

Healthy Families Code 19: Frequently Asked Questions

Patient Identification Number

Health centers are trying to bill Code 19 with the new ID/Client Identification Number (CIN) which begins with an eight and does not have an alphabetical character at the end. Health centers are getting rejections from both their clearinghouse and Medi-Cal.

Medi-Cal only accepts a CIN that begins with a nine and ends with an alphabetical character. Since the new CIN (which begins with the number eight) only contains eight digits, it will not be accepted.

Clinics are being required to submit a Benefits Identification Card (BIC) number, but they cannot always obtain all the BIC numbers, even when they call the plans. What are they supposed to do?

The way to use the patient's medical MCP ID number is to drop the first three alphabetical characters in front and use the numeric portion for the BIC ID. With the exception of Health Net patient ID numbers, Medi-Cal has asked the Managed Risk Medical Insurance Board (MRMIB) to determine if there could be a change to the system that would allow a means to accept Health Net patient ID numbers.

Please note that in the case of Healthy Families Code 19, which is retroactive to October 2009, it will be impossible to pull BIC numbers or CINs because only the latest year of plan data is accessible. Additionally, many of the San Diego clinics are no longer contracted with Health Net and thus, have no access to Health Net data.

FQHC Contact Information

Can the Telephone Service Center (TSC) agents respond to questions in regard to Federally Qualified Health Centers (FQHCs)?

Yes. The TSC agents recently received an updated telephone script in order to assist callers with frequently asked questions in regard to FQHCs.

Managed Care Payment Reductions

Are health centers' Code 19 payments being reduced by the amount already received by MCPs?

No. Health centers should receive their managed care payments plus their Code 19 rate for Healthy Families patients. Managed care payments are already calculated in the Code 19 rate. Providers will be paid the rate that has been established for Code 19 with no reduction. Inclusion of any amounts in Box 54 of the *UB-04* claim will result in a reduced Code 19 reimbursement. In the event that Code 19 only has \$1.00 as their rate, the provider will need to complete a Department of Health Care Services (DHCS) 3105 form and submit that to request a rate increase. When the provider submits the reconciliation report at the end of the fiscal year, the provider may be reimbursed for the additional money based on the rate for that fiscal year.

Delay in payments

Who may providers contact if they have not received payment on the following claim types?

- **Crossovers (paper)**
- **Inpatient (paper)**
- **Code 19 Healthy Families (HF) (electronic)**
- **Code 18 (wrap) (electronic)**

If a provider for a clinic has not received the appropriate claim payment(s), that provider may contact the TSC at 1-800-541-5555 and file a service request that will be assigned to either a Regional Representative or the Research Unit. The provider then will be given a service request number. If a provider does not receive a call back within 48 hours, the provider can contact the TSC in order to escalate their issue.

Who should a clinic contact for billing issues in regard to Code 19?

The first step for resolving any billing issues is to contact the TSC in order to create a service request. A service request is then assigned to either a Research Unit or a Regional Representative to assist the provider.

Who should a clinic contact for questions regarding electronic Remittance Advice (RA) and checkwrites?

A provider should contact the Computer Media Claims (CMC) Help Desk at 1-800-541-5555, option one for English. Providers should then select option one again, followed by options four and two. For a complete guide to TSC menu prompts, providers should visit the Medi-Cal website. Click the Contact Medi-Cal tab and select the *TSC Main Menu Prompt Options* under the Phone Support heading.

How can a clinic resolve an outstanding Accounts Receivable (A/R) issue that originated prior to ACS assuming operations and cannot be viewed on the Remittance Advice Details (RAD)?

Outstanding A/R questions should be directed to the Cash Control Unit at the following:

Attention: Cash Control
ACS
PO Box 13029
Sacramento, CA 95813-4029

Since ACS cannot provide patient eligibility via the phone when Transaction Services is down, how can a clinic obtain this information? Providers are no longer able to enter a patient's Social Security Number (SSN).

Providers should contact the Automated Eligibility Verification System (AEVS) at 1-800-456-2387. Providers may access *AEVS Menu Prompt Options* on the Medi-Cal website. Click the Contact Medi-Cal tab and select the *AEVS Menu Prompt Options* under the Phone Support heading.

How can a clinic request a provider enrollment update?

The California Primary Care Association (CPCA) should send specific questions to the Provider Enrollment Division (PED). All updates are posted on the Medi-Cal website. If there are specific questions for the PED, the CPCA or providers may send an email to the PED at: PEDcorr@dhcs.ca.gov.

For paper claims, should providers bill to the standard address (orange envelope) or to the Over-One-Year Unit?

Providers should bill to the following orange envelope address:

Medi-Cal Fiscal Intermediary
PO Box 15600
Sacramento, CA 95852-1600

Claims from Prior Periods

Timeliness—Claims Denied or Reduced Inappropriately

Health center claims are being denied or reduced when the claims are more than six months old. Since the health centers were unable to bill recently, is there a penalty?

There is no penalty. An Erroneous Payment Correction (EPC) has been implemented to override timeliness for Code 19.

Should providers submit paper claims for incorrect payments?

Providers do not need to resubmit their erroneously denied claims under Code 19.

What should a provider do to follow up on a denied or a lost claim?

Providers should contact the TSC. To follow up on a denied claim, providers should supply the Claim Control Number (CCN) that was denied. If the claim is lost, the provider will need to rebill the claim.

Will the submission of paper claims affect the EPC when it is implemented?

No. The submission of paper claims is not affected.

When the EPC is implemented, will health centers be required to submit paper claims or will they receive automatic reimbursements?

When the EPC is implemented, providers will receive an automatic reimbursement for the previously erroneously denied claims under Code 19 only. Providers do not need to resubmit claims in paper format for the erroneously denied claims.

For which timeliness issues would providers need to rebill paper claims?

Providers need not rebill claims. The EPC will reprocess underpaid, as well as denied claims.

Do health centers bill just for 2009 and 2010 claims or do they also bill for current claims that were incorrectly adjusted for timeliness?

Providers should not re-bill any Code 19 related claims.

When will ACS train on how to bill for Code 19?

Code 19 training is currently being developed. ACS will schedule and conduct training for Code 19. The specific date and time will be posted in a future Medi-Cal bulletin.



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