Services and submit claims. The following electronic methods require that the provider have a telephone or personal computer. Refer to the specific manual sections or Medi-Cal website user guides for the detailed requirements of each electronic method.

## Telephone

The following methods require a touch-tone telephone.

### **Automated Eligibility Verification System**

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers to access recipient eligibility, clear Share of Cost liability and/or reserve a Medi-Service. Refer to the *AEVS: General Instructions* section in this manual for additional information.

### **Provider Telecommunications Network**

The Provider Telecommunications Network (PTN) is an automated voice-response system used as a primary source of checkwrite, claim and authorization information for services rendered through the Medi-Cal program, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP). Refer to the *Provider Telecommunications Network (PTN)* section in this manual for additional information.

**Note:** The system provides checkwrite-only information for therapeutic abortion-related services.

## **Personal Computer/Internet**

The following methods require a personal computer, modem and/or Internet access.

### **Computer Media Claims**

The Computer Media Claims (CMC) system permits the submission of Medi-Cal claims via modem (telecommunications) or on the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). Refer to the *CMC* section in this manual for additional information.

Some claims require electronic attachments. Electronic attachments can be sent to Medi-Cal by an approved third-party vendor who will preprocess the attachments and submit them on behalf of the provider. For electronic attachment submissions, the (Attachment Control Number) ACN will be supplied to the provider by the vendor and must be entered in the ASC X12N 837 v.5010 *Paperwork (PWK) Segments*. Contact information for electronic attachment vendors can be found on the Medi-Cal Web site in the *CMC Developers, Vendors and Billing Services Directory*.

## Electronic Claims Resubmissions/Voids: 837I and 837P

The 837 electronic transactions claim format allows a provider to initiate changes to already-adjudicated claims. Providers can electronically resolve a claim denial or incorrect payment for inpatient, outpatient, general medicine, obstetric, allied health, long term care or vision care claims originally submitted via 837I or 837P electronic claims or as *CMS-1500* or *UB-04* paper claims.

The claim is resubmitted through Transactions Services on the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) with either frequency type code "7" (replacement of prior claim) or "8" (void/cancel of prior claim). The timeline for resubmitted claims is within six months of the claim payment or denial date of the *Remittance Advice Details* (RAD) on which the claim appeared.

To resubmit claims, providers must follow standards outlined in the X12 Technical Review Type 3 (TR3) 837 implementation guide and in particular instructions for National Uniform Billing Data Element Specifications Loop 2300 CLM05-3. TR3 documents are available for purchase from the Washington Publishing Company website at [www.wpc-edi.com](http://www.wpc-edi.com).

Replacement and void claims can be sent in the same batch as new claims.

**Table Outlining Use and Claim-Filing Guidelines for  
Claim Frequency Codes '7' and '8'**

<b>Claim Frequency Code/Definition</b>	<b>Use</b>	<b>Filing Guidelines</b>	<b>Result</b>
7 (Replacement of claim)	Use to replace a claim line or entire claim in an already adjudicated paid or denied claim (see following instructions per claim type)	File the claim line or entire electronic claim including all services for which reconsideration is requested	«Medi-Cal will adjust the original claim. The corrections submitted will be reflected on the 835 Transaction»
8 (Void/Cancel of prior claim)	Use to eliminate an already adjudicated claim for a specific provider, recipient and date of service (see following instructions per claim type)	File the claim electronically and include all claims data and charges that were on the original claim	«Medi-Cal will void the original claim from history based on request, which will be reflected on the 835 Transaction»

«Claims resubmitted with Frequency Type code “7”

Electronic allied health, long term care, medical services, obstetric, outpatient and vision care claims submitted with frequency type code “7” (replacement claim):

- Are used to modify only one claim. They cannot be used to replace multiple original claims.
- Must contain corrected information for the original claim.
- Must include the 13-digit Claim Control Number (CCN) from the original paid claim. For the claim to be considered for full reimbursement, the RAD date for the previous claim payment or denial must be within six months of the date the replacement was submitted.

Electronic inpatient claims resubmitted with frequency type code “7” (replacement claim):

- Replace the entire inpatient claim.

Claims resubmitted with Frequency Type code “8”

Electronic long term care, medical services, outpatient and vision care claims resubmitted with Frequency Type code “8” (void/cancel of prior claim):

- Must include the 13-digit CCN from the original paid claim.
- Serve as a full void for one claim line only. Multiple original claim lines cannot be voided with one void claim transaction.

Electronic inpatient claims resubmitted with frequency type code “8” (void/cancel of prior claim):

- Void the entire inpatient claim.>>

### «Correct Claim Control Number for Crossover Claims

Providers resubmitting a Medicare to Medi-Cal crossover claim should take care to enter the CCN from the Medi-Cal claim they are resubmitting and not the CCN from the Medicare claim.

### Claim Attachments

Attachments required with the initial claim submission are required for replacement claim submissions. Copies of claims initially submitted on paper are not needed. Information from the paper claim will already have been keyed into the claims processing system.

No attachments are required when voiding a claim. No proof of timeliness is required.

Information about submitting attachments for electronic claims are available in the *Billing Instructions: Acceptable Claims, Attachments and ASC X12N 835 v.5010 Transactions* section of the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*.

### Reimbursement

If the initial adjudicated claim was subject to a reimbursement reduction due to late claim submission, then reimbursement for the resubmitted claim also will be reduced.»

## Internet Professional Claim Submission System

The Internet Professional Claim Submission (IPCS) system allows providers to submit single professional medical claims. IPCS does not perform online adjudication. For additional information, refer to the *Internet Professional Claim Submission (IPCS) User Guide*, which is available on the Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

**Note:** Only professional medical claims may be submitted at this time. Institutional or vision claims may not be submitted using IPCS.

## Medi-Cal Website

The Medi-Cal website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) allows providers to verify recipient eligibility, clear Share of Cost and reserve Medi-Services.

**Note:** The Family PACT Web page, located on the Medi-Cal website, allows providers to perform client activation, inquiry, update, recertification and deactivation transactions. Information about the Family PACT Web page is available on the Web or in the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual. For information about the PPBI manual, contact the Telephone Service Center (TSC) at 1-800-541-5555.

Providers who submit automated eligibility transactions on the Medi-Cal website need to limit the size of their data stream to 255 bytes or characters. The data stream is submitted through cookies set via their Internet browser. These providers should check their software manual for information about configuring their systems around this limitation.

## **Legend**

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

<b>Symbol</b>	<b>Description</b>
«	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.