
Electronic Methods for Eligibility Transactions and Claim Submissions

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«Medi-Cal offers a variety of electronic methods that allow providers to 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.

«Electronic Data Interchange (EDI) Transaction Sets

The following types of Electronic Data Interchange (EDI) transaction sets are available in the Medi-Cal Provider Portal:

ASC X12N 837 v.5010

ASC X12N 837 v.5010 claims can be submitted electronically in the Medi-Cal Provider Portal. For more information, refer to the *Electronic Data Interchange (EDI) 837 Claims Overview* section of the *Medi-Cal Program and Eligibility* manual.

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 the attachments 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*.

ASC X12N 270/271

The ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response transaction is used to verify patient eligibility information of Medi-Cal recipients.

The successful completion of this test transaction is mandatory. Once completed, the Real-Time Internet Eligibility (RTIE) application will be available to submit production Eligibility Benefit Inquiry 270 transactions.

For more information, refer to the *Real-Time Internet Eligibility Inquiry and Response Testing User Guide* or the *Batch Eligibility Benefit Inquiry and Response Testing User Guide*.»

«ASC X12N 276/277

Providers can access the Medi-Cal Provider Portal to conduct ASC X12N 276/277 transactions. Providers can send a Health Care Claim Status Request (276) electronically and receive a Health Care Claim Status Response (277) back.

ASC X12N 835

ASC X12N 835 is also known as an Electronic Remittance Advice file. An 835 provides information about the healthcare services that are being paid for, denied, reduced, or adjusted.

Medi-Cal fee-for-service providers registered in the Provider Portal can designate up to two entities to receive an 835 transaction and manage these receivers through the affiliation process. The two receivers can be either the provider or an outside party (such as a billing service, clearinghouse or another provider). For more information about 835 transactions, refer to the *CA-MMIS 835 Companion Guide* on the Medi-Cal Providers website.»

Electronic Claims Resubmissions/Voids: 837I and 837P

«The 837 electronic claims 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.

The claim is resubmitted through the Medi-Cal Provider Portal 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.

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’

Claim Frequency Code/Definition	Use	Filing Guidelines	Result
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 *CA-MMIS 837 Claim 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 Providers website.»

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

«Single Subscriber Eligibility

The Single Subscriber Eligibility application in the Medi-Cal Provider Portal allows providers to find subscriber information and view eligibility responses.

Once a response appears, providers can perform Share of Cost (SOC) inquiry or perform a new eligibility inquiry. For additional information, refer to the *Provider Portal User Guide: Eligibility Transactions*, which is available on the Medi-Cal Providers website.

Multiple Subscriber Eligibility

Providers with multiple subscribers can expedite eligibility inquiries in the Medi-Cal Provider Portal. Eligibility can be checked for up to 99 subscribers by uploading the template provided. Responses can then be downloaded or viewed in the Responses page. For additional information, refer to the *Provider Portal User Guide: Eligibility Transactions*, which is available on the Medi-Cal Providers website.

Share of Cost

Some Medi-Cal recipients may be required to pay a portion of their medical expenses before Medi-Cal will reimburse providers for services. Providers can conduct Spend Down or Spend Down Reversals within the Provider Portal and view responses. For additional information, refer to the *Provider Portal User Guide: Eligibility Transactions*, which is available on the Medi-Cal Providers website.»

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.

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.