Claim Payment Flowchart

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This step-by-step guide to getting paid for Medi-Cal services is not designed to be all inclusive. Refer to the provider manual index for information about the specific steps outlined below.

Step 1: Determine If Recipient Is Eligible For Medi-Cal And For What Services.

Using the information on the recipient's ID card, access the eligibility verification system through one of the following methods:

- AEVS
- Internet Eligibility
- Internet Batch Eligibility Application (IBEA)
- State-Approved Vendor Software

The eligibility verification system will show if the recipient:

- Is eligible for all Medi-Cal services (full-scope coverage)
- Is eligible for limited scope coverage (see aid code)
- Qualifies for County Medical Services Program services
- Is a member of a managed care plan (refer to Managed Care Section in Medi-Cal Part 1 manual)
- Has Other Health Coverage (OHC) or Medicare
- Qualifies for special program services
- Is required to pay a Share of Cost

Step 2: Determine If Recipient Must Draw On Other Benefits Before Medi-Cal.

If the recipient has Other Health Coverage (OHC), Medicare or is a member of a Medi-Cal managed care plan, determine if the recipient must use those benefits before Medi-Cal, or must receive services from a specific provider network. Refer to the Other Health Coverage and Managed Care sections of the Medi-Cal Part 1 manual.

Providers must bill Other Health Coverage (OHC) carriers and/or Medicare before billing Medi-Cal.

Step 3: If Recipient Is Medi-Cal Eligible, Determine If Services Are Medi-Cal Benefits.

Refer to provider-specific Medi-Cal Part 2 manuals to identify Medi-Cal benefits. The following lists may be helpful:

- *Medical Supplies*
- Medi-Cal List of Contract Drugs
- *Incontinence Medical Supplies*
- MAIC and FUL List
- TAR and Non-Benefit List
- Injections: Code List

Step 4: Determine If Services Require Authorization.

Refer to provider-specific Medi-Cal Part 2 manuals to determine if service requires authorization.

Step 5: Clear Share Of Cost (SOC), If Applicable.

Providers cannot be reimbursed until SOC is certified (completely cleared) online. Refer to SOC in provider-specific Medi-Cal Part 2 manuals.

Step 6: Reserve A Medi-Service, If Applicable, And Render Service(s). (Refer To Provider-Specific Medi-Cal Part 2 Manuals.)

Reserve a Medi-Service before billing for the following services:

- Acupuncture
- Audiology
- Psychology
- Chiropractic
- Occupational Therapy
- Podiatry
- Psychology
- Speech Pathology

Step 7: Bill Medi-Cal For Service(s) Rendered. (Refer To Provider-Specific Medi-Cal Part 2 Manuals.)

Step 8: Review Remittance Advice Details (RAD) And Check Claim Payment Status.

Reconcile payments and denials to records. Check that each claim for that pay period (checkwrite) was appropriately paid.

Step 9: Follow-Up On Denied Or Inappropriately Paid Claims, Including:

- Rebill denied claim, if claim is being resubmitted within the six-month billing limit.
- Submit Claims Inquiry Form to adjust payment, request reconsideration of a denied claim or to trace a claim.
- Submit appeal for adjustment of a paid claim or reconsideration of a denied claim.

‹‹Legend››

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

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.