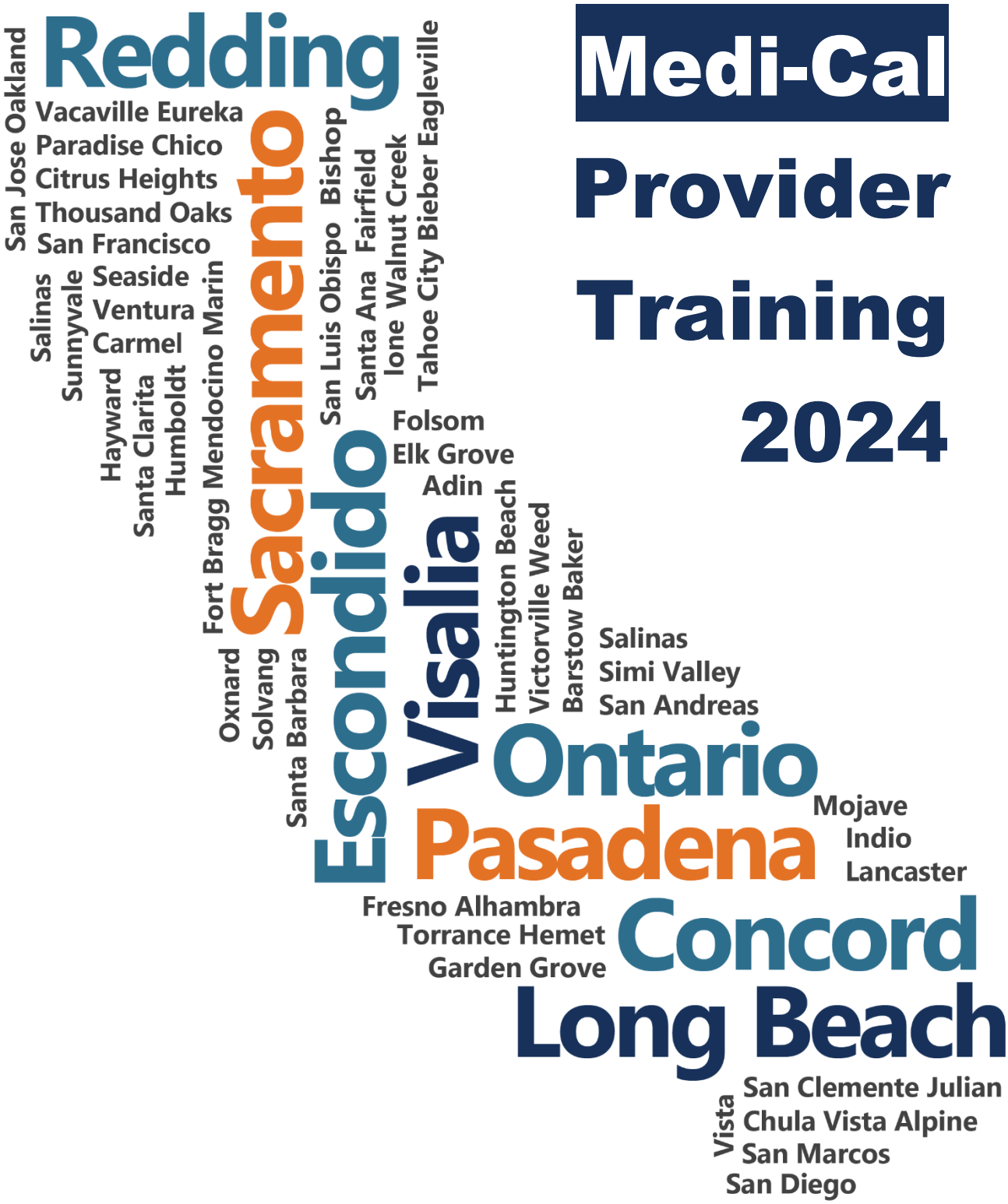

Medi-Cal Provider Training 2024

Medi-Cal Provider Resources 101

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

Table of Contents

Medi-Cal Provider Resources 101

Introduction

Purpose

The purpose of this class is to provide an in-depth look at information available to providers in the Medi-Cal program.

Prior to attending this class, all participants should have completed the following classes:

- Recipient Eligibility
- *Treatment Authorization Request* (TAR)
- *CMS-1500* and/or *UB-04* Claim Completion
- Share of Cost
- Claims Follow Up

Module Objectives

- Review Provider Manual Resources
- Identify Provider Responsibilities
- Discuss Eligibility Guidelines
- Review Medi-Cal Rates
- Identify Reconciliation Process
- Introduce Provider Member Services Organization (PMSO)
- Discuss Claim Resolution Process
- Provide Resource Information

Building Blocks of Medi-Cal

As an active provider in the Medi-Cal program, there are key areas that providers should always be aware of:

- Medi-Cal Policy & Procedures
- Recipient Eligibility
- *Treatment Authorization Request* (TAR), eTAR & Service Authorization Request (SAR)
- Billing Requirements
- Financial Reconciliation
- Claims Follow-Up
- Provider Relations

Provider Manuals

Medi-Cal provider manuals are a provider's primary resource for information pertaining to Medi-Cal and Specialty Programs. Provider manuals are designed to provide policy and billing information.

The Department of Health Care Services (DHCS) and the California MMIS Fiscal Intermediary (CA-MMIS FI) have developed custom manuals for your billing practice.

Part 1 Manual: Part 1 *Medi-Cal Program and Eligibility* is a general reference that applies to all Medi-Cal providers. This manual offers an orientation to Medi-Cal services, programs, claim reimbursement and complete information about recipient eligibility and provider participation.

Overview sections in Part 1 generally have correlating Part 2 provider manual sections with more detailed information.

Part 2 Manual: Part 2 *Medi-Cal Billing and Policy* is a custom provider manual for day-to day use. This manual contains specific program policies, code lists, claim form and follow-up instructions.

In addition, there is a specialty program manual for Family PACT (Planning, Access, Care and Treatment) Policies Procedures and Billing Instructions (PPBI) that works in combination with the Medi-Cal Part 1 and Part 2 manuals for the purposes of outlining health care program policies and billing the specialty program.

Provider manual sections are organized alphabetically by locator keys.

The locator keys are an abbreviated form of the section title located at the top of each manual page to help identify information quickly.

Provider Manual Page Elements

Section Title

The manual section title is located on the top left-hand side of page on page 1 of the document.

Page Header

The page header includes the locator key and page number on the top right-hand side of the document. In the Figure 1 example on the next page, the title of the manual section is Provider Guidelines, and the locator key is prov guide. The page number is placed below the locator key.

Sections

Manual sections include multiple topics. In Figure 1, Provider Enrollment is the first main topic which has two sub-topics: How to Enroll and DHCS Provider Enrollment Division.

Footer

The footer is located at the bottom left of the page and reads “Part 1 – Provider Guidelines.” This includes the manual part number and section title.

Provider Guidelines

Page updated: December 2021

This section contains information to guide medical practitioners who wish to participate as Medi-Cal providers.

Provider Enrollment

How to Enroll

Practitioners rendering services to Medi-Cal recipients must be approved as Medi-Cal providers by the Department of Health Care Services (DHCS) in order to bill Medi-Cal for services rendered. ‹‹In order to enroll in Medi-Cal, providers must submit an e-Form application using the Provider Application and Validation for Enrollment (PAVE) Provider Portal which is an improved web-based alternative to the former paper application enrollment process.››

‹‹For assistance with the application process, practitioners may contact the Provider Enrollment Division (PED):

Visit the PED web page and select the Inquiry Form link under "Provider Resources" for the PED Online Inquiry Form››

DHCS Provider Enrollment Division

‹‹DHCS PED assists providers as follows:››

- Accepts and verifies all applications for enrollment
- ‹‹Enrolls each provider using their 10-digit National Provider Identifier (NPI)››
- Maintains a Provider Master File of provider names and addresses
- Updates the enrollment status of providers for Medi-Cal records

Figure 1: Sample Provider Manual Page

Getting Started: Where to Find Answers

The *Getting Started* section of the provider manual guides you to information on the following topics:

Table of *Getting Started* Section Topics

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

Provider Responsibility

Provider Regulations

The Medi-Cal provider manual provides regulations and guidelines for providers who participate in the Medi-Cal program. These regulations and guidelines are found in the *California Welfare and Institutions Code* (W&I) and *California Code of Regulations* (CCR). For more information, refer to the *Provider Regulations* section (prov reg) located in the Part 1 provider manual.

Requirements for providers approved for participation in the Medi-Cal program include:

1. Compliance with the Social Security Act (United States Code, Title 42, Chapter 7: the Code of Federal Regulations, Title 442; the *California Welfare and Institutions Code* (W&I Code) Chapter 7 (commencing with Section 14000) and, in some cases, Chapter 8; and the regulations contained in the *California Code of Regulations* (CCR), Title 22, Division 3 (commencing with Section 50000), as periodically amended.
2. Agreement to keep necessary records.
3. Non-discrimination against any recipient based on race, color, national or ethnic origin, sex, age, physical or mental disability.

Confidentiality

W&I Code provides that names, addresses and all their information concerning circumstances of any applicant or recipient of Medi-Cal services for whom or about whom information is obtained shall be considered confidential and shall be safeguarded. Both the release and possession of confidential information in violation of this statute are misdemeanors.

Record-Keeping

Providers should carefully review the regulations regarding the keeping and availability of records in the CCR.

- Providers must keep, maintain and have available records that fully disclose the type and extent of services provided and must be made at or near the time of rendering the services.
- Services rendered by Non-Physician Medical Practitioners (NMPs) must include the signature of the NMP and countersigned by the supervising physician.
- Practitioners who issue prescriptions must maintain, as part of the recipient's chart concerning each prescription and records concerning medical transportation.
- Records of psychiatric and psychological services must include patient logs, appointment books or similar documents showing the date and time allotted for patient appointments, and the time actually spent with each patient.
- Providers must make available all pertinent financial books and records concerning health care services provided to Medi-Cal recipients to any authorized DHCS or California Department of Justice (DOJ) representative.
  - Failure to produce such records may result in sanctions, audit adjustments, or recovery of overpayments in accordance with CCRs.
- Agree to keep necessary records for a minimum period of three years from the date of service.

- The provider also must agree to furnish these records and any information regarding payments claimed for providing the services, on request, to:
  - DHCS
  - Bureau of Medi-Cal Fraud
  - California Department of Justice
  - DHCS Audits and Investigations (A&I)
  - State Controller's Office (SCO)
  - U.S. Department of Health & Human Services; or their duly authorized representatives
  - Additionally, providers must certify that all information included on the printed copy of the original document is true, accurate and complete
- Providers or their agents who electronically submit claims to Medi-Cal via the Point of Service (POS) network or Computer Media Claims (CMC) must retain sufficient data to meet all record-keeping.

Billing Compliance

As a provider it is your responsibility to know what is covered by the Medi-Cal program and to always verify procedure codes and to confirm whether the service requires a TAR.

Emergency or Pregnancy-Related Medical Services: Covered Benefits

For recipients whose coverage is limited to emergency and/or pregnancy-related medical benefits, the following services are covered when ordered by the primary provider:

- Pharmacy
- Radiology
- Laboratory
- Dialysis and dialysis-related services

Emergency Medical Condition

An “emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction to any bodily organ or part

Eligible individuals are entitled to all inpatient and outpatient services that are necessary for the treatment of an emergency medical condition.

Continuation of medically necessary inpatient hospital services and follow up care after the emergency has resolved shall not be authorized or reimbursed for undocumented aliens eligible for restricted benefits only.

When billing for emergency services providers must indicate emergency treatment on the claim and submit a statement that describes the nature of the emergency, including relevant clinical information about the patient’s condition and why the emergency service rendered were considered to be immediately necessary. The statement must be signed by the provider.

Other Health Coverage (OHC)

In most circumstances Other Health Coverage (OHC) must be billed prior to billing Medi-Cal.

This is dependent on the recipients OHC code. For more information refer to Part 1 *Other Health Coverage* (OHC) *Guidelines for Billing* (other guide).

A recipient is required to utilize their OHC prior to Medi-Cal when the same service is available under the recipient's private health coverage. Providers are not allowed to deny Medi-Cal services based upon potential third party liability. If the recipient elects to seek service not covered by Medi-Cal, Medi-Cal is not liable for the cost of those services. To establish Medi-Cal's liability for a covered Medi-Cal service, the provider must obtain an acceptable denial letter from the OHC entity. Refer to *Other Health Coverage* (OHC) *Guidelines for Billing* in the Part 1 provider manual, for more information.

Providers are required by law to exhaust the recipient's OHC before billing Medi-Cal.

When a recipient has both Medicare fee-for-service and OHC, the provider must bill payers in the following order:

1. Medicare for Medicare-covered services
2. OHC carrier
3. Medi-Cal. Attach the *Medicare Explanation of Medicare* benefits (EOMB)/*Medicare Remittance Notice* (MRN) or *Medicare Common Working File* documentation and the OHC Explanation of Benefits (EOB) to the Medi-Cal claim.

Delayed Insurance

In order to keep your claims timely with Medi-Cal, and a response from the OHC carriers is not received within 90 days of the provider's billing date, providers may bill Medi-Cal. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. Include "90-day response delay" statement on the claim form. Claims are subject to deny due to other health coverage (RAD Code 0657).

For more information on OHC refer to:

- *Other Health Coverage* (OHC) *Guidelines for Billing* (other guide)
- *Other Health Coverage* (OHC) (oth hlth)

Managed Care Plans (MCPs)

In order to render services to a Medi-Cal beneficiary that has an MCP, you as the provider, must be enrolled in that plan to render services to that patient. Each MCP receives a monthly fee, or per capita rate, from the state for every enrolled recipient.

Each MCP is unique in its billing and service procedures. Providers must contact the individual plan for billing instructions. Services excluded from the plan's contract require billing through the fee-for-service program, which may require prior authorization. Denial letters from MCPs are not accepted by Medi-Cal for plan-covered services rendered to MCP members.

For more information on MCP refer to:

- *MCP: An Overview of Managed Care Plans* (mcp an over) section of the Part 1 provider manual.

Medi-Cal Dental Program vs Medi-Cal

The fee-for-service dental portion of the Medi-Cal program is known as Medi-Cal Dental. The Medi-Cal Dental program is administrated by Delta Dental. Claims for inpatient and outpatient dental procedures are billed to Medi-Cal Dental.

Some treatments are covered for children, but not for adults. A recipient is considered a child until the last day of the month in which he or she turns 21 years old. Services rendered to a child, however, continue to be covered until treatment is complete if the child continues to be eligible for Medi-Cal and the dental care is a necessary service.

Two toll-free telephone numbers are available for Medi-Cal Dental:

- For providers: 1-800-423-0507
- For recipients:1-800-322-6384

For more information on Medi-Cal Dental refer to:

- *Medi-Cal Dental Program* (denti) section of the Part 2 provider manual
- *Medi-Cal Dental Program for Inpatient and Outpatient Services* (denti io) section of the Part 2 manual.

For providers that are Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) and the patient is located in Los Angeles or Sacramento County and the patient is enrolled in a Medi-Cal Dental Managed Care Plan, the clinic can render services and submit a claim to Medi-Cal.

Medi-Cal Transactions

Medi-Cal online transactions are available to all Medi-Cal providers and allows providers to perform secure transactions. The specific transaction options available are based on the provider/submitter enrollment type. These transactions are available from the Medi-Cal providers website.

Eligibility

When checking eligibility, the Eligibility Response gives you the information needed to determine if a patient is eligible for services through Medi-Cal. The eligibility response provides a detailed message of the coverage and alerts you to any restrictions pertaining to the coverage.

1. To check eligibility, navigate to the Medi-Cal Provider Portal website at**.** Enter the user's email address and select **Next.**

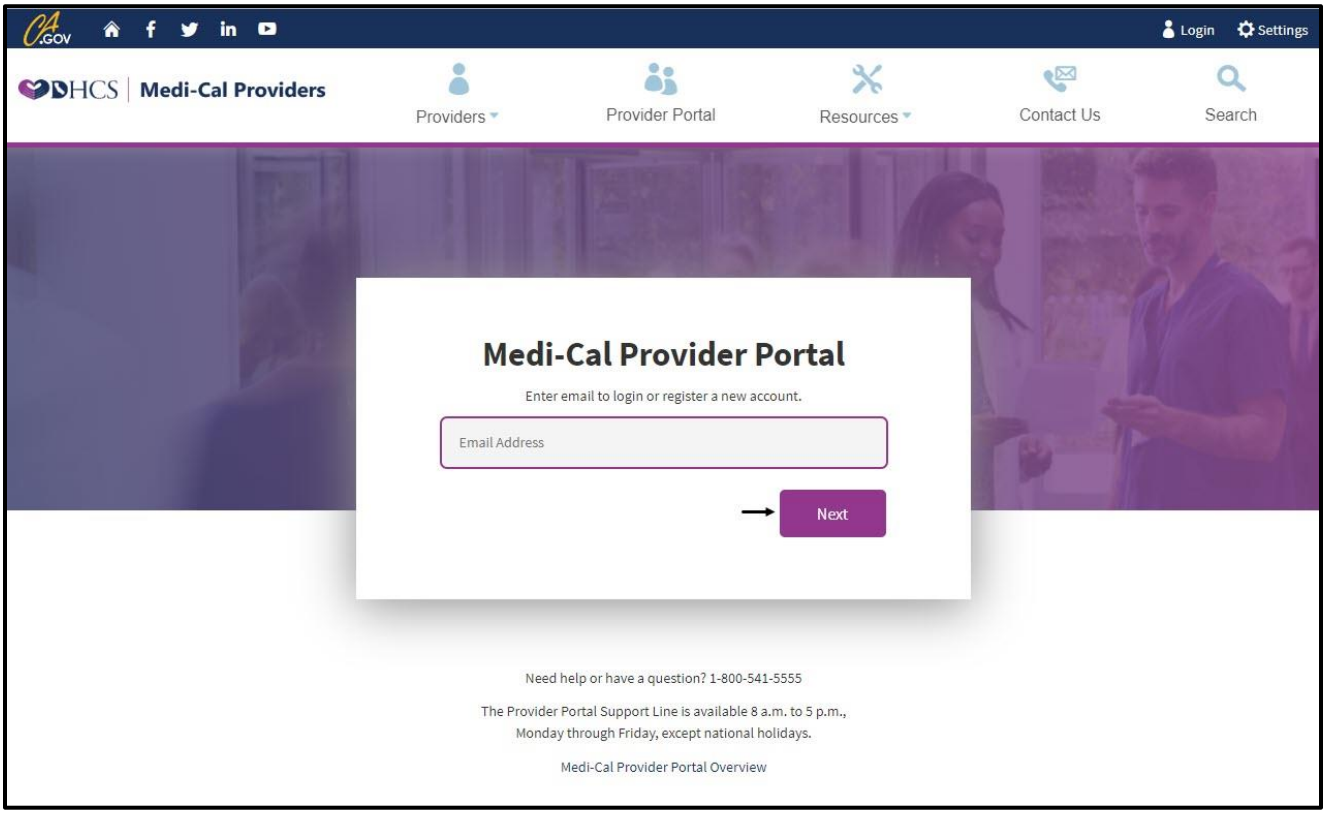

Figure 3.1: Enter email address to login to the Medi-Cal Provider Portal.

2. On the Log In screen, enter the user's password and select **Log In**.

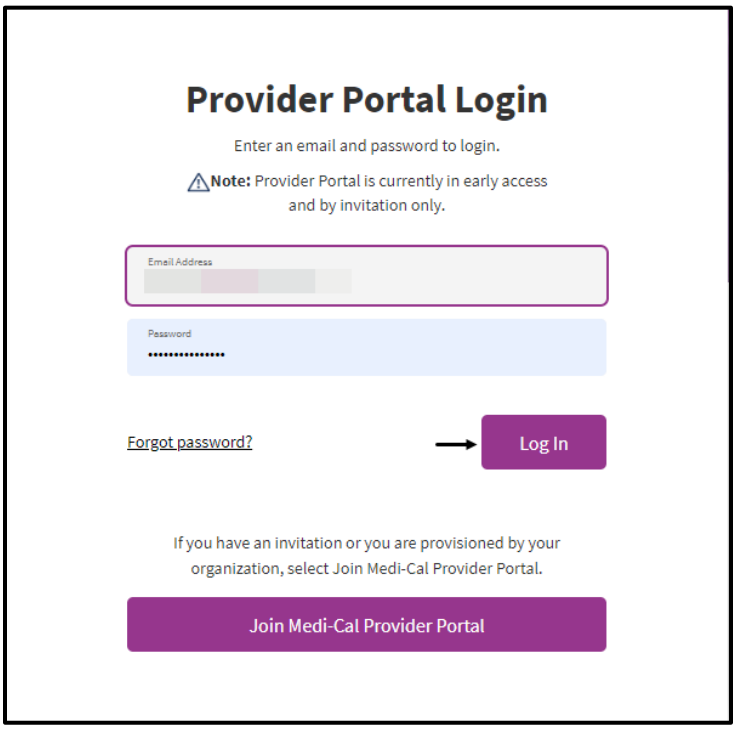

Figure 3.2: Provider Portal Log In screen.

3. Read the System Use Notification, check the “I confirm that I have read and agree to the above”, then select **Next**.

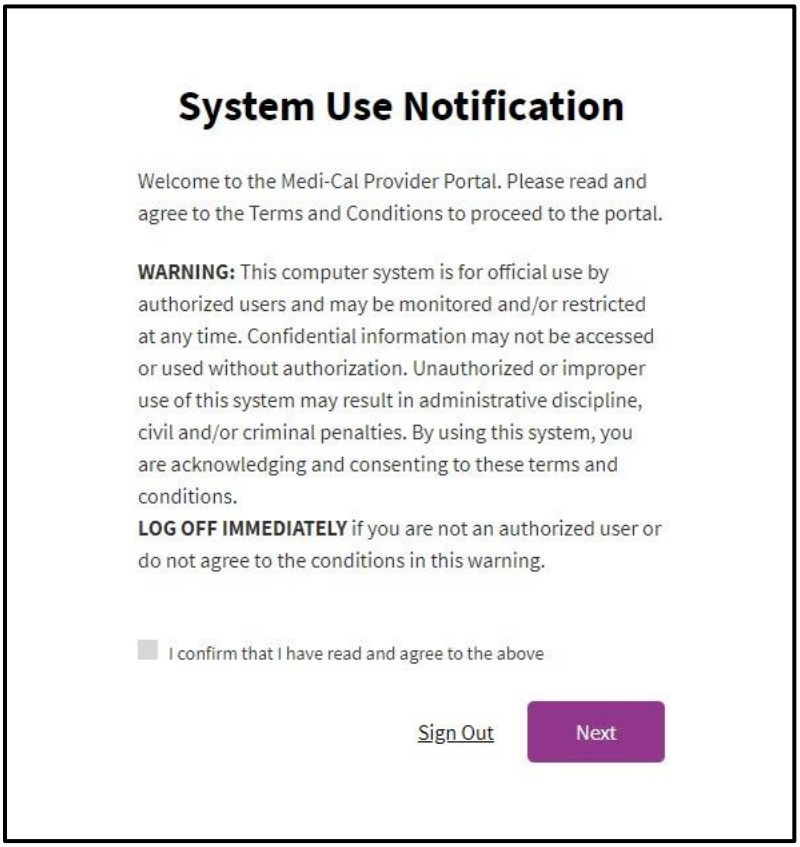

Figure 3.3: System Use Notification screen.

4. If the user who is logging in is a member of several organizations a Select an organization screen will appear. The organizations displayed are determined by an Organization Admin when a user's account is set up. If the user is assigned to a single organization, the Provider Portal homepage appears.

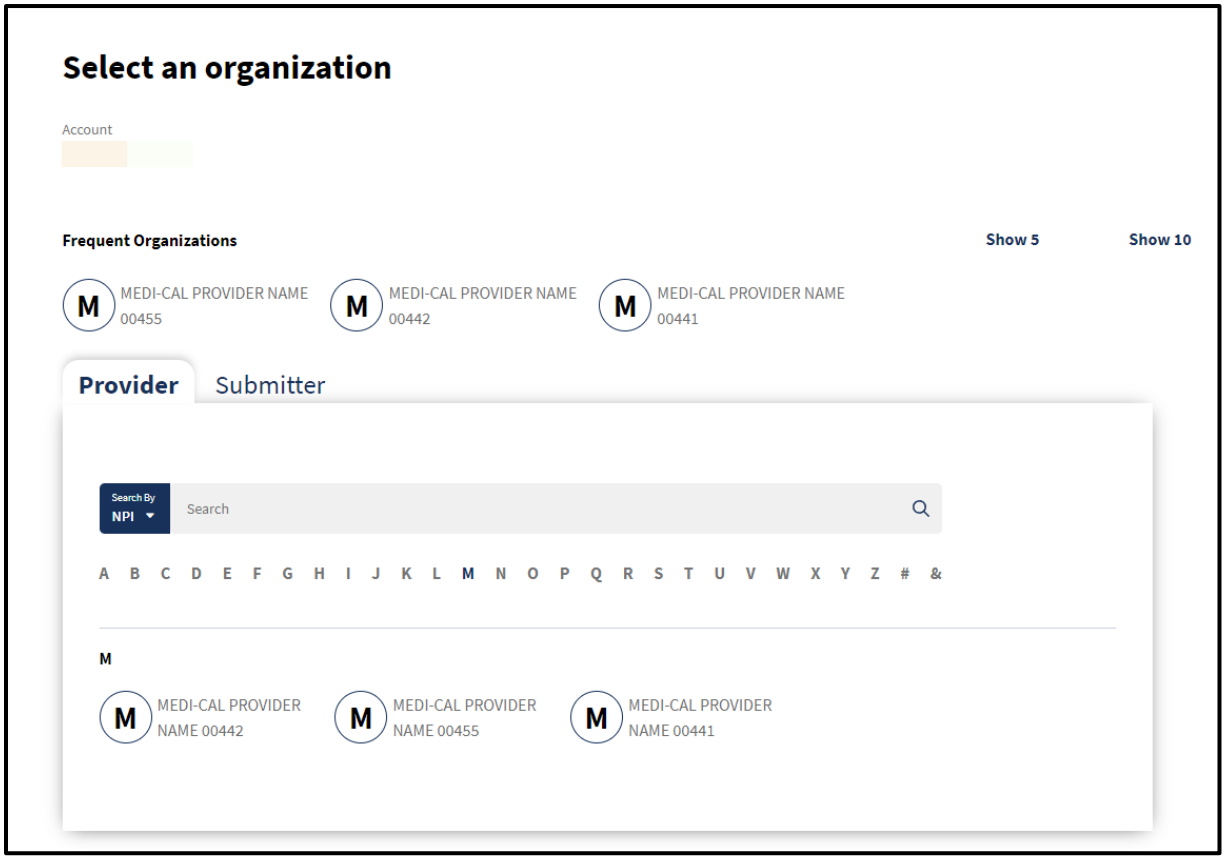

Figure 3.4: Select an organization page.

5. Navigate to the **Transaction Center.**

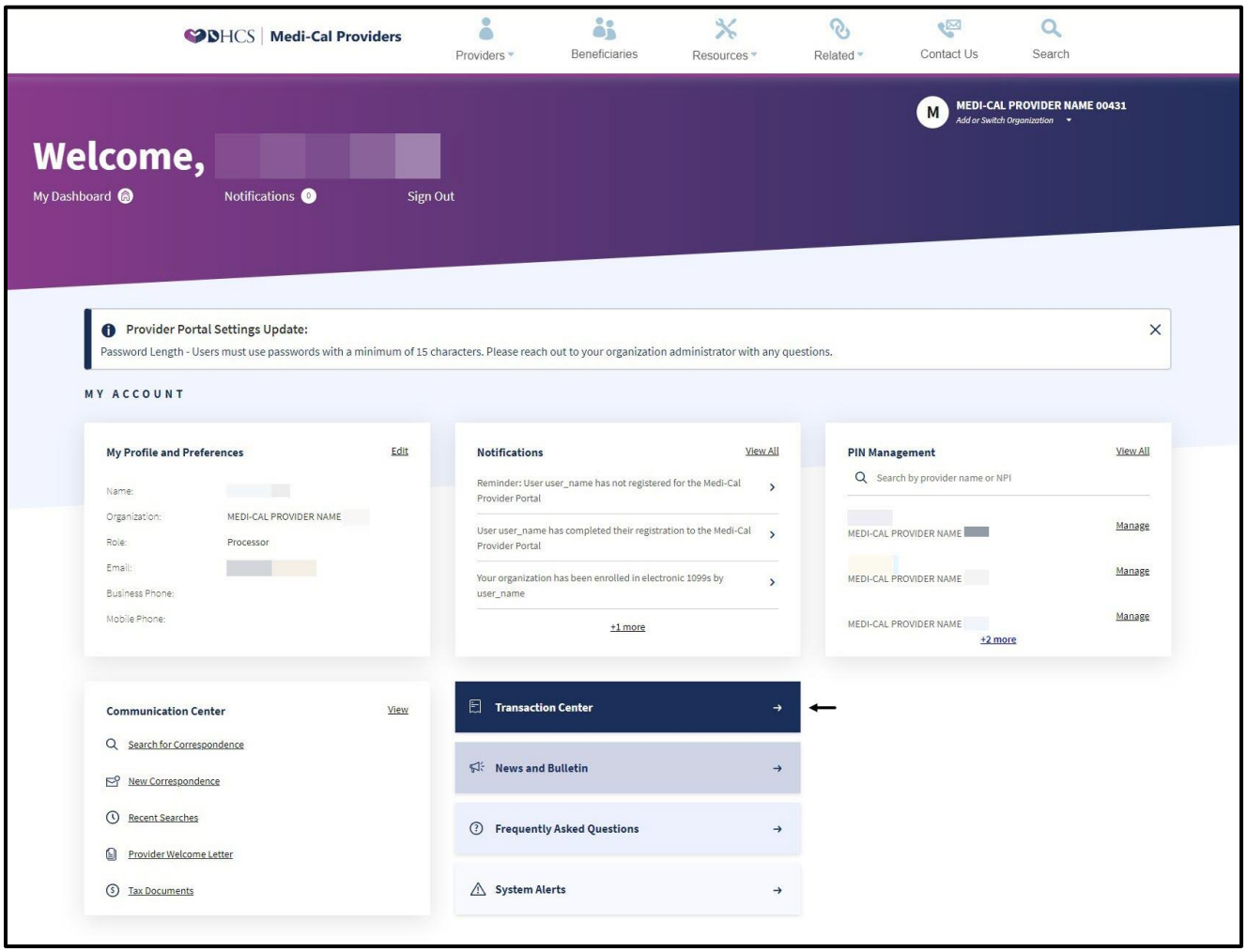

Figure 3.5: Provider Portal homepage.

6. From the drop-down menu, choose the desired National Provider Identifier (NPI) then select **Enter Transaction Services**.

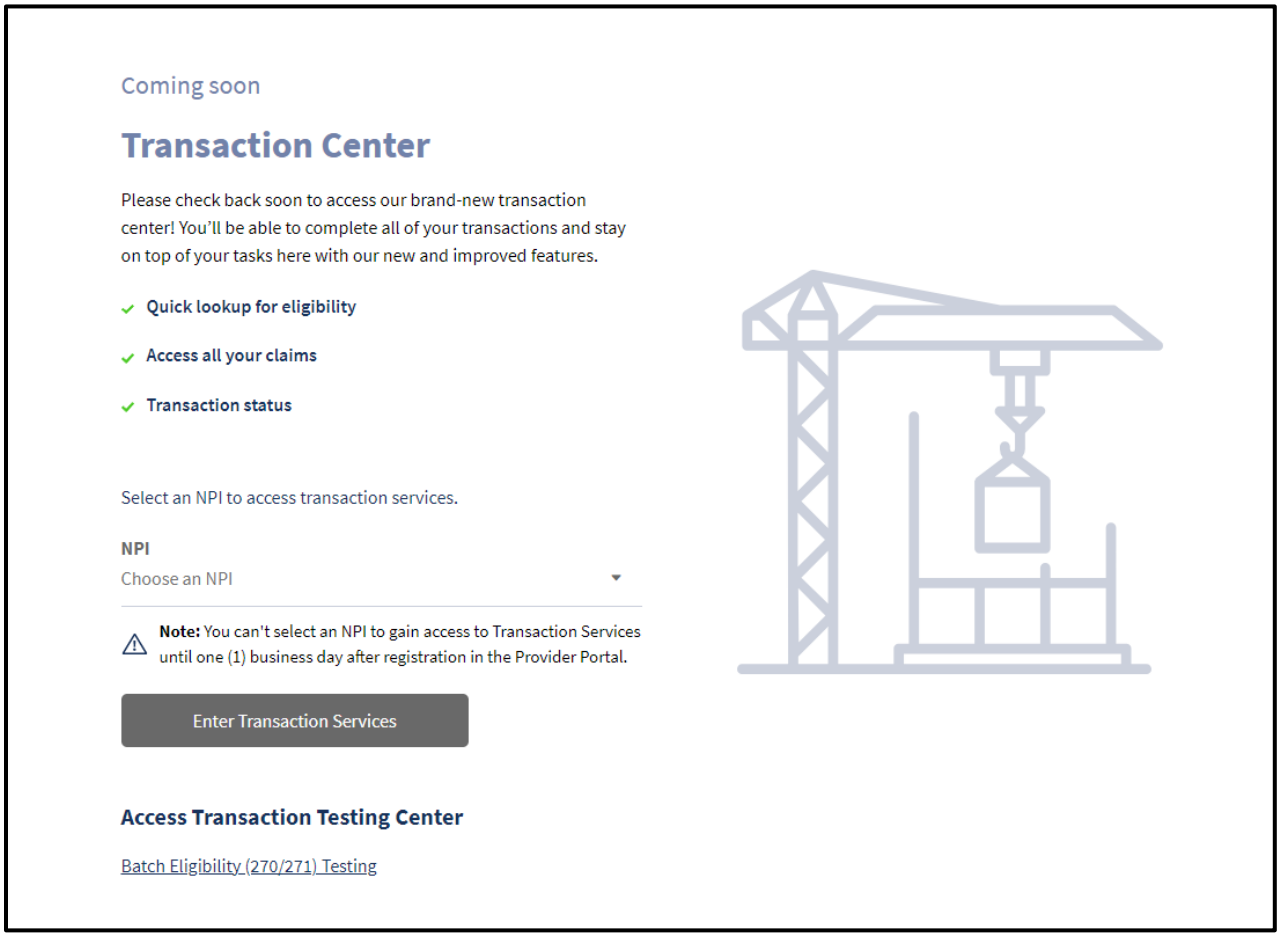

Figure 3.6: Transaction Center.

7. Under Eligibility, select **Single Subscriber.**

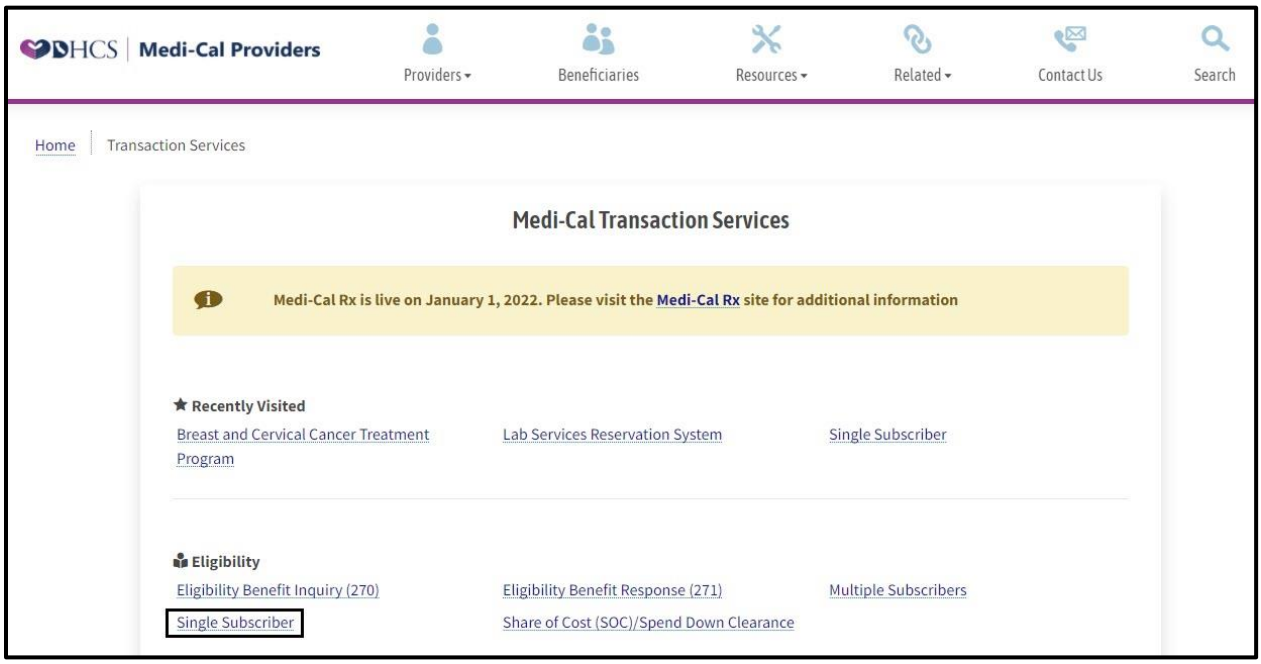

Figure 3.7: Single Subscriber selection located under Eligibility.

8. Fill out the **Single Subscriber form** and select **Submit**.

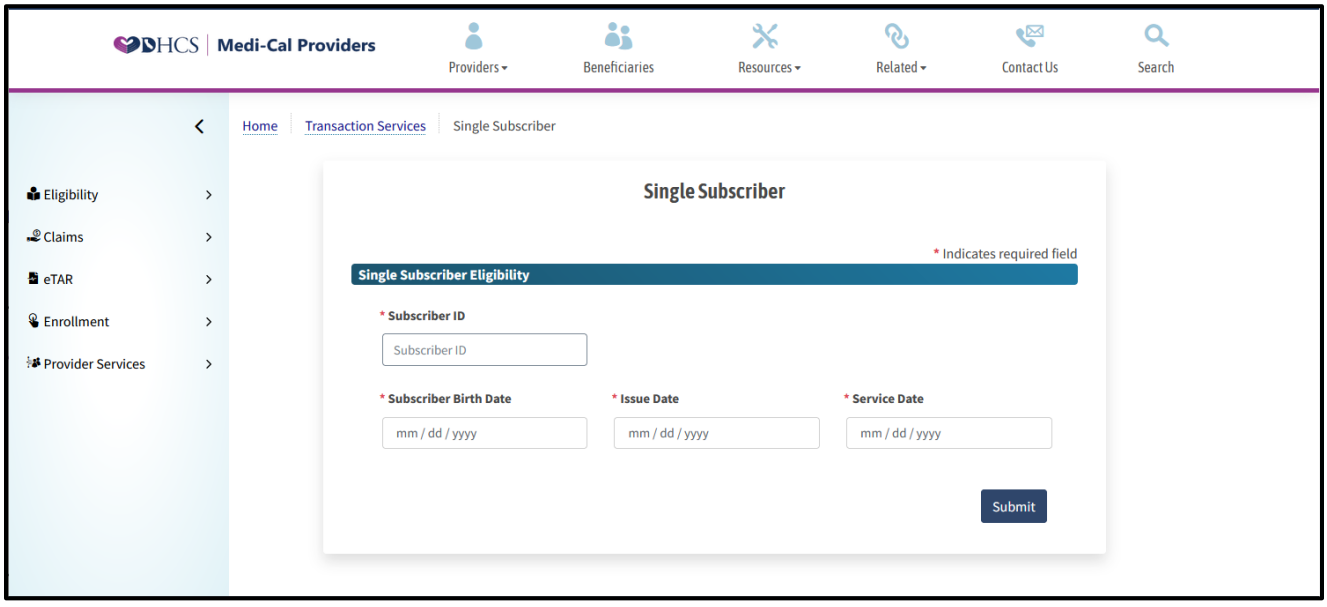

Figure 3.8: Single Subscriber form.

Below is an Eligibility Response example.

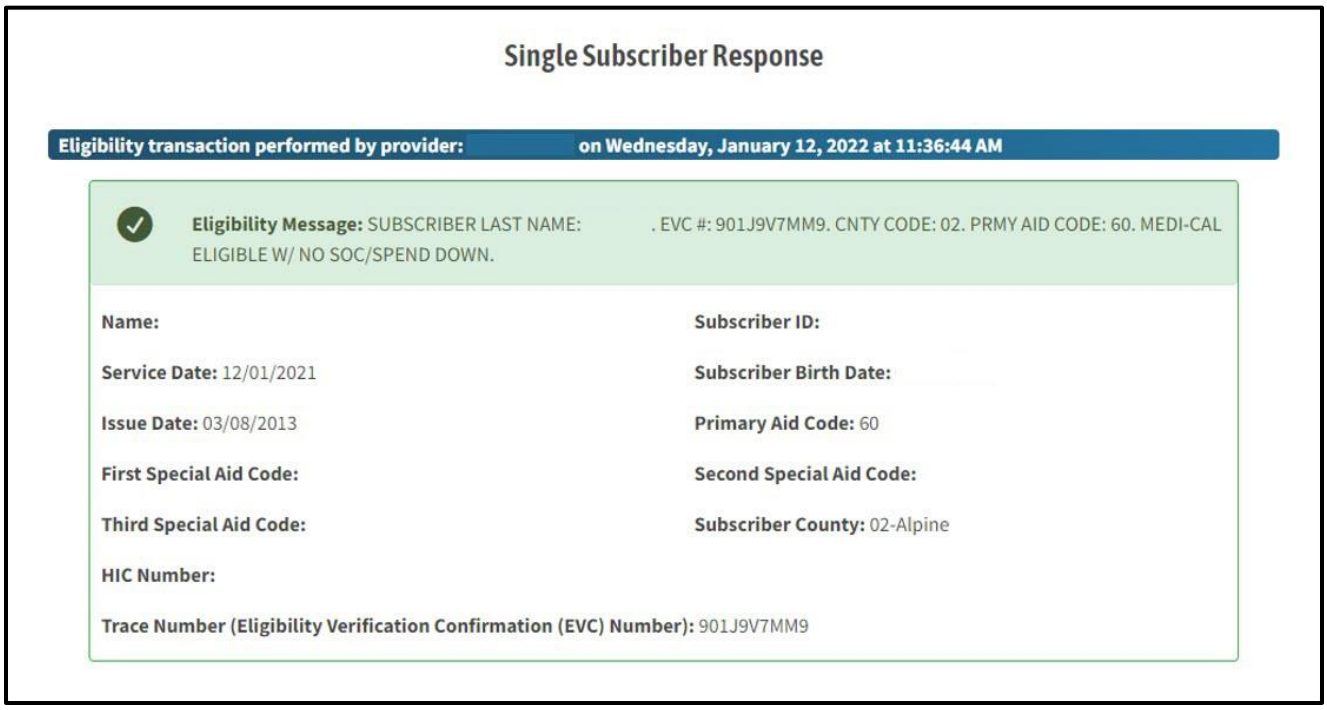

Figure 3.9: Response example on the Eligibility Response page.

Restrictions

Providers may face challenges when verifying eligibility. Below are some of the restrictions that may impact eligibility.

OBRA/IRCA/Restricted Services

Restricted or full-scope Medi-Cal benefits are extended to previously ineligible aliens, effective on or after October 1, 1988. This program was mandated by the *Federal Omnibus Budget Reconciliation Act of 1986* (OBRA) and the *Immigration Reform and Control Act of 1986* (IRCA).

DHCS has assigned seven aid codes to identify various types of OBRA, IRCA and Non-Permanently Residing Under Color of Law (Non-PRUCOL) recipients. Refer to Part 1 *OBRA and IRCA* (obra). These codes are 5F, 51, 52, 55, 56, 57 and 58.

Procedure Code Inquiry

It is important to verify if a procedure code is allowed within the Medi-Cal Program and will assist in determining if a TAR is required.

Reference to specific sections of the provider manual for TAR requirements and/or the *TAR and Non* section in the Part 2 provider manual.

Providers may obtain code-specific information and the Medi-Cal maximum reimbursement rate through the Procedure Code Inquiry Transaction screen.

To search a procedure/service code to determine coverage and/or determine whether an authorization is required log into Transaction Services, then follow these steps:

1. Under Provider Services, select **Procedure Code Inquiry**.

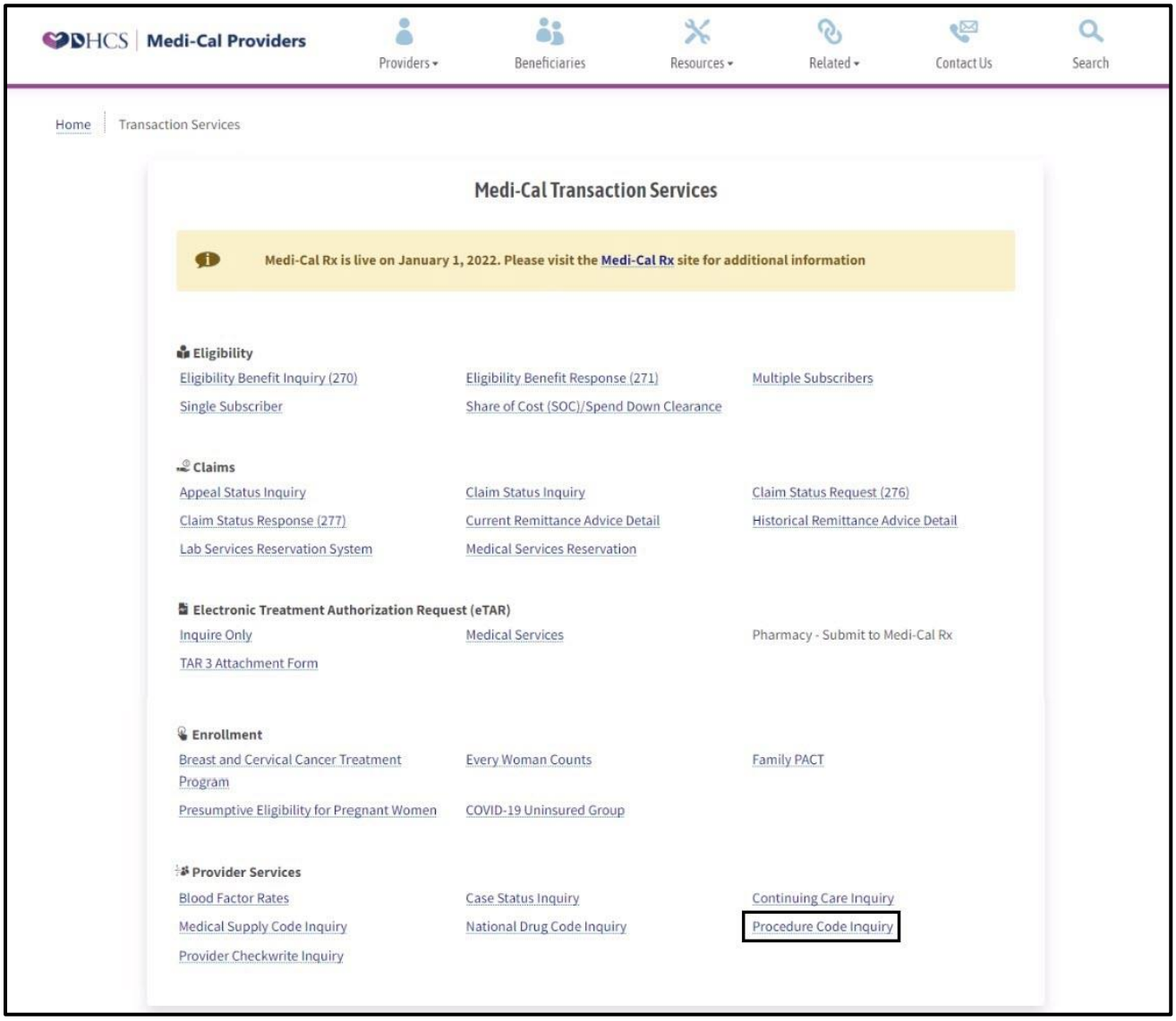

Figure 4.1: Under Provider Services, select Procedure Code Inquiry.

2. To complete an inquiry for procedure code, enter the code in the Procedure Code box and select **Submit**.

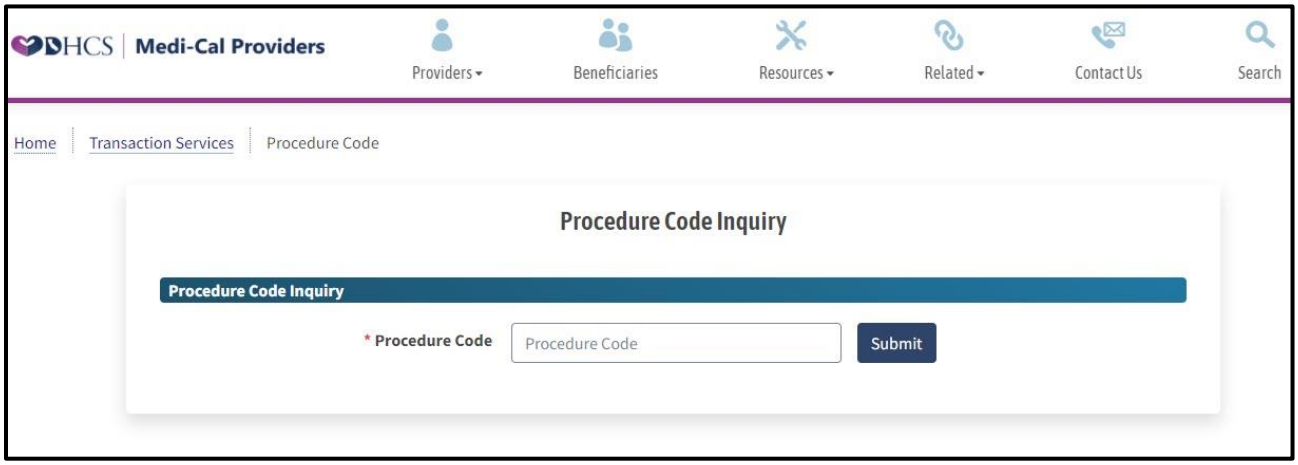

Figure 4.2: A code may be entered to begin Procedure Code Inquiry.

3. The response screen will display the description, the procedure code level, the procedure type and the effective dates of the code. The response also indicates if there is a gender or age restriction when billing for the code, the maximum allowed amount for the code and a message at the bottom with any detailed requirements such as if an authorization is required.

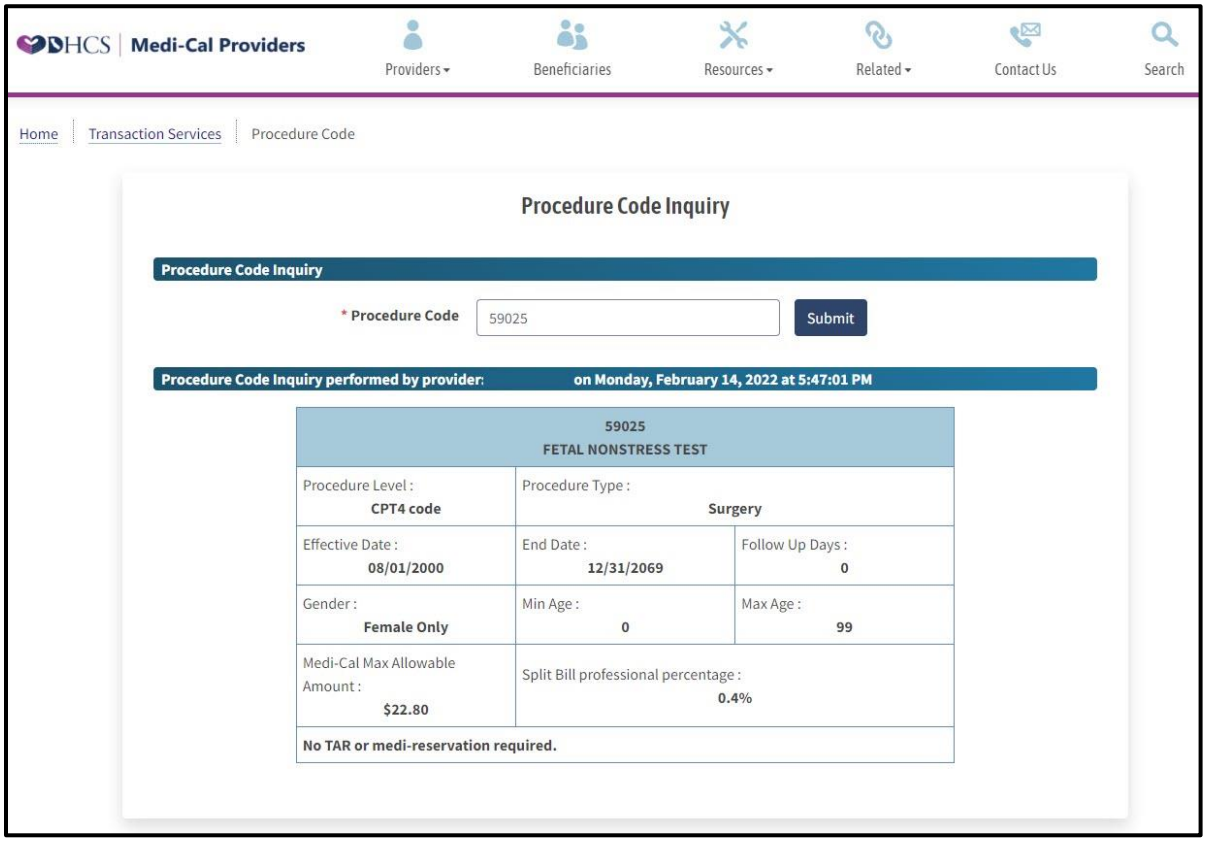

Figure 4.3: Detailed list of information regarding Procedure Code Inquiry Response.

Medi-Cal Rates

Medi-Cal Rates can be impacted by the Medi-Cal Rates Conversion Factor. The conversion indicators and conversion factors listed in the *Rates* worksheet are used in the Medi-Cal pricing system to calculate maximum reimbursement rates for physicians, Non-Physician Medical Practitioners (NMP), hospital outpatient departments and podiatrists (for example, conversion factor X unit value equals the maximum rate). The chart in this section can be used to calculate rates for other provider types (for example, clinics).

To access Medi-Cal rates, follow the steps below:

1. From the homepage of the Medi-Cal Providers website, under the Resources drop-down menu, select **References**.

Figure 5.1: References may be accessed from the Resources drop-down menu.

2. Next, select the **Medi-Cal Rates** link.

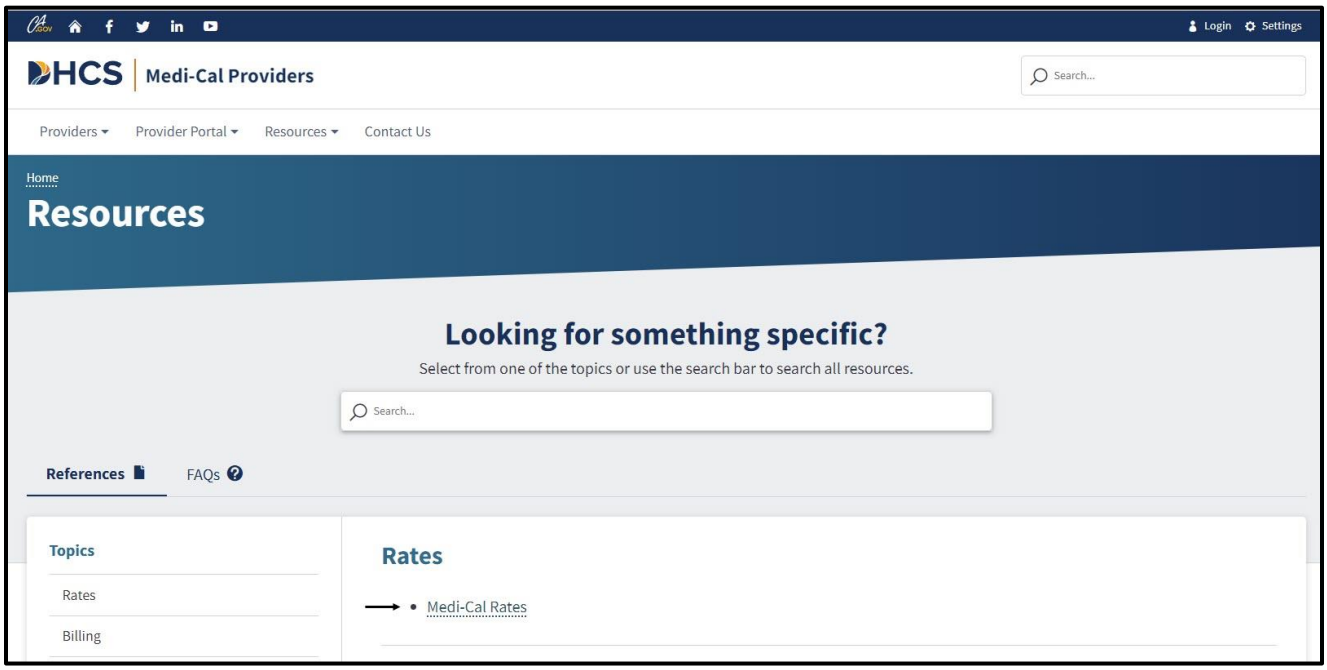

Figure 5.2: The Medi-Cal Rates link.

3. Read the Medi-Cal Rates Disclaimer and then select **Accept.**

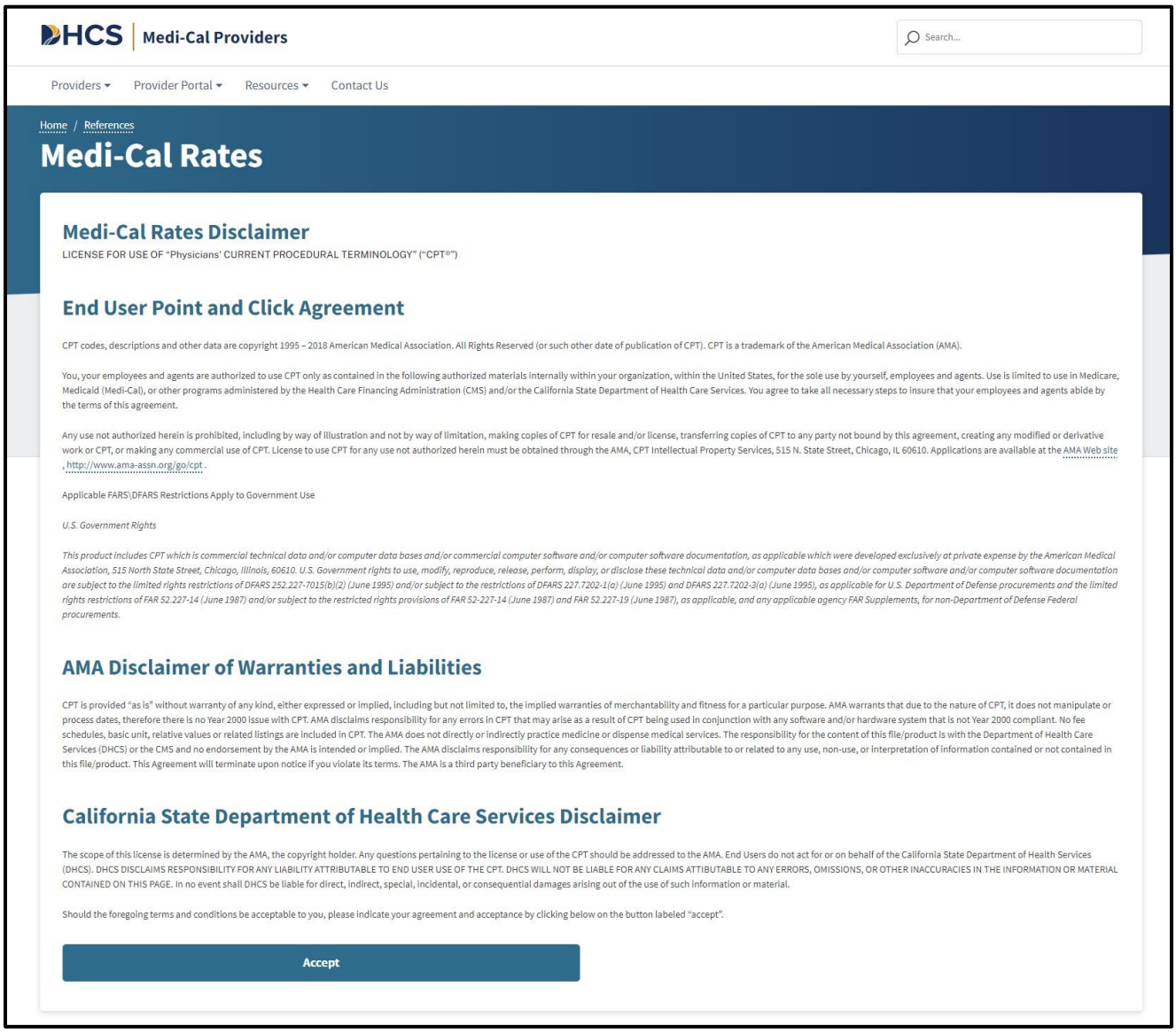

Figure 5.3: The Medi-Cal Rates Disclaimer page.

4. After selecting Accept, the *Medi-Cal Rates* screen will appear. If the **Download All Medi-Cal Rates** is selected, in the upper right corner of the address bar displays a progress ring. Once the download is complete, the file can be found on the user's PC under Downloads.

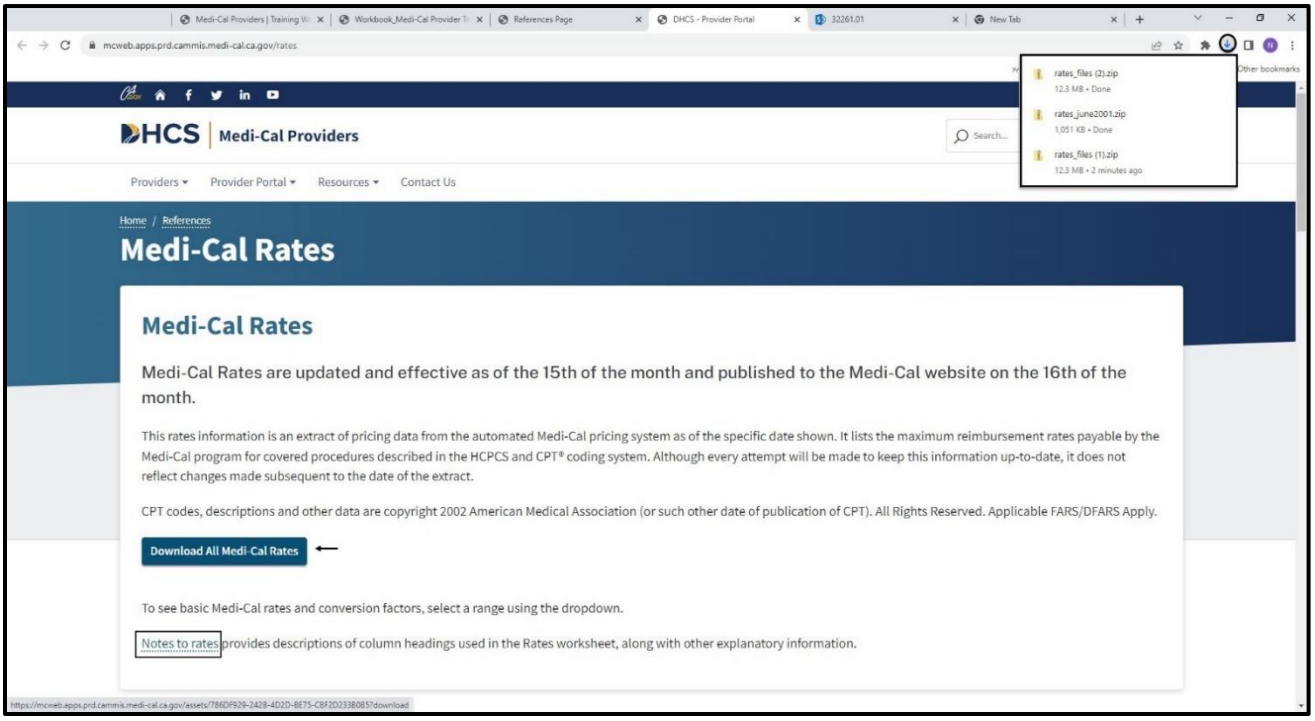

Figure 5.4: Medi-Cal Rates downloads.

Notes to rates provides column heading descriptions used in the Rates worksheet along with additional information.

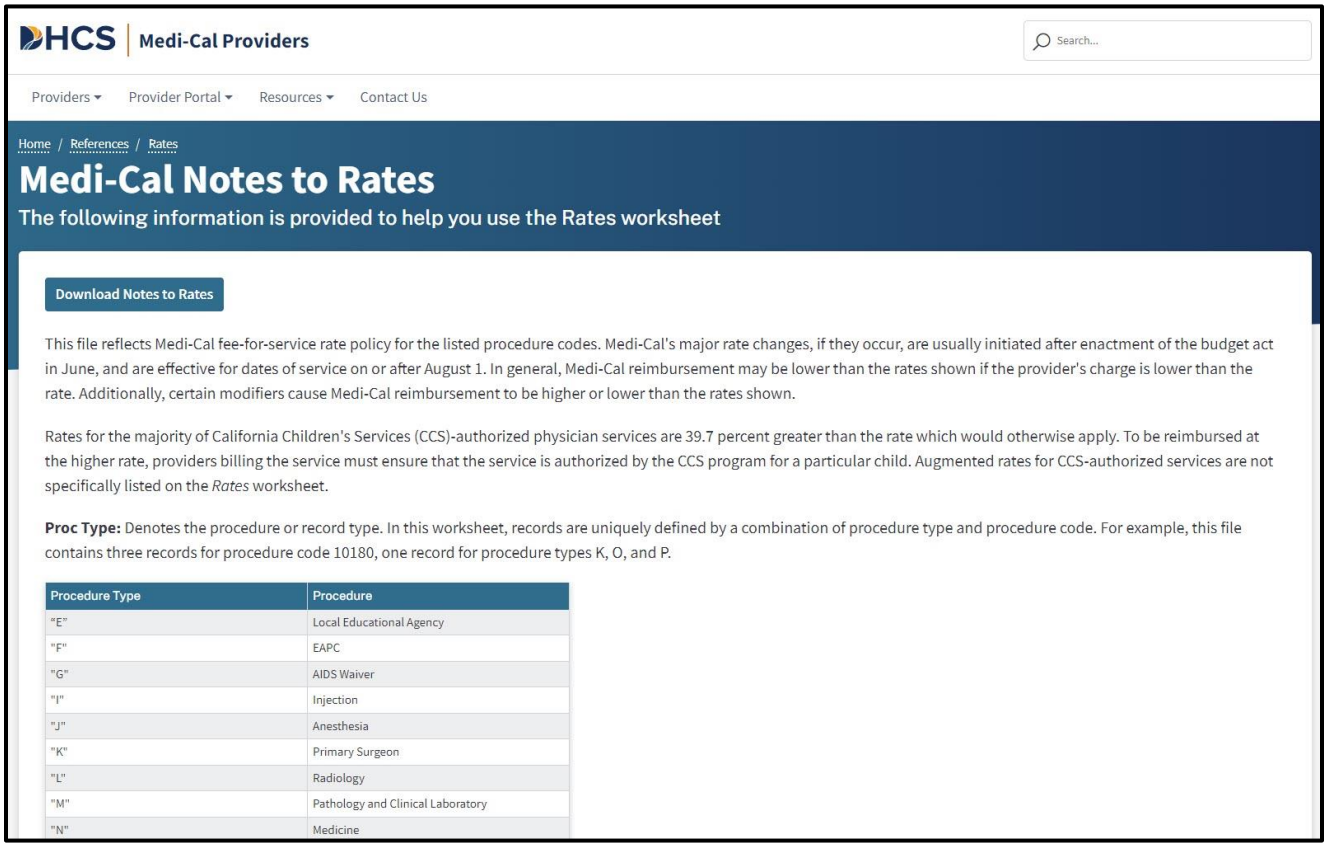

Figure 5.5: The Notes to Rates page includes procedure types and descriptions.

5. **Rates by Procedure Codes** allows a user to search by a Procedure Code or use the Select a page drop-down menu.

Figure 5.6: Medi-Cal Rates by Procedure Code.

Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cut-back Ind	Prof %	Rental Rate	Non-Physn. Med.Prac.Ind
O	15822	REVISION OF UPPER EYELID	0.00	$0.00	---	--	004	1	0	0.00	$0.00	Y
O	15823	REVISION OF UPPER EYELID	0.00	$0.00	---	--	004	1	0	0.00	$0.00	Y
K	15823	REVISION OF UPPER EYELID	9.06	$337.30	---	$425.37	004	1	0	0.00	$0.00	Y
K	15840	NERVE PALSY FASCIAL GRAFT	30.00	$1116.90	---	$1408.50	004	1	0	0.00	$0.00	Y
O	15840	NERVE PALSY FASCIAL GRAFT	6.00	$223.38	---	$281.70	004	1	0	0.00	$0.00	Y
O	15841	NERVE PALSY MUSCLE GRAFT	6.70	$249.44	---	$314.57	004	1	0	0.00	$0.00	Y
K	15841	NERVE PALSY MUSCLE GRAFT	33.52	$1247.95	---	$1573.76	004	1	0	0.00	$0.00	Y
K	15842	NERVE PALSY MICROSURG GRAFT	33.98	$1265.08	---	$1595.36	004	1	0	0.00	$0.00	Y
O	15842	NERVE PALSY MICROSURG GRAFT	6.80	$253.16	---	$319.26	004	1	0	0.00	$0.00	Y

Figure 5.7: Medi-Cal Rates by Page drop-down menu selection.

6. In the example below, the procedure code 10061 is showing billable for Procedure types, P, O and K. According to the inquiry response, the description indicates this code is payable for one of the three options. If there is no basic rate indicated for a provider type, the listed code is not payable.

Note: In certain situations, if no basic rate is listed for a provider type, and the procedure is determined to be medically necessary, the code may be billed with an approved authorization.

Proc Type	Proc Code	Procedure Description	Unit Value	Basic Rate	Child Rate	ER Rate	Conv Ind	ER Ind	Cut-back Ind	Prof %	Rental Rate	Non-Physn. Med.Prac.Ind
P	10061	INCISION/DRAINAGE OF ABSCESS;COMPLICATED	0.00	$0.00	---	--	015	0	0	0.00	$0.00	Y
O	10061	INCISION/DRAINAGE OF ABSCESS;COMPLICATED	0.00	$0.00	---	--	004	1	0	0.00	$0.00	Y
K	10061	INCISION/DRAINAGE OF ABCESS;COMPLICATED	75.76	$75.76	---	--	042	0	0	0.00	$0.00	Y

Figure 5.8: Example of procedure code 10061.

Reconciliation

It is a provider's responsibility to maintain, reconcile and follow-up on each claim submitted according to their business practices. Remittance Advice Details (RAD) is a tool that providers should use to maintain their accounts.

Providers can identify the following:

- Adjustments
- Approves
- Denies
- Suspends
- Accounts Receivable (A/R) Transactions

Note: If a claim is showing in a Suspense status, no follow-up is necessary the claim is still processing. Keep in mind that a claim may take up to 45 days to adjudicate.

Remittance Advice Details (RAD)

Providers are reimbursed for Medi-Cal covered services with warrants issued by the State Controller's Office (SCO). Both institutional and non-institution providers receive a RAD that lists providers' claims for a particular payment period, or check write. The RAD is produced by the SCO from a payment tape received from the CA-MMIS FI and is used by providers to reconcile their records with claims that have been paid, denied or suspended. Providers also receive a summary sheet called the *Medi-Cal Financial Summary* that includes a State-issued Negotiable Warrant (check), a Direct Deposit Advice or a No Payment Advice. For more information refer to the Part 1 Medi-Cal provider manual *Checkwrite* schedule settlement date.

The RAD is designed for line-by-line reconciliation of claim transactions. Reconciliation of the RAD to providers' records will help determine which claims are paid, denied or not yet adjudicated. Through the Medi-Cal Provider Portal website, providers will be able to view and download current and historical RADs and *Medi-Cal Financial Summary* documents within the Communication Center.

As part of this service, providers will be able to “opt out” of receiving paper RADs. The new secure service is part of Medi-Cal’s continuous effort to improve service speed and convenience for providers. Provider will still need to write into the Cash Control Unit (CCU) if they are unable to obtain RADs through PDF. The written request must contain the National Provider Identifier (NPI), warrant number and warrant release date. The address to send those requests is:

California MMIS Fiscal Intermediary
ATTN: Cash Control
P.O. Box 13029
Sacramento, CA 95813-4029

Navigating to RADs

To access a RAD, the following steps need to be taken:

1. Navigate to the Medi-Cal Provider Portal. Enter the email address and select **Next.**

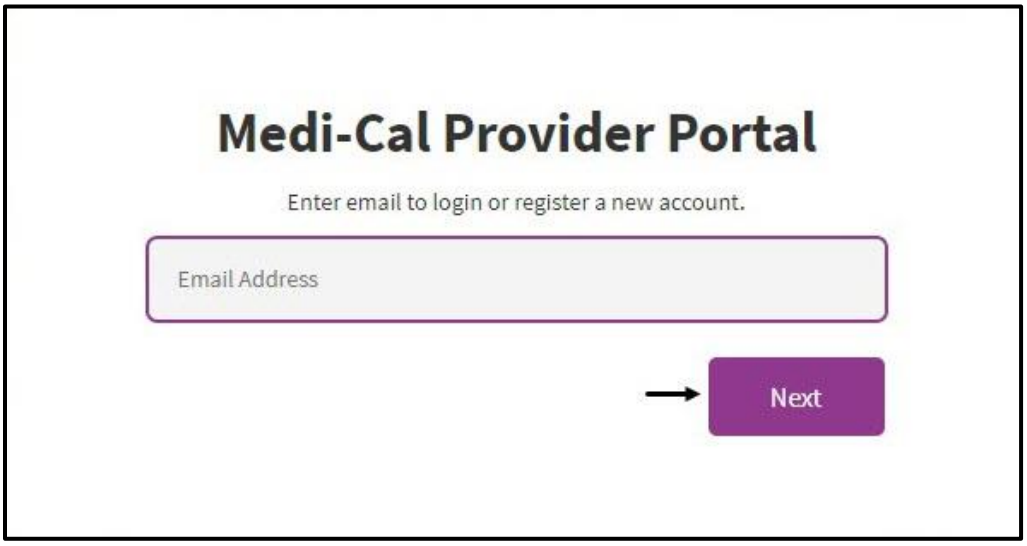

Figure 6.1: Medi-Cal Provider Portal login page.

2. On the Log In screen, enter the password and select **Log In.**

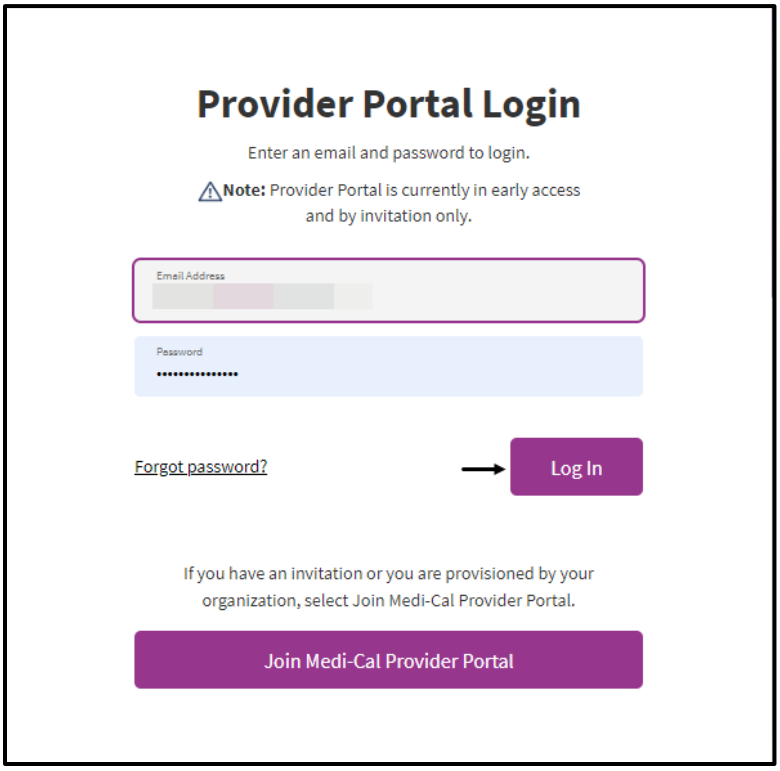

Figure 6.2: Provider Portal login screen.

3. Navigate to the Communication Center and select **Search for Correspondence**.

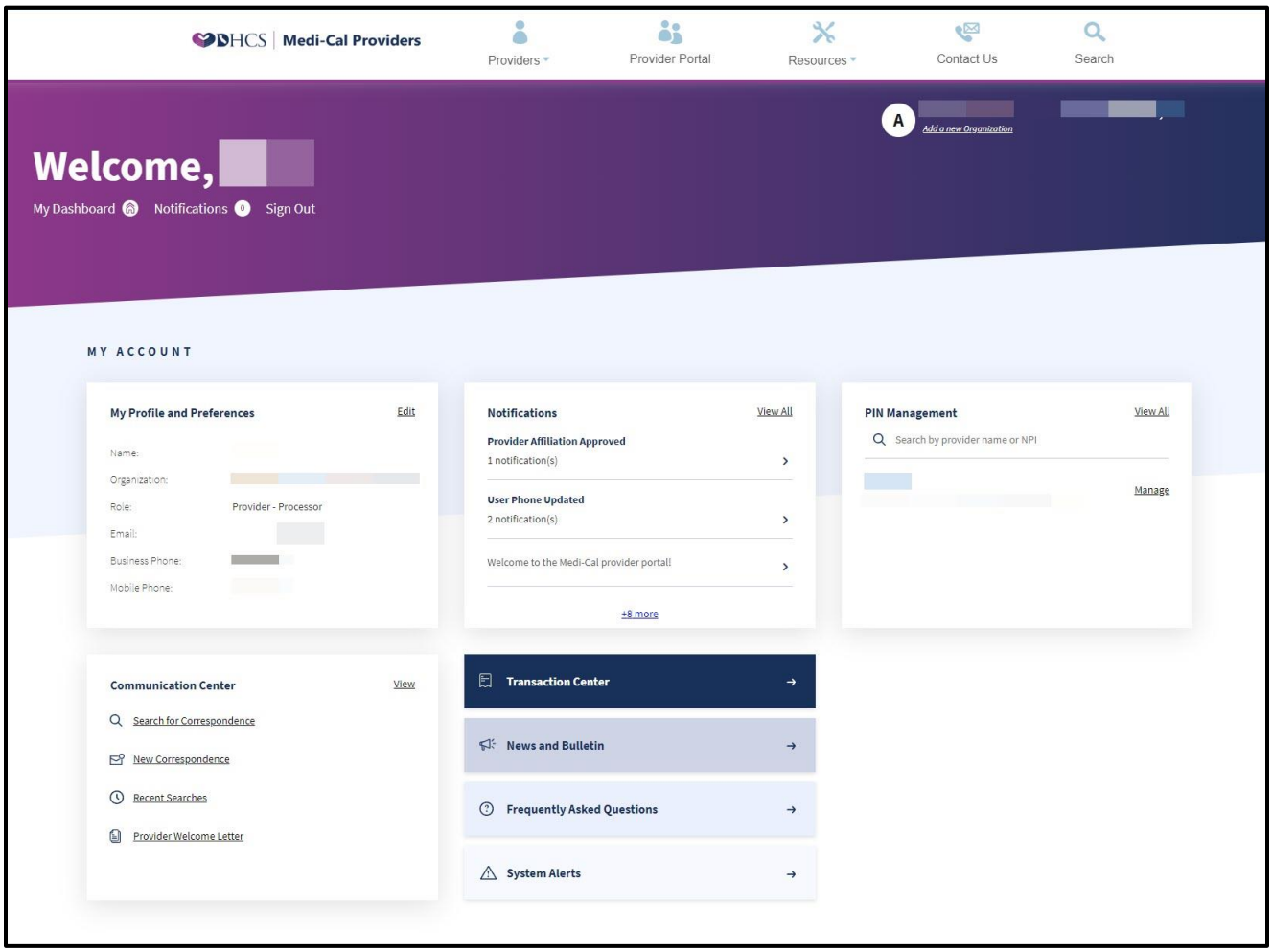

Figure 6.3: Provider Portal homepage.

4. Select the preferred method to receive a one-time passcode and select **Submit**.

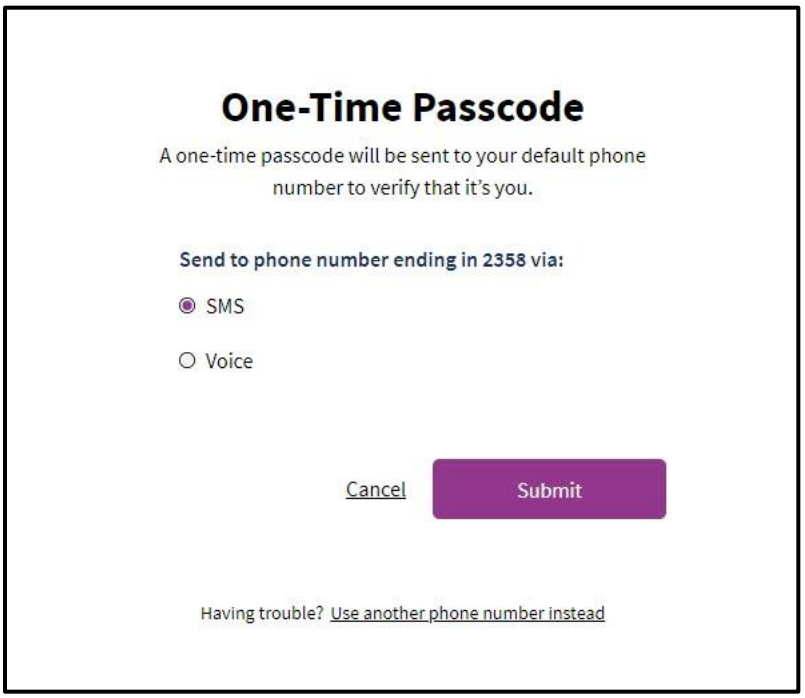

Figure 6.4: One-Time Passcode request.

5. Enter the one-time passcode and select **Next**.

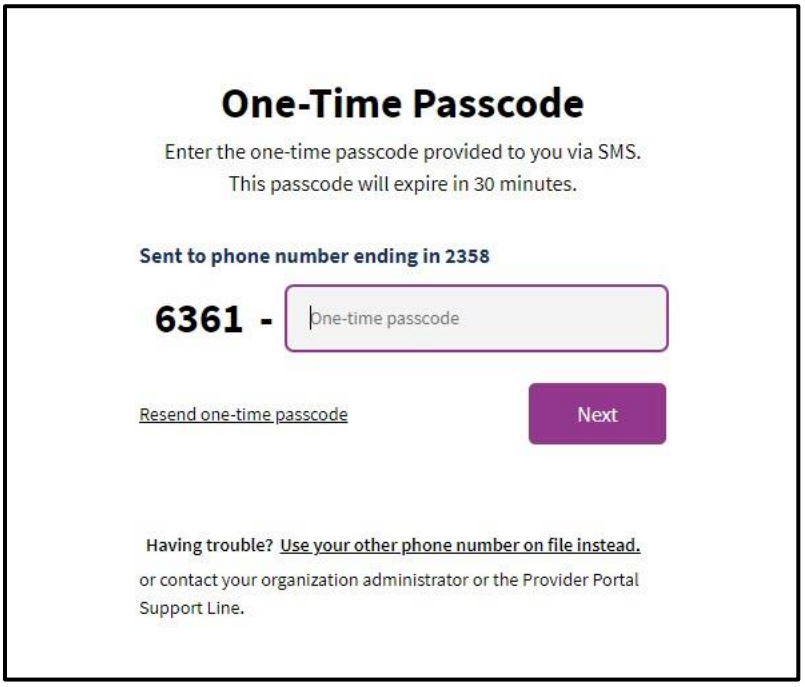

Figure 6.5: One-Time Passcode screen.

6. Select an NPI from drop-down menu, choose PDF Remittance Advice Detail from the Correspondence type drop-down and then enter a date range.

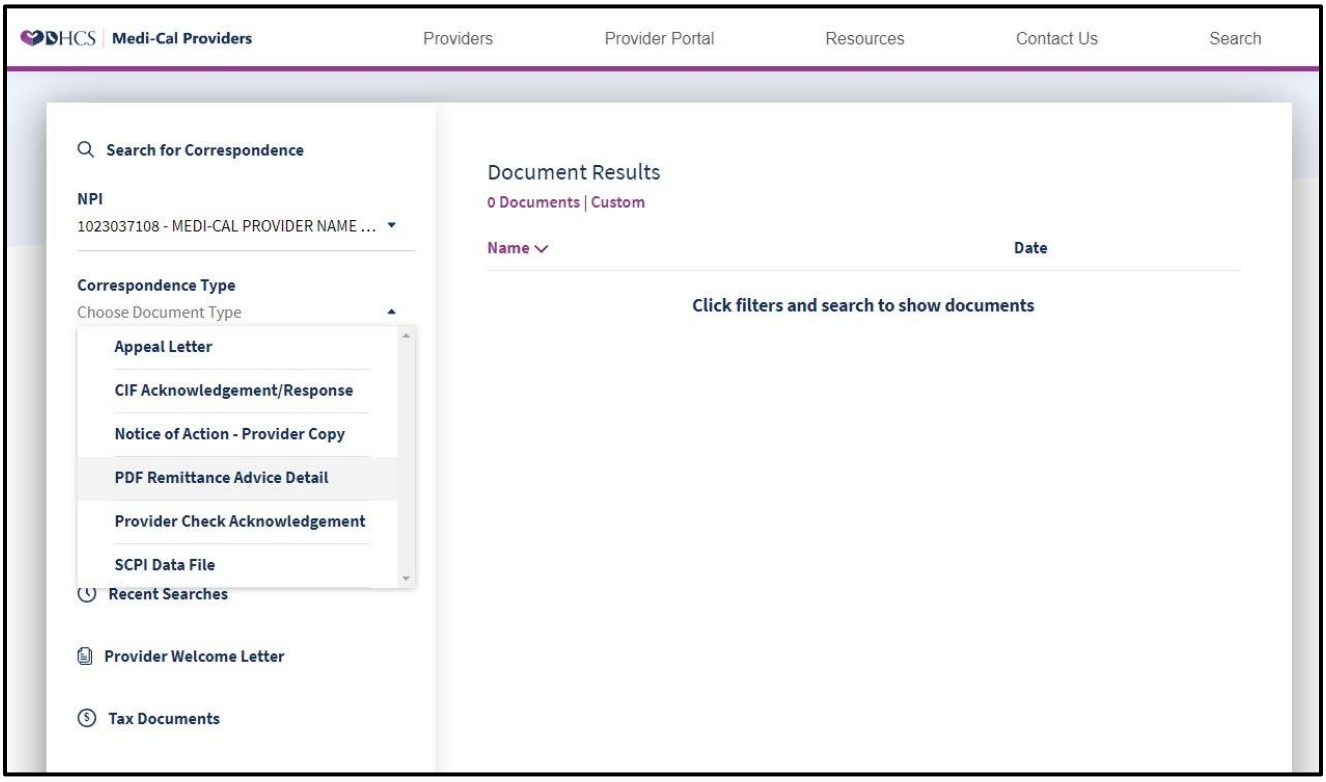

Figure 6.6: Search for Correspondence page.

7. Select the desired RAD, navigate to the vertical ellipse and select the format to download the RAD.

Figure 6.7: Download format options.

Accounts Receivables (A/R)

Providers can easily track negative balances by reviewing the RAD to identify any adjustments and locating the negative balance on the last page if positive claims do not cover adjustments. Providers can also identify relevant RAD forms by referencing the 10-digit A/R number that was created from the negative balance on subsequent checkwrites. The fourth and fifth digits of this number indicate the year and the sixth; seventh and eighth digits are the Julian date, which indicates the date the negative balance was created. Providers may reference the Julian Date Calendar in the *Claim Submission and Timeliness Overview* section of the appropriate Part 1 provider manual to find the associated calendar date. The checkwrite for that date should contain the original claim adjustments that created the negative balance.

For example:

A/R = 3312102009
21 = 2021
020 = the 20th day of the year (January 20)

In this example, the checkwrite showing the original adjustment was issued on January 20, 2021.

Electronic Fund Transfer (EFT)

EFT allows providers the option of receiving Medi-Cal payments via direct deposit. Through EFT, providers may have their payments electronically deposited into their bank accounts and eliminate the need for paper warrant (check).

- The EFT option is available to in-state and border-state providers (Arizona, Nevada and Oregon). Other out-of-state and out-of-country providers are not eligible for EFT.
- All providers electing this option are required to submit an *Electronic Fund Transfer Authorization* form to the address provided on the form.

To successfully apply for EFT, the following instructions apply:

- An original bank letter for savings accounts must be submitted with the EFT form. The provider's name, routing number and account number on the letter must match what is entered on the form. A bank letter must be signed and dated by a bank representative.
- An NPI or legacy number must be valid and entered on the EFT form.
- Only one NPI or legacy number may be entered on each form.
- No additional documentation is required for checking accounts.
- The EFT form must be an original, signed by the provider in blue ink only.
- The form must be **notarized** and signed by the notary in **blue ink** only.

Once the form is processed, a provider is notified in writing about their enrollment status. The form is returned to a provider if it is not completed correctly.

- The first EFT payment will be electronically deposited into the designated account within 6 to 8 weeks after the EFT authorization form is approved.
- Providers receive an acknowledgement letter prior to the first electronic payment.
- If an EFT payment is returned due to invalid account information, a paper warrant will be issued instead.
- A change in bank account or financial institution will take approximately 6 to 8 weeks to process; EFT payments will continue to be deposited into the existing account until the California MMIS (CA-MMIS) Fiscal Intermediary (FI) processes the request.
- To change accounts or institutions, providers must complete and submit a new EFT authorization form with the new information. The old account should not be closed until the first payment is deposited into the new account.

To cancel an old bank account, send an EFT authorization form to the address provided on the form. Submit a separate EFT authorization form to open a new account.

Note: If payment has not been deposited according to the EFT payment schedule, which can be found in, Part 1 of the provider manual in the *Checkwrite* section, providers should verify proof of deposit with their financial institution. After contacting the bank, provider should call the Telephone Service Center (TSC) and an agent will assist with payment issues.

EFT cancellations will occur upon:

- A provider’s request
- Liens or levies
- Special Claims Review
- Change in Medi-Cal provider status

Note: A provider whose EFT is cancelled must re-apply and submit a new EFT authorization form for reinstatement.

Address Changes

Providers who have changed their pay-to-address, mailing address, status or any other related information must notify the DHCS Provider Enrollment Division (PED).

The provider must report any changes in information to DHCS within 35 days of the change. Deactivation of the provider billing number will occur if DHCS is unable to contact a provider at the last known pay-to, business or mailing address.

Note: Changing a business address requires a complete application package. Individual physician practices, relocating their business location within the same county, may submit the *Medi-Cal Change of Location Form for Individual Physician Practices Relocating Within the Same County* (DHCS 9096) in place of submitting a complete application package.

A change of pay-to address, mailing address, telephone or status must be submitted on the *Medi-Cal Supplemental Changes* form (DHCS 6209).

Inpatient, Outpatient and Long-Term Care providers (institutional providers) must contact the local Licensing and Certification Division of DHCS to change their business addresses or other information. To change a pay-to address, institutional providers must send a signed, notarized *Pay-To Address Change Notification* (DHCS 6209) to DHCS PED.

Pay-to address, mailing address, telephone number or status changes submitted on the *Medi-Cal Supplemental Changes* (DHCS 6209) form should be mailed to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P.O. Box 997412
Sacramento, CA 95899-7412

Lock Box

If a provider enters into a lock box agreement with a financial institution, the provider must ensure that arrangements are made to have documents other than the paper warrants or live check to be forwarded to the appropriate contact person.

Provider Member Services Organization (PMSO)

PMSO is the primary liaison between the provider community and the Medi-Cal program. PMSO provides billing and training assistance to providers. Provider Relations is responsible for:

- Answering provider billing questions
- Assisting providers in obtaining reimbursement for services
- Conducting provider training
- Informing providers about Medi-Cal policies and procedures
- Maintaining effective channels of communication among DHCS, the CA-MMIS FI, Medi-Cal providers and their associations
- Recommending improvements to increase provider satisfaction and participation in the Medi-Cal program

(PMSO) is comprised of the following:

- Telephone Service Center (TSC)
- Correspondence Specialist Unit (CSU)
- Provider Field Representatives
- Small Provider Billing Assistance and Training Program
- Out-Of-State (OOS)
- Financial Cash Control Unit (FCCU)

Telephone Service Center (TSC)

- TSC is the first line of communication between providers and the CA-MMIS FI. TSC is staffed with knowledgeable agents who can assist providers with the following:
- Medi-Cal billing policies and procedures
- Clarification of the provider manual
- Assistance with correct completion of Claim forms, *Claims Inquiry Forms* (CIFs), and *Appeal* forms
- Claim denials
- Check status for CIF, Appeals and Over-One-Year claims

Note: TSC is available 8 a.m. to 5 p.m., Monday through Friday, except holidays.

Correspondence Specialist Unit (CSU)

The TSC operators may refer providers to CSU for inquires that require additional research. CSU specializes in various claim types and conducts in-depth research.

Providers may write directly to CSU for clarification about recurring billing issues that have not been resolved through either the CIF or Appeal process and have resulted in claim denials or potential unsatisfactory payments.

When writing to CSU for assistance, providers should enclose up to three Claim Control Numbers (CCNs) pertaining to the billing issue. A lack of necessary records may delay research. Include as much of the following documentation as possible with your inquiry:

- Legible claim form
- Proof of eligibility (if date of service is beyond one year)
- Necessary documentation, operative report, invoice, etc.
- Copies of RADs
- Copies of all CIF acknowledgements and/or correspondence letters
- Copies of all Appeal acknowledgements and/or response letters
- Copies of all dated correspondence from the CA-MMIS FI

Letters to CSU should be addressed to the CA-MMIS FI as follows:

California MMIS Fiscal Intermediary
Attn: CSU
P.O. Box 13029
Sacramento, CA 95813-4029

Note: Provider with numerous or various billing issues should not write to CSU but instead request an onsite visit from a Provider Field Representative.

Provider Field Representatives

Provider inquiries that cannot be handled by TSC or CSU are referred to a Provider Field Representative. Provider Field Representatives are located throughout the state and visit providers in their offices or facilities. They conduct one-on-one billing assistance, training and tailored workshops free of charge. Provider Field Representatives will schedule an onsite visit with providers when:

- Reimbursement is delayed because of billing errors.
- Claims are being denied and the staff cannot correct the claim.
- Billing staff is unfamiliar with Medi-Cal billing procedures.

To request a referral for a Provider Field Representative in your area, call TSC at 1-800-541-5555.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is a full-service billing assistance and training program for medical services providers who submit up to 100 Medi-Cal claim lines per month and do not use a billing service or agency. Representatives assist providers who have little or no Medi-Cal billing experience. Provider participation is determined jointly by DHCS and the CA-MMIS FI.

For enrollment information, providers may call (916) 636-1275 and speak with a representative. Representatives are available from 8 a.m. to 5 p.m., Monday through Friday, except holidays.

Out-Of-State Provider Unit (OOS)

The OOS Provider Unit addresses the billing needs of non-California providers. *California Code of Regulations* (CCR)(*ccr.oal.ca.gov*), Title 22, Chapter 3, Article 1.3, Section 51006 allows reimbursement for medically necessary emergency services provided by an out-of-state provider to California Medicaid (Medi-Cal) recipients who are temporarily in another state. However, **all providers must be enrolled in the Medi-Cal program before they can receive reimbursement**.

To enroll as an out-of-state provider, you must complete the one-page *Out-of-State Provider Express Enrollment* form. This is the only form required for basic enrollment and it can be found on the Medi-Cal Providers website. Select References from the Resources drop-down menu then navigate to Provider Enrollment.

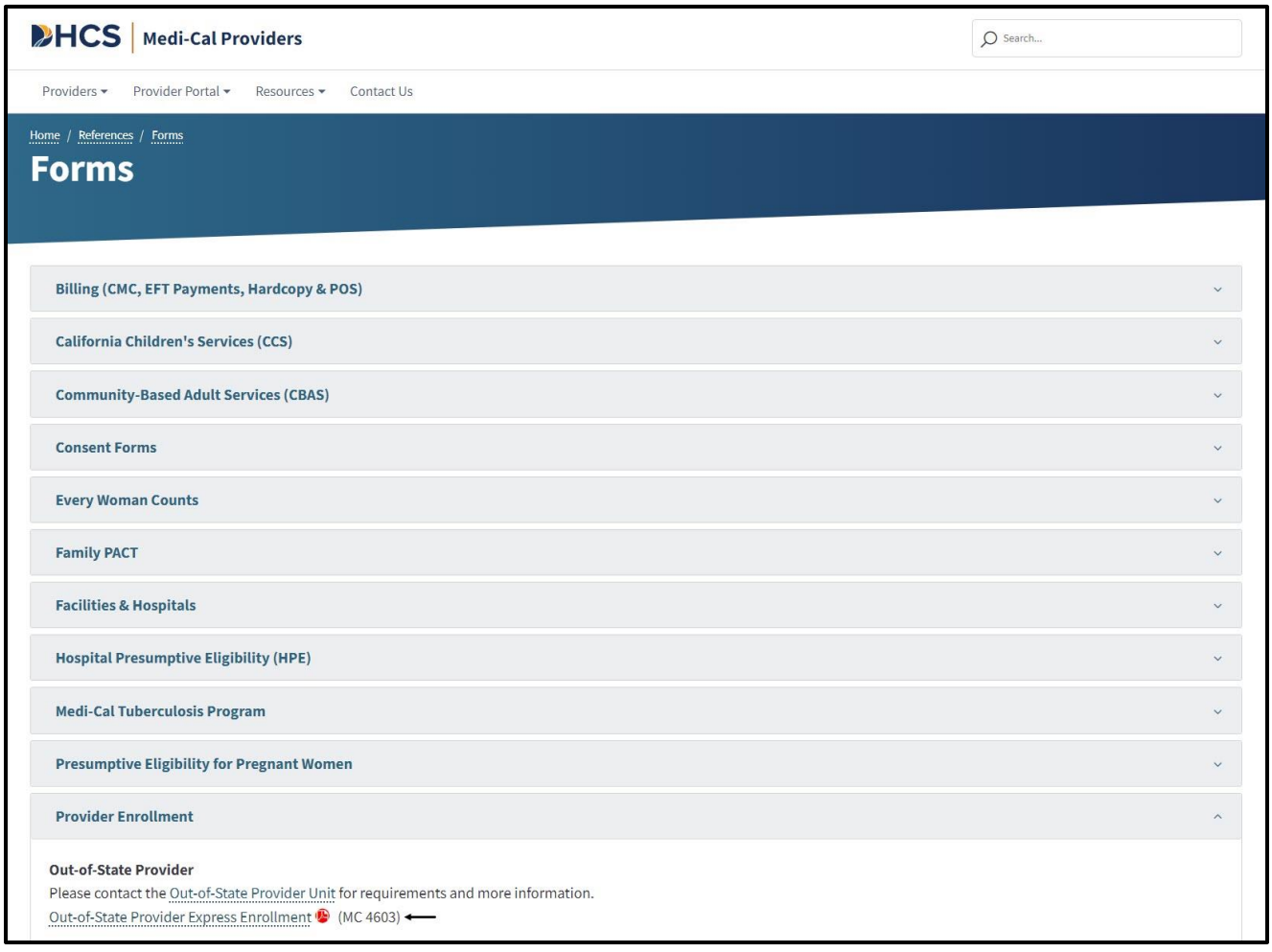

Figure 7.1: Out-of-State Provider Express Enrollment form (MC 4603)

To learn more about the out-of-state provider program or to access links to other out-of-state provider forms and agreements, review the Out-of-State Providers Frequently Asked Questions located in the FAQ section on the Medi-Cal Providers website. These FAQs are a one-stop resource for out-of-state providers and can be printed for future reference.

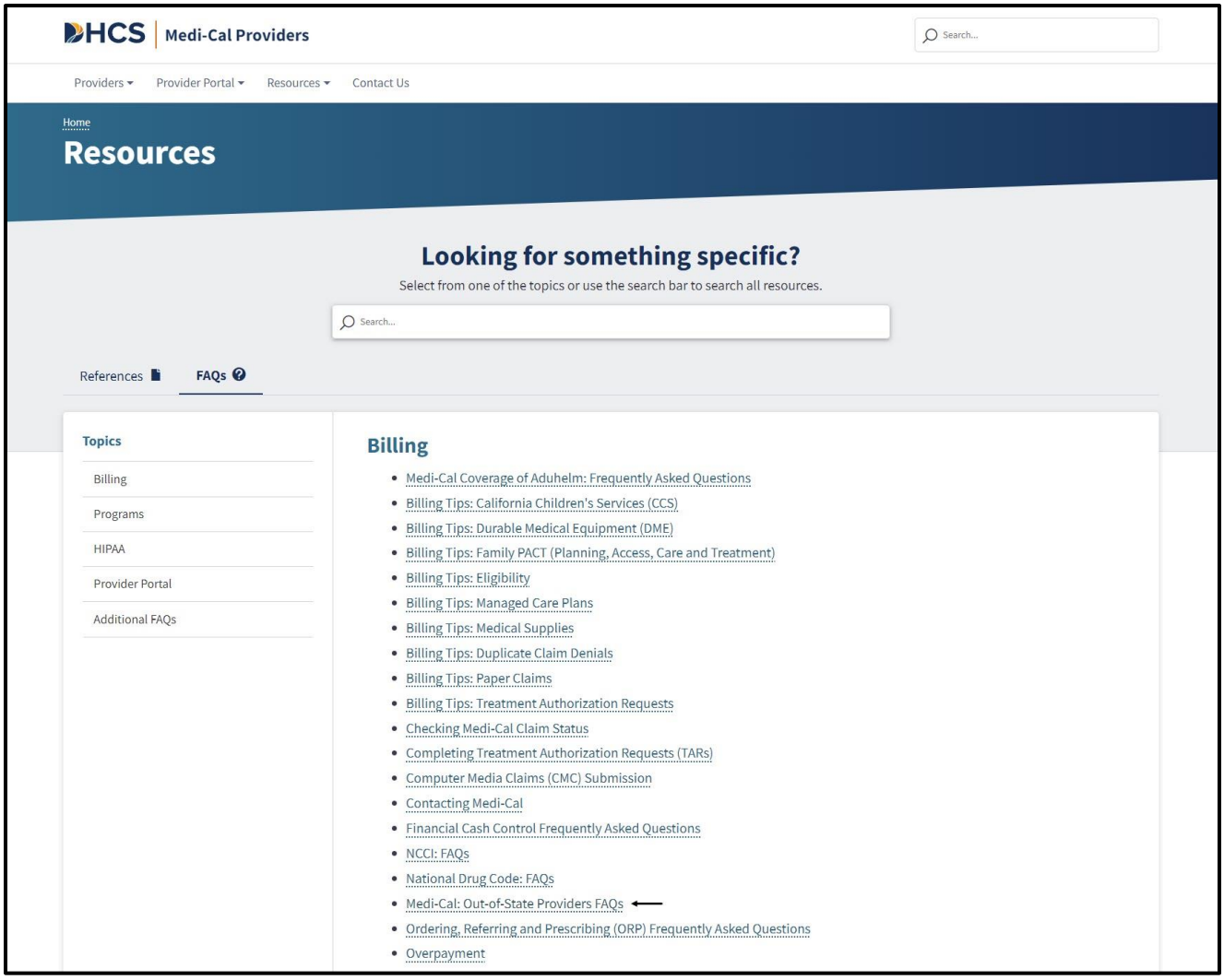

Figure 7.2: Medi-Cal Out-of-State Providers FAQs.

Border providers and out-of-state providers in need of billing assistance can call (916) 636-1960. Providers may be directed to a particular specialty unit for assistance. If you are an out-of-state biller calling on behalf of an in-state provider, call (916) 636-1200.

Financial Cash Control Unit (FCCU)

FCCU assists providers with questions regarding missing, lost or returned warrants, (RADs), A/R transactions, 1099s and provider refund checks. This unit also enrolls providers in EFTs and processes requests for Paid Claim Summary and Claims Detail Reports (CDR).

Providers are now able to utilize the Provider Financial Data Request Form (4520), when requesting financial data from the FCCU. Using this form will enable Providers to save time determining what is needed for questions regarding missing warrants, copies of RADs, accounts receivable transactions and copies of 1099's. This form can be found on the Medi-Cal Provider website. Select References from the Resources drop-down menu then navigate to Billing (CMC, EFT Payments, Hardcopy & POS).

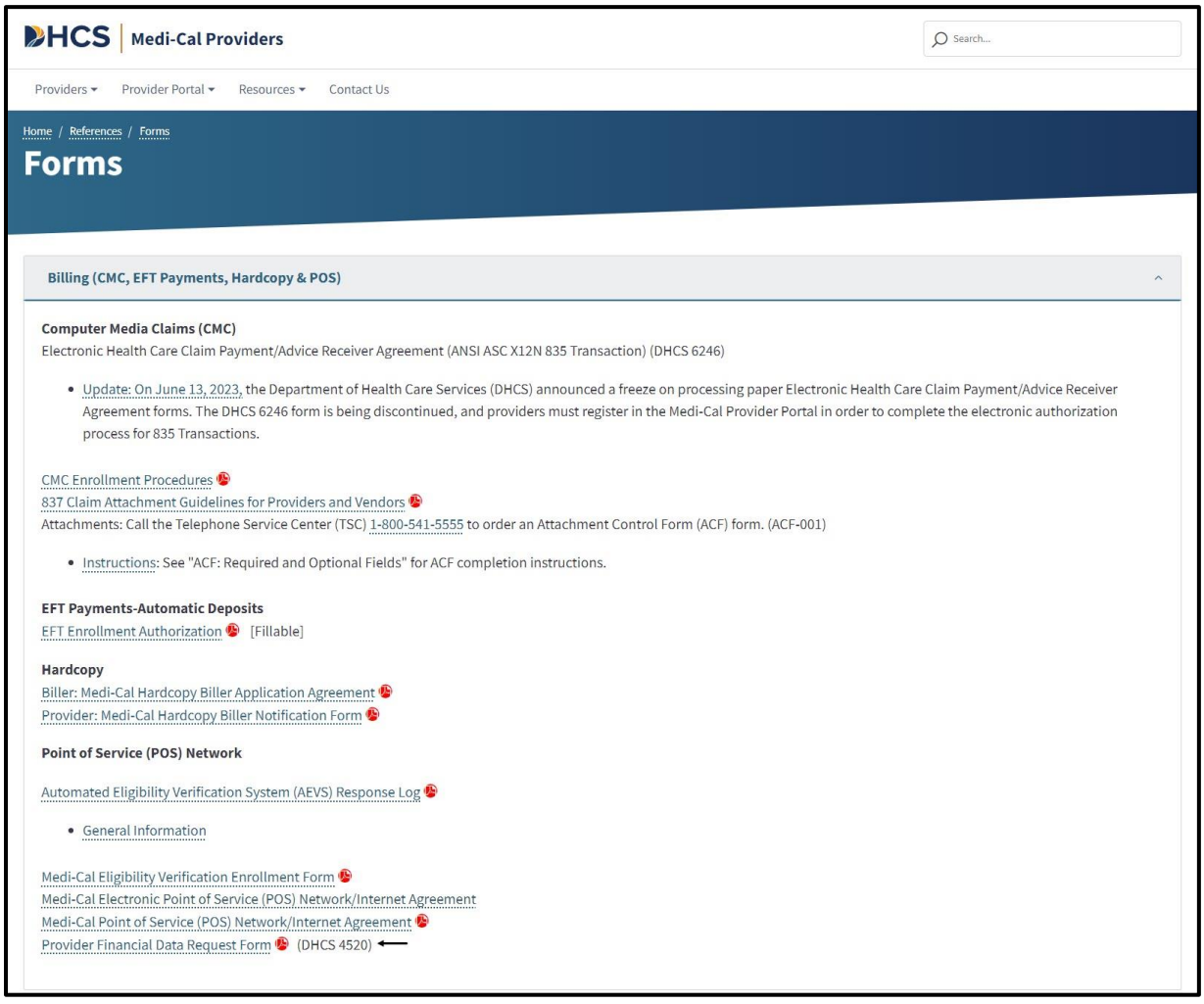

Figure 7.3: Provider Financial Data Request Form (DHCS 4520).

Providers reaching out to the FCCU for assistance with any of these services must complete the Provider Financial Data Request Form. Please note that each form may only contain a single request and must be filled out in its entirety including provider number, reason for request and signature to avoid delays due to missing information.

Mail the completed form to the following address:

California MMIS Fiscal Intermediary
Attn: Financial Cash Control Unit
P.O. Box 13029
Sacramento, CA 95813-4029

Resolution Process

When an issue has not reached satisfactory resolution, providers can escalate their issues/concerns within the PMSO leadership team. The appropriate team will review and confirm the issue/concern and work with DHCS as appropriate for resolution.

Resolution process flow

Step 1: Issue is identified.

- Once an issue has been identified by the provider, a call should be placed to TSC

The following outcomes can result in a resolution when an issue has been identified, TSC may recommend/refer the following:

- Complete CIF
- Complete Appeal
- Write to CSU
- Provider Field Representative visit

Step 2: If the above steps were completed and a resolution has not occurred, a provider may escalate the issue via any of the PMSO Unit leaders.

Step 3: PMSO leaders will review and confirm the issue.

Step 4: PMSO leaders will research and may collaborate with DHCS (if applicable) regarding the issue.

Step 5: Findings will be communicated to the provider with any action plan, if required.

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a subscription service, free of charge, which enables anyone to subscribe and receive links to Medi-Cal news, Medi-Cal Update bulletins and or System Status Alerts via email. For more information and subscription instructions, visit the Medi-Cal Provider website and click on MCSS.

MCSS subscribers can choose to receive one or more of the following:

- **Medi-Cal Update** – monthly bulletins containing the latest program and policy news.
- **Medi-Cal News** – news that is time sensitive, critical and/or affects a large number of subscribers.
- **System Status Alerts** – alerts related to current and/or future system outages.

References

The following reference materials provide Medi-Cal program, eligibility, billing and policy information.

Resource Information

Medi-Cal Providers website

- Provider Manuals
- Provider Bulletins
- Medi-Cal Subscription Service (MCSS)
- Medi-Cal Learning Portal (MLP)
- Telephone Service Center (TSC) 1-800-541-5555
- Provider Field Representatives
- Virtual Claims Assistance Room (VCAR)
- Small Provider Billing Assistance and Training 916-636-1275

Provider Manual References

Part 1

Claim Payment Flowchart (claim pay)
Electronic Fund Transfer (eft)
Getting Started: Where to Find the Answers (0C get start)
How to Use This Manual (0B hw to use)
MCP: An Overview of Managed Care Plans (mcp an over)
OBRA and IRCA (obra)
Other Health Coverage (OHC) *Guidelines for Billing* (other guide)
Provider Guidelines (prov guide)
Provider Guidelines: Billing Compliance (prov guide bil)
Provider Regulations (prov reg)
Provider Relations Directory (prov rel)
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit)
Remittance Advice Details (RAD) and Reconciling Medi-Cal Payment (remit and)
Remittance Advice Details (RAD): Electronic (remit elect)

Part 2

Medi-Cal Dental Program (denti)
Medi-Cal Dental Program for Inpatient and Outpatient Services (denti io)
Other Health Coverage (OHC) (other hlth)

Other References

Forms

Electronic Health Care Claim Payment/Advice Receiver Agreement (ANSI ASC X12N 835- Transaction) (DHCS 6246)

Medi-Cal Supplemental Changes (DHCS 6209)

"Pay-To" Address Change Notification (DHCS 6129)

Supplemental Claims Payment Information User Manual

Appendix

Acronyms

Acronym	Description
A&I	Audits and Investigations
A/R	Accounts Receivable
CA-MMIS	California Medicaid Management Information System
CCN	Claim Control Number
CCU	Cash Control Unit
CCR	California Code of Regulations
CDR	Claims Detail Report
CIF	Claim Inquiry Form
CMC	Computer Media Claims
CSU	Correspondence Specialist Unit
DHCS	Department of Health Care Services
DOJ	Department of Justice
E&M	Evaluation and Management
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
Family PACT	Family Planning, Access, Care and Treatment
FCCU	Financial Cash Control Unit
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center
IRCA	Immigration Reform and Control Act of 1986
MCP	Managed Care Plan
MCSS	Medi-Cal Subscription Service
MLP	Medi-Cal Learning Portal
MRN	Medicare Remittance Notice
NMP	Non-Physical Medical Practitioners

Acronym	Description
NPI	National Provider Identifier
OBRA	Federal Omnibus Budget Reconciliation Act of 1986
OHC	Other Health Coverage
OOS	Out of State
PED	Provider Enrollment Division
PMSO	Provider Member Service Organization
POS	Point of Service
PPBI	Policies, Procedures and Billing Instructions
PTN	Provider Telecommunications Network
RAD	Remittance Advice Details
RHC	Rural Health Center
SAR	Service Authorization Request
SCO	State Controller's Office
TAR	Treatment Authorization Request
TSC	Telephone Service Center
W&I Code	Welfare and Institutions Code

Enter Notes Here