Medi-Cal Resources 101

Medi-Cal Provider Training 2019

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Medi-Cal Resources 101
The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP’s easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at http://www.medi-cal.ca.gov/education.asp.

**Free Services for Providers**

**Provider Seminars and Webinars**
Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

**Regional Representatives**
The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

**Small Provider Billing Unit**
The four SPBU Specialists are dedicated to providing 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 SPBU 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!
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Medi-Cal Resources 101

Introduction

Purpose

The purpose of this class is to provide an in-depth look at information that is 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 Relations Organization (PRO)
- 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 sections with more detailed information.

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

In addition, there are specialty program manuals (such as Family PACT Policies Procedures and Billing Instructions [PPBI]) that work in combination with the Medi-Cal Part 1 and Part 2 manuals for the purposes of outlining health care program policies and billing these specialty programs.

Provider manual sections are organized alphabetically and contain locator keys, and graphic tags.

The locator keys are an abbreviated form of the section title located at the top of the manual page to help identify information quickly.
Figure 2. Manual Page Elements.
Getting Started: Where to Find Answers

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

<table>
<thead>
<tr>
<th>Billing Overview</th>
<th>Share of Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient Eligibility</td>
<td>Medi-Services</td>
</tr>
<tr>
<td>Other Health Coverage</td>
<td>Claim Completion</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Remittance Advice Details</td>
</tr>
<tr>
<td>Authorization</td>
<td>Claims Follow-Up</td>
</tr>
</tbody>
</table>
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) in Part 1 of the 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 on the basis of 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 Department of Health Care Services (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 and Human Services; or their duly authorized representatives. In addition, 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 Treatment Authorization Request (TAR).
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.

Below is an Eligibility Response example.

![Eligibility Response Example](image)

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.
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 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 a 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: Part 1
MCP: An Overview of Managed Care Plans (mcp an over)

Denti-Cal vs Medi-Cal

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

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 Denti-Cal.

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

For more information on Denti-Cal refer to:
Denti-Cal Program (denti) Part 2 provider manual
Denti-Cal Program for Inpatient and Outpatient Services (denti io) 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 Denti-Cal Managed Care Plan, the clinic can render services and submit a claim to Medi-Cal.
Transaction Services

Utilizing the Provider Telecommunication Network (PTN) within Transaction Services will allow you to verify if a procedure code is allowed within the Medi-Cal Program and will assist in determining if a Treatment Authorization Request (TAR) is required.

You may also refer to specific sections of your provider manual for TAR requirements and/or the TAR and Non section in Part 2 of the provider manual.

In addition, PTN also provides the allowed amount and restrictions. Please refer to the "Medi-Cal Rates" section under the "References" tab of the Medi-Cal website.

To search a procedure/service code and determine coverage and whether an authorization is required, follow these steps:

1. Log into the "Transactions" section of the Medi-Cal Website using your National Provider Identifier (NPI) and PIN.

   **Note:** If you are not signed up for transaction services, you will not have this access.
2. Select the option for “Automated Provider Services (PTN)” from the Elig Tab.

3. From the screen below, select the option for “Perform Procedure Code Inquiry.”

4. When the procedure code screen populates, enter the code you are researching. For this example, we will use Evaluation and Management (E & M) code 99215.
5. The response screen that populates will show the description, the procedure code level, the procedure type, and the effective dates of the code. The response also tells you 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.

![Image of a table showing details for a medical code](image)

**99215 OFFICE/OUTPATIENT VISIT E**

<table>
<thead>
<tr>
<th>Procedure Level:</th>
<th>Procedure Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT4 code</td>
<td>Medicine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>End Date</th>
<th>Follow Up Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01/2000</td>
<td>12/31/2069</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Min Age</th>
<th>Max Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both</td>
<td>0</td>
<td>99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medi-Cal Max Allowable Amount</th>
<th>Split Bill professional percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$57.20</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

This procedure may be subject to a 20% reduction if performed in a hospital outpatient department or surgical clinic. No TAR or medi-reservation required.
Medi-Cal Rates

The Medi-Cal Rates feature can be found on the Medi-Cal website under the "References" tab.

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).

Navigating the Rates Section

On the Medi-Cal website, within the reference tab, the Medi-Cal Rates section contains a listing of procedure types found on the Medi-Cal Rates Information page, along with the rate/description of the procedure(s). To access this list, the following steps need to be taken:

1. From the Medi-Cal website select the References tab.

2. A list will appear with several options. Select the option that shows "Medi-Cal Rates."
3. **Important Payment Information** page will be displayed. Select either “Download All Medi-Cal Rates” or “View Medi-Cal Rates By Procedure Code”. In this example we have selected “View Medi-Cal Rates by Procedure Code.”

4. The Medi-Cal Rates Disclaimer appears allowing you to “Accept” or “Do Not Accept.” In order to obtain rates you must select “Accept.”
5. Once you have selected “Accept” the Medi-Cal Rates Range Display screen will populate with the available code ranges billable to Medi-Cal for the specified period. It is recommended that you select the "Notes to Rates" option first to identify your procedure type, however; if you know your procedure type, you may select the appropriate code range hyperlink.

6. If you have selected the “Notes to Rates,” a listing will appear containing “Procedure type” codes with the description of the procedure. This code will be used when viewing individual code rate.
Selecting a Rate to View

1. To view the rates for a specific procedure code from the "Medi-Cal Rates Range Display" screen, select the range for the code you are inquiring about.

2. When the "Medi-Cal Rates Information" is displayed, you can either scroll down to your code or use the "Control F" function to find your code.
3. When you select “Enter,” it will take you directly to your procedure code on the list. In the example below, the 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.

<table>
<thead>
<tr>
<th>Proc. Type</th>
<th>Proc. Code</th>
<th>Procedure Desc.</th>
<th>Unit Value</th>
<th>Basic Rate</th>
<th>Conv. Ind</th>
<th>ER Ind</th>
<th>Cut-back Ind</th>
<th>Prof %</th>
<th>Rental Rate</th>
<th>Non-Physn Med. Prac. Ind</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>10061</td>
<td>INCISION / DRAINAGE OF ABCESS; COMPLICATE</td>
<td>0</td>
<td>$0.00</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$0.00</td>
<td>Y</td>
</tr>
<tr>
<td>O</td>
<td>10061</td>
<td>INCISION / DRAINAGE OF ABCESS; COMPLICATE</td>
<td>0</td>
<td>$0.00</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>$0.00</td>
<td>Y</td>
</tr>
<tr>
<td>K</td>
<td>10061</td>
<td>INCISION / DRAINAGE OF ABCESS; COMPLICATE</td>
<td>$75.76</td>
<td>$75.76</td>
<td>42</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$0.00</td>
<td>Y</td>
</tr>
</tbody>
</table>
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 are able to 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 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 website, providers will be able to view and download current and historical PDF RADs and Medi-Cal Financial Summary documents on the Transaction Services page (https://www.medi-cal.ca.gov/eligibility/login.asp). Providers currently are able to view PDF RADs going back as far as April 2017. In the future, providers will only be able to access up to 3 years back in historical RADs. 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 in to 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
Electronic RAD:
The ASC X12N 835 transaction known as the Electronic Health Care Claim Payment/Advice form is available on the "Transaction Services" area of the Medi-Cal website (www.medi-cal.ca.gov). Providers and intermediaries log on to the Medi-Cal website to retrieve remittance advice information. The Medi-Cal website contains the 835 transactions generated for the last six weeks in individual, weekly files for each receiver (provider or intermediary). The 835 transactions are available on the Medi-Cal website by the Medi-Cal warrant date. Files older than six weeks will not be available. Receivers requiring older copies may obtain paper or PDF RADs.

PDF RAD:
Through the Medi-Cal website, providers will be able to view and download current and historical PDF RADs and Medi-Cal Financial Summary documents on the Transaction Services page (https://www.medi-cal.ca.gov/eligibility/login.asp). 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 its providers.

NOTE: Paper or PDF RADs are required for Claim Inquiry Form (CIF) and/or Appeals. Medi-Cal does not accept 835 as proof of timeliness.

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 = 3311502009
15 = 2015
020 = the 20th day of the year (January 20)

In this example, the checkwrite showing the original adjustment was issued on January 20, 2015.

If providers do not have RADs or access to them, a written request may be sent to the Cash Control Unit for copies of previous RADs. The written request must contain the National Provider Identifier (NPI), warrant number and warrant release date.
Electronic Funds Transfer (EFT)

Electronic Fund Transfer (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. The form must be submitted correctly with all of the proper documents attached.

To successfully apply for EFT, refer to the following instructions:

- An original pre-imprinted voided check for checking accounts or an original bank letter for savings accounts, must be submitted with the form. The provider name, routing number and account number on either of those documents must match what is entered on the form. A bank letter must be signed and dated by a bank representative.
- An NPI number must be valid and entered on the EFT form. Only one NPI number may be entered on each form.

**NOTE:** Enter a legacy number if you are an atypical provider.

- 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.
- The provider name on the form, the voided check and the Medi-Cal Provider Master File must match.

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 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.
- 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 Fiscal Intermediary (CA-MMIS 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.
• 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. However, effective July 1, 2008, 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 Relations Organization (PRO)

PRO is the primary liaison between the provider community and the Medi-Cal program. PRO 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 the Department of Health Care Services (DHCS), the CA-MMIS Fiscal Intermediary (FI), Medi-Cal providers and their associations
- Recommending improvements to increase provider satisfaction and participation in the Medi-Cal program

(PRO) is comprised of the following:

- Telephone Service Center (TSC)
- Correspondence Specialist Unit (CSU)
- Provider Field Representatives
- Small Provider Billing Unit (SPBU)
- 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 inquiries 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 Fiscal Intermediary (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 regional 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 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 Unit (SPBU):
SPBU is a full-service billing assistance 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. SPBU 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 SPBU 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), 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.

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 (FAQs). These FAQs are a one-stop resource for out-of-state providers and can be printed for future reference.

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).

Letters to FCCU must include the provider’s NPI for tracking purposes and should be addressed as follows:

California MMIS Fiscal Intermediary
Attn: Cash Control
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 PRO 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 PRO Unit leaders.

Step 3: PRO leaders will review and confirm the issue

Step 4: PRO 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 free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, Medi-Cal Update bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

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

Educational Resources

Medi-Cal Learning Portal (MLP)
- Computer Based Training (CBT)
- Instructor-Led Training (ILT)
- Seminars
- Webinars
  - Live & Recorded
- Tutorials

Training Services
- Provider Field Representative
- Small Provider Billing Unit (SPBU) 916-636-1275
- Telephone Service Center (TSC) 1-800-541-5555
  - Billing Questions
  - Provider Enrollment Assistance
  - Provider Field Representative Referrals
Provider Manual References

Part 1
Claim Payment Flowchart (claim pay)
Electronic Fund Transfer (eft)
Getting Started: Where to Find the Answers
How to Use This Manual
MCP: An Overview of Managed Care Plans (mcp an over)
Manual Organization
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): Electronic (remit elect)
Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit)
Remittance Advice Details (RAD) and Reconciling Medi-Cal Payment (remit and)

Part 2
Denti-Cal Program (denti)
Denti-Cal 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)
SCPI User Manual
Medi-Cal Point of Service (POS) Network/Internet Agreement